MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 2nd October 2025**
Time: **09:00 – 12:50**
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 – A Patient's ICU battle with flu - Why the jab matters** Phil Bolton, Chief Nurse, and Phaedra Kay, Department Lead in Adult Critical Care Unit (ACCU)	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 7th August 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	**Acting Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	09:45	**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** • **Learning from Deaths** Report of the Chief Medical Officer	Assurance Assurance	Enclosure 9.1 Enclosure 9.2
10.	10:05	**Strategic Objective 2 – Empower and support our people to be the best they can be** • **Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual report** Report of the Chief Nurse (presented by the Associate Director of Nursing Workforce)	Assurance	Enclosure 10.1

	Time	Item	Status	Paper
		• **Guardian of Safe Working** Report of the Chief Medical Officer	Assurance	Enclosure 10.2
		• **Freedom to Speak up (FTSU)** Report of FTSU Guardian	Assurance	Enclosure 10.3
11.	10:50	**Strategic Objective 3 - Improve health and wellbeing within our communities** • **Flu Annual Checklist** Report of the Chief People Officer	Assurance	Enclosure 11.1
12.	11:00	**Strategic Objective 4 – Continuously learn and improve** • **Research Report** Report of the Chief Nurse (presented by the Head of Research and Innovation)	Assurance	Enclosure 12.1
		• **NHS Impact** Report of the Chief Medical Officer	Assurance	Enclosure 12.2
	BREAK (10 mins)			
	Operational			
13.	11:30	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 13
14.	12:10	**Winter Plan** Report of the Chief Operating Officer (presented by Mark Bolton, Associate Director of Operational Performance)	Approval	Enclosure 14
	Governance			
15.	12:20	**Board Assurance Framework** Report of the Acting Chief Executive	Assurance	Enclosure 15
16.	12:25	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting)	Assurance	Enclosure 16.1
		• Finance Committee Report of the Committee Chair (last meeting)	Assurance	Enclosure 16.2
		• Quality Committee Report of the Committee Chair (last meeting)	Assurance	Enclosure 16.3
		• People Committee Report of the Committee Chair (last meeting)	Assurance	Enclosure 16.4
17.	12:45	**Spotlight on – The one beat cardiac CT - Revolutionising heart scanning**	Assurance	Presentation
18.	12:50	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
19.	12:55	**Any Other Business**		

	Time	Item	Status	Paper
20.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **4th December 2025, 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 15 **Enc 16.1** **Enc 16.2** **Enc 16.3** **Enc 16.4**	• **Significant Risks Summary** • **Audit and Assurance Committee – previous minutes** • **Finance Committee – previous minutes** • **Quality Committee – previous minutes** • **People Committee – previous minutes**

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 7th August 2025, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Chair	GW
	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
	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
	Shantell Miles	Director of Nursing	SM
	James Thomas	Deputy Chief Medical Officer	JT
In Attendance:	Debbie Kearsley	Deputy Chief People Officer	DK
	Leanne Featherstone	People Promise Manager	LF
	Paula Shore	Director of Midwifery	PS
	Claire Hinchley	Director of Strategy and Partnerships	CH
	Mark Bolton	Associate Director of Operational Performance	MB
	Clare Jones	Minutes	
	Olivia Bower	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Claire Page	360 Assurance	
	Philip Marsh		
	No members of the public		
Apologies:	Jonathan Van Tam	Associate Non-Executive Director	JVT
	Steve Banks	Vice Chair	SB
	Barbara Brady	Non-Executive Director	BB
	Simon Roe	Chief Medical Officer	SR
	Phil Bolton	Chief Nurse	PB

Item No.	Item	Action	Date
25/158	**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.		
25/159	**DECLARATIONS OF INTEREST**		
2 mins	GW noted changes to his role with Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. MG noted addition to her role with Milton Keynes Integrated Care Board (ICB). Both declarations were acknowledged, and updates were confirmed to be made to the register. There were no other declarations of interest.		
25/160	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Jonathan Van Tam - Associate Non-Executive Director, Steve Banks – Vice Chair, Barbara Brady – Non-Executive Director, Phil Bolton – Chief Nurse and Simon Roe – Chief Medical Officer. It was noted Shantell Miles was attending the meeting deputising for the Chief Nurse and James Thomas deputising for the Chief Medical Officer.		
25/161	**STAFF STORY – THE PEOPLE PROMISE**		
8 mins	DK and LF joined the meeting. DK and LF introduced the Patient Story, which highlighted the Trust's involvement in a national People Promise programme aimed at improving staff wellbeing, safety, and retention. Key initiatives included flexible working, sexual safety, violence prevention, and support for veterans. The Trust has received national recognition, including award nominations and invitations to present at NHS events. The Board of Directors praised the video presentation and the passion shown by staff. No concerns or actions were raised. DK and LF left the meeting.		
25/162	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 5th June 2025, the Board of Directors APPROVED the minutes as a true and accurate record.		

25/163	**MATTERS ARISING/ACTION LOG**		
2 min	The Board of Directors AGREED that actions 25/054, 25/094 and 25/132 were complete and could be removed from the action tracker.		
25/164	**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. GW welcomed SI as the new Chief Operating Officer to the first public meeting and acknowledged the contributions of those who previously covered the role. The appointment of a new substantive Chief Executive was announced, with a start date of 27th October 2025 and interim engagement planned. The recruitment process was described as highly competitive. Thanks were extended to DS as Acting Chief Executive for leadership during a challenging period. A fuller tribute was deferred to the next meeting. Changes to Board roles were confirmed, with the Vice Chair stepping down and a new appointment made. The upcoming Annual General Meeting (AGM) on 16th September 2025 was noted, with encouragement to all to attend and engage. Trust volunteers were recognised for contributing 9,000 hours, and the generous donation of £50,000 from the Daffodil Café was noted. A suggestion was made to invite café volunteers to a future board meeting. The launch of the charity lottery and the upcoming abseil fundraising event were highlighted. A recent 15 Steps visit to Ward 22 was described positively, with reflections on staff engagement and patient care. The Board of Directors were ASSURED by the report.		
25/165	**ACTING CHIEF EXECUTIVE'S REPORT**		
8 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. DS provided updates on national and local developments. A workforce workstream supporting the NHS 10-year plan was underway, with outputs expected by mid-September 2025. Locally, the Trust faced significant disruption due to renewed industrial action by the British Medical Association (BMA), with an 84% absence rate among resident doctors. Emergency and inpatient services were prioritised, but elective procedures were impacted. The Trust anticipated being placed in segment three under the delayed new segmentation framework due to financial criteria.		

	The Mutually Agreed Resignation Scheme (MARS) had closed with 88 applications, and decisions were expected shortly. Progress continued on digital transformation, including partnerships for Electronic Patient Records (EPR) and ambient Artificial Intelligence (AI). Additional updates included the opening of the Macmillan Cancer Centre in Newark, student-led design of a commemorative garden, and continued support for veterans. The communications team was praised for refreshing the Trust intranet and internet. The Board of Directors were ASSURED by the report.		
25/166	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
15 mins	PS joined the meeting **Maternity Update** PS presented the July 2025 scorecard, confirming performance was within guidance. A cluster review showed no major themes but highlighted communication gaps, particularly around altered foetal movements in underserved areas. Recruitment was strong, with 10.8 midwives, 4 maternity support workers, and a consultant midwife appointed. Matron interviews were underway. Three short unit diversions occurred in July 2025 due to acuity and capacity, with no harm reported. Affected patients received personal apologies. ***Safety Champions update*** PS highlighted safety walkarounds which focused on antenatal clinics and ward staffing, with positive feedback. A joint working group was formed to prepare for the Respiratory Syncytial Virus (RSV) vaccination rollout. An insight visit by regional and Local Maternity System (LMS) teams found Sherwood to be a positive outlier in nine of twelve domains. A published smoking cessation study by a retired team member had been recognised nationally. ***Maternity Perinatal Quality Surveillance Model*** Neonatal staffing support was strengthened through clinical educator funding. The Trust achieved silver awards for both the Bliss and Baby Friendly Initiative standards and is aiming for gold. LM raised concern in terms of red flags and staffing resilience. PS confirmed that red flags were tracked every four hours. The highest red flag related to induction of labour, which would be a focus for planned care improvements. Staff coping mechanisms were discussed, including escalation policies, regional coordination, and support from specialist and matron teams. PS noted that staffing levels had improved significantly, with fewer missed breaks and overtime.		

	NM praised the calm and professional environment during busy periods. DS referenced the recruitment of 160 applicants, including many trained internally which was highlighted as a strength. GW suggested submitting a charitable funds case to support a milk preparation room, which was identified as the only barrier to achieving gold standard in infant feeding. LM queried upstream education for expectant parents, which was confirmed by SM to be already in progress. The Board of Directors were ASSURED by the report. PS left the meeting.		
25/167	**STRATEGIC OBJECTIVE 6 – WORK COLLABORATIVELY WITH PARTNERS IN THE COMMUNITY**		
27 mins	CH joined the meeting. **Fit for the Future – The 10-year plan** CH presented a high-level overview of the NHS 10-Year Plan, published in July 2025. The plan was described as a major shift from outdated hospital-centric care to community-based, preventative, and digitally enabled services. Key themes included integrated neighbourhood health teams, personalised care via the NHS app, and a focus on narrowing health inequalities. The plan also emphasised patient empowerment, transparency, and outcome-based funding. The presentation outlined nine chapters, covering areas such as digital transformation, workforce reform, and acute care redesign. The Trust's strategy was said to align well with the national plan, particularly in neighbourhood care, partnerships, and sustainability. An application had been submitted to join a national programme for neighbourhood health working. Board members raised several questions and reflections. MG queried whether the Trust's strategy should be more explicit about patient voice, noting the plan's emphasis on rebuilding public trust. CH agreed and described current engagement efforts, including coffee chats and collaboration with voluntary and council partners. The need for consistent feedback mechanisms across services was also acknowledged. DS highlighted the NHS's continued focus on complaints rather than positive feedback. It was then noted that patient-reported outcome measures were limited to hip and knee replacements, with low response rates. Plans to expand across specialties were discussed. MG requested a clear strategic narrative around patient experience and satisfaction, which was agreed as a priority. ARB enquired whether the Trust had identified the resources needed to deliver the plan. CH confirmed that resource planning would follow the release of delivery chapters in autumn. ARB made the suggestion to use Newark and Mansfield sites to pilot neighbourhood health models.		

	CH supported this, with confirmation that initial strategic development work was underway. NM raised concern about the financial implications of delivering the plan, especially the prevention agenda. GW noted that prevention had long been discussed but under-delivered, DS stated that narrowing the healthy life expectancy gap would require significant partnership working to deliver a 10-year health plan. GW concluded that the plan was welcomed and aligned well with the Trust's direction. The flexibility of the plan was seen as an opportunity to shape local delivery through strong partnerships. The Board of Directors were ASSURED by the report. CH left the meeting.		
25/168	**INTEGRATED PERFORMANCE REPORT (IPR)**		
50 mins	DS introduced the Integrated Performance Report covering June 2025, structured around four domains: quality of care, people and culture, timely care, and best value care. The report included enhanced benchmarking and a new data quality assurance column, which showed red indicators due to audit processes rather than data accuracy concerns. **QUALITY CARE** SM presented the report. Concerns were raised about Clostridioides difficile (C. diff) rates and a reported Methicillin-resistant Staphylococcus aureus (MRSA) case. The Trust had implemented actions including antibiotic stewardship, environmental audits, and reinforced training. A never event involving patient misidentification was under investigation, with immediate communications issued to staff. MG queried whether any root causes had been missed. SM confirmed that all known causes had been addressed and that regional partners were consulted for further insight. SM explained the deep clean process. GW requested a trajectory for C. diff and Venous Thromboembolism (VTE) performance to support assurance, which was agreed. **Action: To provide a trajectory for Clostridioodes difficile (C. diff) and Venous Thromboembolism (VTE) performance.** **PEOPLE AND CULTURE** RS presented the report; positive trends were reported in turnover, mandatory training, and appraisals. The Trust achieved its lowest-ever bank usage and improved compliance with the agency price cap. Two new metrics were introduced: time to hire and medical job planning, both showing strong performance. However, sickness absence remained above target at 4.9%, though below the national average.	**PB**	**02/10/25**

	MG queried whether agency use was being flexibly managed. RS and JT confirmed that decisions were guided by cost comparisons and workforce familiarity. RS referenced the ultimate aim to recruit substantively. ARB questioned the 9.5% vacancy rate. RS explained that some vacancies were linked to transformation programmes and digital processes and that some may be non-essential. The need to reset budgets and distinguish between active and suppressed vacancies was discussed. A discussion then took place in terms of the logistics of a regional bank and sickness absence rates and the plans in place to mitigate. **TIMELY CARE** SI presented the report; urgent care performance remained strong, with 77% of patients seen within four hours and ambulance handovers well managed. However, July 2025 performance had declined. Elective care performance was at 64%, reporting slightly below plan but the best in two years. The 52-week wait target was on track. Diagnostics performance was at 88%, with 'echo' services under review. Cancer performance showed improvement, with 76% of patients diagnosed within 28 days and a reduced 62-day backlog. MG queried cancer recovery and transformation plans. SI confirmed that tumour site plans were in place, with further oversight and histopathology improvements in progress. LM expressed concern in terms of patients waiting beyond targets, which SI acknowledged. The need for better tracking and patient flow was emphasised. **BEST VALUE CARE** RM presented the report; the Trust reported a £1.8 million deficit at the end of quarter 1, in line with plan. However, there was a £2.8 million shortfall in efficiency savings and reduced elective income. These were offset by non-recurrent budget flexibilities. Bank and agency spend were significantly lower year-on-year. Cash flow remained stable, though better payment practice performance required improvement. Risks included ongoing industrial action and contractual uncertainties. RC noted the importance of managing both revenue and cost pressures, especially with potential disruptions from strikes. RC raised a final question in terms of whether the IPR would evolve to reflect the NHS 10-Year Plan. DS confirmed that current metrics aligned with operational plans and would evolve as national segmentation and transparency frameworks developed. The Board of Directors were ASSURED by the report.		

25/169	**DRAFT WINTER PLAN**		
16 mins	MB joined the meeting. SI introduced the draft Winter Plan, commending MB in terms of the work undertaken and highlighting key areas of development. MB presented the draft Winter Plan, developed collaboratively across divisions and corporate teams. The plan built on lessons from previous years and was structured using emergency management principles. It remained in draft form pending system-level and regional stress tests scheduled for August and September 2025. A final version would be submitted in October 2025, alongside a required NHS Board Assurance Statement. Key modelling assumptions included maintaining 96% bed occupancy, avoiding elective cancellations, and introducing a decant ward in summer and surge ward in winter. The plan forecasted a peak residual bed deficit of 10 beds in January 2026. A major mitigation was the expansion of the acute frailty unit, which would require reconfiguration of same-day emergency care and day case services. This was expected to reduce medical outliers and support elective orthopaedic activity. LM queried ambulance handover pressures and upstream interventions. MB confirmed that the Trust had a “call before you convey” system with high success rates, though usage needed improvement. Work was ongoing with East Midlands Ambulance Service (EMAS) to increase engagement. JT noted that primary care partners were involved in similar triage initiatives. ARB emphasised the importance of maintaining elective activity, particularly for income protection, then enquired in terms of bed optimisation across sites. MB confirmed that Mansfield Community Hospital was well utilised, and further work was underway to improve use of Newark beds and transfer appropriate elective procedures. LM queried the potential use of virtual wards. MB confirmed that they remained part of the plan, with modest expansion planned. MG referenced best practice from another Trust and offered to share insights. MG then queried flu vaccination targets. RS confirmed that a 5% improvement target was set, with revised incentive strategies in place. MG finally addressed system-wide engagement. MB confirmed that the Integrated Care System (ICS) winter delivery group was meeting regularly, with all partners contributing plans. The system submission to NHS England was underway, and the Trust’s organisational plan would feed into this. The Board of Directors APPROVED the progress made and recognised the next steps required before final submission. MB left the meeting.		

25/170	**WEL LED ACTION PLAN REVIEW**		
5 mins	SBS presented an update on the Well Led Action Plan, originally developed following the February 2025 review by Grant Thornton LLP. The report focused on progress made against its 33 actions, with particular emphasis on those related to Freedom To Speak Up. The Board was asked to approve the sign-off of two actions from the unitary board section and four actions from the Freedom to Speak Up section, which had already been reviewed and recommended by the People Committee. It was proposed that the remaining actions be completed by the end of the financial year, rather than extending into 2026 as previously planned. A further update would be brought to the December 2025 meeting, with final reporting in April 2026. SBS confirmed that all Freedom To Speak Up referrals for the current year had been successfully migrated to the new database. A centralised record of evidence supporting action sign-off would be maintained to ensure transparency and readiness for future inspections. The Board of Directors APPROVED the recommendations.		
25/171	**USE OF THE TRUST SEAL**		
1 min	SBS presented the report which confirms the Trust Official Seal has been affixed to the following document, in accordance with Standing Order 10 and the Scheme of Delegation: • Seal number 121 was affixed to a document on 13th June 2025 between Sherwood Forest Hospitals NHS Trust (Trust), Central Nottinghamshire Hospitals PLC (Project Co) and AECOM Limited (External Consultant). The document related to a Letter of Appointment of Electrical Consultant (relating to electrical compliance requirements at KMH, MCH and Newark) The Board of Directors NOTED the use of Trust Seal number 121.		
25/172	**FIT AND PROPER PERSON**		
4 mins	SBS provided an update on the Trust's compliance with the Fit and Proper Person Test. The annual checks had been completed for all board members, including deputies, and recorded in the mandated Electronic Staff Record (ESR) system. Verification was carried out by the Chair and the Senior Independent Director, with cross-checking to ensure independence in the process. The submission was made on 9th June 2025 and had been acknowledged by the National Coordinating Centre. An internal audit had also been completed, providing significant assurance. Two low-level recommendations were noted: one to confirm an individual's professional registration status and another to check the Charity Commission register of disqualified trustees. Both actions had been completed and signed off by internal audit. The Board of Directors were ASSURED by the report.		

25/173	**DATA SECURITY PROTECTION TOOLKIT SUBMISSION**		
2 mins	SBS presented the annual submission of the Data Security Protection Toolkit. The toolkit is a mandatory self-assessment used to demonstrate compliance with data protection and cyber security standards. This year's submission incorporated new requirements aligned with the National Cyber Assessment Framework, which increased the complexity of evidence gathering. The final submission was made on 30th June 2025, with the Trust achieving a rating of "standards met." An internal audit was also completed, providing significant assurance. Four low-risk areas were identified, primarily relating to policy updates, which were attributed to operational pressures. These actions were already being addressed. The Board of Directors were ASSURED by the report.		
25/174	**ASSURANCE FROM SUB COMMITTEES**		
10 mins	**Audit and Assurance Committee** The Audit and Assurance Committee reported a productive session with detailed discussions on counter fraud and external audit progress. One concern was noted regarding capital scheme actions, which were referred to the Finance Committee. The Board of Directors were ASSURED by the report. **Finance Committee** The Finance Committee reviewed productivity metrics and contracting arrangements with the ICB. A reduction in risk for the (Magnetic Resonance Imaging) MRI programme was noted. No questions were raised. The Board of Directors were ASSURED by the report. **Quality Committee** The Quality Committee discussed cancer performance, histopathology delays, and a recent never event. Assurance was provided on recovery plans and equipment investment. Concerns about mental capacity and Deprivation of Liberty Safeguards (DoLS) compliance were noted as ongoing issues. The committee will continue to monitor these areas. The Board of Directors were ASSURED by the report. **People Committee** The People Committee focused on the impact of financial pressures and industrial action on staff and patient care. Positive assurance was given on the Trust's violence prevention work, which had been showcased nationally. A new governor observer was welcomed, and the "hot topic" format was praised. The Board of Directors were ASSURED by the report.		

	Partnerships and Communities Committee The Partnerships and Communities Committee held a detailed discussion on the NHS 10-Year Plan, noting strong alignment with the Trust's strategy. Concerns were raised about the effectiveness of quality impact assessments by partners. The Trust had submitted an application to join the pilot national neighbourhood health programme and signed a memorandum of understanding with Nottingham Trent University. The Board of Directors were ASSURED by the report. **Charitable Funds Committee** The Charitable Funds Committee discussed long-term planning and grant opportunities. The Daffodil Café's £50,000 donation was acknowledged. Updates were provided on the upcoming abseil event and charity lottery, both showing strong engagement. The Board of Directors were ASSURED by the report		
25/175	**SPOTLIGHT ON – THE PARKINSON'S GROUP AT MANSFIELD COMMUNITY HOSPITAL (MCH)**		
8 mins	A short video was played highlighting the work of The Parkinson's Group at Mansfield Community Hospital. Board of Directors responded positively. LM shared a personal story about a family member with Parkinson's and reflected on the stigma and lack of support in earlier years. SM commented on the multidisciplinary nature of the programme and its impact on mental health and wellbeing. The clinical lead's passion and leadership were praised, and the initiative was described as a model that could be replicated nationally. A discussion followed in terms of the broader definition of prevention. It was noted that while Parkinson's cannot be prevented, early support and education can significantly improve quality of life. The programme was seen as an example of holistic care and a strong candidate for future funding and expansion.		
25/176	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Parkinson's Group video • People Promise video • Appointment of Chief Executive and step-down of Acting Chief Executive • Vice Chair appointment • Volunteers and charity work • MARS process and organisational impact • Trust AGM 16th September 2025, 5.30pm • Clinical Diagnostic Centre (CDC) drop-in session 13th August 2025, 10.00am – 2.00pm		

	• NHS 10-year Plan • Operational and performance challenges referred to within the IPR		
25/177	**ANY OTHER BUSINESS**		
1 min	No other business was raised.		
25/178	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 2nd October 2025 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:07.		
25/179	**CHAIR DECLARED THE MEETING CLOSED**		
	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.

25/145	**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.		
25/146	**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.		

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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
25/129	05/06/2025	Deep dive into third and fourth degree tears to be presented to Quality Committee later in the year, once work completed by consultant midwife	Public Board of Directors	Quality Committee	TBC	P Bolton	P Shore		Grey
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			Grey
25/168	07/08/2025	To provide a trajectory for Clostridioodes difficile (C.diff) and Venous Thromboembolism (VTE) performance.	Public Board of Directors	None	02/10/2025	P Bolton		**Update 25/09/2025** Included in relevant section of Integrated Performance Report (IPR) **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:**	2nd Oct 2025
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Graham Ward, Chair		
Presented By:	Graham Ward, Chair		

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

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

AGM = Annual General Meeting
AMM = Annual Members' Meeting
CARE = Compassion, Accountability, Respect, Excellence
NHS = National Health Service
NUH = Nottingham University Hospitals
PR = Principal Risk
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.

Thanking our Acting Chief Executive

I will start this month's report by paying tribute to the Trust's Acting Chief Executive, Dr David Selwyn, in what will be his final public meeting of our Trust Board of Directors.

Dave announced his plans to step-down from the role to explore new opportunities beyond the NHS at our public meeting of the Trust's Board in August.

I have worked with Dr Selwyn for just over six of his 40-plus years in the NHS and would like to place on record my thanks to Dave for his exemplary leadership during that time.

During his most recent years with the Trust, he has helped to lead us through some of the most challenging periods in its recent history, including the Covid pandemic, unprecedented periods of industrial action and leading the organisation following the untimely passing of our former Chief Executive, Paul Robinson, earlier this year.

His leadership has helped me immeasurably, as well as bringing much-needed stability to the Trust. During that year, he has delivered the first year of our new *Improving Lives* strategy, all while managing the operational and financial challenges we are seeing across the whole of our NHS.

We thank him for his dedication throughout his time here at Sherwood and within the wider NHS.

Trust hosts Annual General Meeting (AGM) and Annual Members' Meeting (AMM)

The Trust's Annual General Meeting and Annual Members' Meeting was held on Tuesday 16th September in the Education Centre at King's Mill Hospital.

The meeting welcomed dozens of Trust partners, governors, public members of the Trust, and members of the public to learn more about the Trust's achievements, performance and challenges from over the 2024/25 financial year gone by.

The AGM was preceded by a public *Improving Lives* event where attendees learned more about the Trust's services and future plans, as well as giving feedback to help shape Trust services.

Thank you to everyone who attended this year's Trust Annual General Meeting and Annual Members' Meeting.

Councillor John Doddy appointed for third term as Trust governor

We have been delighted to welcome Councillor John Doddy back to Sherwood Forest Hospitals over recent months, as he returned for a third term on the Trust's Council of Governors as an appointed governor from Nottinghamshire County Council.

We look forward to working with Councillor Doddy once again over the coming months.

Celebrating our Trust colleagues

Celebrating the efforts of colleagues at our annual *Excellence Awards*

A recently-retired midwife who helped more than 300 families to quit smoking during pregnancy won the prestigious Lifetime Achievement Award at our annual Trust *Excellence Awards* in September.

Claire Allison, who has dedicated her working life to nursing and midwifery, retired from her role as Tobacco Dependency Maternity Lead for the Phoenix Team in May.

She had established the team which supports parents-to-be to stop smoking in 2021 and succeeded in making it the gold standard of services for the country. Her work has been published in the British Journal of Midwifery, the European Journal of Marketing, and it features in the NHS Saving Babies Lives Care Bundle - national guidance to make maternity care safer and more personal.

Described by her colleagues as someone who acts with the greatest humility and kindness, Claire put her heart and soul into her work at SFH and leaves behind a powerful legacy of leadership, compassion, innovation and excellence in care.

Elsewhere, the award voted for by members of the public, *The People's Award*, was presented to the Trust's Day Case Unit.

The team received exceptional feedback and was described as providing 'not just care, but love', after going above and beyond to ensure that a couple (who had not spent a night apart in 52 years) could stay together on New Year's Eve whilst one of them was in hospital. The team was commended for their unwavering compassion and dedication towards their patients.

It was also my absolute privilege to award our Trust Chaplain, Reverend Rodney Warden, with my Chair's Award to recognise his place as a treasured member of the SFH family. It was great to see the standing ovation he rightly received on the night.

Rodney was chosen for providing compassionate spiritual and pastoral care to patients, families, and staff. He was described as a true embodiment of the Trust's CARE values and known for his calm, steady presence and close work with bereavement midwives and Early Pregnancy Unit.

Families often ask for Rodney by name, finding comfort and strength during unimaginable loss, while colleagues feel supported the moment they arrive on the ward. His impact is lasting and deeply felt by all.

The Paul Robinson CARE Award, a new award named in memory of former Trust Chief Executive Paul Robinson, who sadly passed away earlier this year, was also awarded to a colleague who has demonstrated their dedication to the Trust's CARE values.

Jade Harrison, Cancer Support Worker, was chosen for her unwavering commitment to patient care and excellence in healthcare, with her name regularly appearing in feedback from patients. Jade goes above and beyond daily and a recent example of this was the comfort, stability and strength she offered to a patient during a deeply distressing time. Jade's compassionate presence and clear, honest communication was noted from the very first consultation, and she was specifically named by the patient, who explained that Jade's empathy and professionalism helped them to navigate such a sensitive journey.

Other notable winners include the Daffodil Café Volunteers who won the Volunteer of the Year Award, and the Amazon Breast Cancer Support Group, who have raised £300,000 to support breast cancer care at King's Mill Hospital over many years, took home the Community Hero Award.

The Excellence Awards are our way of saying thank you to the many colleagues who work selflessly throughout the year. Whether a winner or a nominee, these are the colleagues who ensure that our patients are looked after with the utmost care, respect, and dignity.

We look forward to the Excellence Awards each year, as they never fail to bring forward stories filled with emotion and dedication and it is always a deeply humbling experience to be part of those moments and celebrate the incredible contributions of our colleagues.

The awards evening took place at the One Call Stadium in Mansfield, home of Mansfield Town Football Club. It was funded entirely by donations and support from the Sherwood Forest Hospitals Charity, corporate sponsors Managed Healthcare, Datix, the Radford Foundation, and Mills & Reeve.

The full list of winners are listed and below – and we thank them once again for their brilliant work!

- Multidisciplinary Team of the Year – Lower GI Improvement Team 'Bottoms up' project
- Most Improved Team – Orthogeriatric Liaison Team
- The Chris McFarlane Award – Sidra Kalsoom, Biomedical Scientist in Histopathology
- Rising Star Award – Irvine Makani, Lead Nurse, Emergency Department
- Non-Clinical Team of the Year – Emergency Department Reception
- Non-Clinical Individual of the Year – Holly Baxter, Paralegal, Legal Services Team
- Nursing, Midwifery & AHP Team – Neurological Outpatients and Sherwood Rehabilitation Team
- Nursing, Midwifery & AHP Individual – Jade Smithson, Pneumonia Service Nurse, Respiratory
- Doctor and Consultant Team – Gastroenterology Consultant and Lead Nurse Endoscopists, Emergency Department and Urgent Treatment Centre
- Doctor and Consultant Individual – Dr Ahmed Bakeer, Consultant, Emergency Department
- Specialist Healthcare Team – Sexual Health Services
- Specialist Healthcare Individual – David Cunningham, Assistant Practitioner, Radiology
- Outstanding contributions to Equality, Diversity and Inclusion - Keela Darby Ward Sister, Surgical Assessment Unit and Surgical Same Day Emergency Care Unit
- Exceptional Contributions to Sustainability – Urgent and Emergency Care Green Initiatives Scheme
- Volunteer of the Year – Daffodil Café Volunteers
- Lifetime Achievement Award – Claire Allison, Tobacco Dependency Maternity Lead for the Phoenix Team
- Community Hero – Amazon Breast Cancer Support Group
- Community Partner of the Year – OPUS Music
- The Paul Robinson CARE Award – Jade Harrison, Cancer Support Worker
- The Chair Award – Rodney Warden, Chaplain
- The People's Award – Day Case Unit

Celebrating the long service of Trust colleagues

Over the past two months, we have celebrated the commitments of two incredible colleagues who have dedicated four decades to Sherwood Forest Hospitals.

Julie and Tracey, who both started working in Operating Theatres on the same day back in August 1985. They've worked side-by-side ever since, in the same department, building a friendship that's lasted a lifetime.

Tracey, now Department Leader for Theatres, and Julie, who was Operating Theatres Team Leader for Orthopaedics, have made a lasting impact on the Trust. Julie retired on Sunday 7 September, marking the end of an incredible career.

It was a pleasure to join both of them to celebrate their long service with the Trust at the Trust's Long Service event, where there was over 480 years of experience in total. We thank them all for sharing our commitment to *Improving Lives* here at Sherwood Forest Hospitals.

Recognising the difference made by our Trust Charity and Trust volunteers

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

In August and September alone, 375 Trust volunteers generously gave over 8,500 hours of their time to help make great patient care happen across the 25 services they have supported during the month.

£50,000 commitment from our Trust volunteers

Our fantastic team of volunteer fundraisers have pledged £50,000 of support for several small-scale service improvements to enhance patient experience at King's Mill Hospital.

The donation from profits raised in the Daffodil Café and fundraising stall, will support a number of projects including a treatment couch for Surgical Same Day Emergency Care, artwork for consultation rooms in clinic 10, slippers for falls risk patients, a patient information whiteboard in clinic 8, bags for pre-op patient

information packs, self-soothe boxes for mental health patients, traction equipment for orthopaedics, “I’ve been brave” stickers for the orthoptics clinic as well as ongoing funding for our patient clothing store, emergency food discharge packs and refreshments for patient engagement groups.

We are incredibly grateful to our volunteers who work tirelessly in the Daffodil Café and on the fundraising stall to raise funds which help to make the difference for our patients and visitors at King’s Mill Hospital.

Thank you to all our customers whose contribution turns buying a cup of coffee or a small gift into real, lasting impact.

Celebrating 30 years of support from the Amazon Breast Cancer Support Group

The Amazon Breast Cancer Support Group recently marked 30 years of supporting the community and patients here at Sherwood Forest Hospitals.

The Amazon Breast Care Group are an independent charity who exemplify dedication and commitment to support breast care services at King’s Mill Hospital.

They have raised over £300,000, directly benefiting breast services and patients in the community.

Their fundraising efforts, including charity events and donations, enabled the creation of a new breast cancer support unit with state-of-the-art facilities.

Beyond financial support, they provide emotional care and solidarity, offering hope and compassion to patients and families during treatment. Their tireless work makes them an indispensable partner and a true community hero, enhancing care and support far beyond traditional healthcare settings.

The group welcomes people at all stages of their journey and holds meetings on the second Tuesday of each month (except in August) from 5pm until 6.30pm in the Amazon Lounge in Clinic 14 at King’s Mill Hospital.

We were delighted to see their contributions recognised at our Trust *Excellence Awards*, as they took home the Community Hero Award. Thank you to the Amazons for your brilliant fundraising and the priceless support you offer.

Celebrating the dedication of two of our long-serving volunteers

We have been proud to celebrate the commitment of two of our amazing volunteers for their incredible long service.

Jill Smallwood is a dedicated hub volunteer who chairs our Volunteer Fundraising Committee, helping to make a real difference for patients and staff. We are proud to have celebrated 25 years of Jill volunteering with the Trust.

Jean Allsop volunteers at the Daffodil Café, creating a welcoming space for patients, visitors and staff. She has reached her own milestone of volunteering for 20 years with the Trust.

We thank them both for their dedication and long service.

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

- **Patient information bags**
  Patients due to have a planned operation at King's Mill or Newark Hospital can now be better prepared for their procedure, thanks to the generosity of the Friends of Newark Hospital and the King's Mill Hospital fundraising volunteers.

  They have provided funding for patient information bags to be handed to patients before their operation, which include items such as paperwork relating to their procedure, anti-microbial body wash and mini sharps bins.

  The bags, which can be used to keep a variety of preadmission information and essentials, will help patients to be better prepared. They help to maintain confidentiality and privacy and are also useful to those with mobility issues who may use walking aids. This is because it is safer to have all their essential items in one place rather than expecting them to carry the items individually, which could result in the patient struggling to use their walking aid and potentially dropping their items.

- Thanks to the kind donations made by members of the public, the Sherwood Forest Hospitals Charity has funded equipment which will offer improved comfort and dignity for patients requiring management of symptoms. The charity has purchased a fleet of medication syringe driver pumps for £44,500.

A syringe driver is a small, portable, battery-powered pump which delivers a steady flow of medicine without interruption over 24 hours. The pump helps to manage symptoms for people who can't take oral medications, such as patients receiving end of life care.

Recently, the Trust found out that their current stock of pumps was soon to become obsolete and needed replacing with a new model. The new pumps, with a much longer battery life, mean the Trust can make sure patients are receiving symptom management treatment which is right for them and that they can live in comfort and dignity.

- **'Birthing boxes' introduced to improve the birthing experience**
  The Trust's Maternity Department used feedback from the Local Maternity Voices Partnership, the Birth Afterthoughts Service, Friends and Family tests and other sources to request funds from the Sherwood Forest Hospitals Charity to use to improve the birthing and induction rooms and invest further in the quality of care provided.

  Some of these improvements include safe and approved ambient lighting, a Bluetooth speaker for patient use, birthing aids and future plans for wall décor.

  The new equipment will be provided to families in the Induction of Labour Suite and Birthing Unit that wish to use it via a 'birthing box'. The 'birthing box' will create an environment that feels nurturing and enhances experience regardless of mode of birth, ensuring expectant parents feel well cared for.

- **Non-Executive Director Andrew Rose-Britton's sponsored walk**
  We also owe a 'thank you' to one of the Trust's Non-Executive Directors, Andrew Rose-Britton, who has raised an incredible £345 for the Sherwood Forest Hospitals Charity by taking part in a 190-mile sponsored walk.

  Andrew walked the legendary Coast to Coast route from St Bees in Cumbria to the east coast of North Yorkshire with the intended finish line being Robin Hood's Bay. However, a moorland fire and some exploding World War II bombs meant a diversion to Whitby. Andrew is a keen walker and previously walked the Camino Way in Spain in aid of the charity.

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

Other notable engagements:

- I enjoyed the latest of my regular catch-ups with the Trust's Lead Governor, Liz Barrett OBE DL, as we continue to closely involve our Trust Council of Governors within the Trust's work. This followed our latest *Governors' Conference* which provided positive discussions around how we can further that commitment.

- I undertook a walkaround of the Trust's People Services function alongside the Trust's staff-side lead, Roz Norman.

- I joined the latest of our monthly catch-up meetings with the Regional Director of NHS England (Midlands), Dale Bywater.

- I joined our latest meeting of our local NHS providers' chairs meeting, alongside my counterparts from Nottingham University Hospitals (NUH) and East Midlands Ambulance Service (EMAS).

- We held the latest Committee in Common with colleagues from Nottingham University Hospitals (NUH) to continue our commitment to working together to better provide services to the communities we serve.

- I am due to visit Doncaster and Bassetlaw Hospitals, where I will meet with their Chair and Chief Executive to explore opportunities to work more closely together.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Council of Governors - Chair's Highlight Report to the Trust Board meeting in public

Subject:	Council of Governors (CoG) Highlight Report	**Date:**	2nd October 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Graham Ward, Trust Chair		
Presented By:	Graham Ward, Trust Chair		
Purpose:			
To provide assurance to the Board of Directors from the CoG meeting held on 12th August 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Low attendance by Non-Executive Directors (NEDs) was noted with concern. The Chair expressed disappointment and reiterated expectations for attendance or appropriate cover. **Concerns regarding the radiology reception area** were raised, described as "dark, oppressive and outdated." This is linked to retained estate issues and the five-year improvement plan. Ongoing concern regarding **visibility of Quality Impact Assessments** (QIAs) undertaken by system partners, which may affect the Trust directly or indirectly.	Review of meeting scheduling to avoid August dates in future years. Monitoring of uniformed staff use of the main patient reception area as a rest space. Development of a video briefing by the nursing and communications teams. Establishment of a working group to oversee the procurement of external auditors. Review of 15 Steps visit scheduling to ensure broader ward coverage. Planning for a Newark-specific 'Dragons' Den' charitable funding round in January 2026.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
The 2024/25 audit report from KPMG provided an unqualified audit opinion, with no recommendations. The Annual Report and Accounts had received Board approval, been laid before Parliament and published on the Trust website. The Fit2Sit initiative was positively received, with evidence of improved patient flow and cost-neutral staffing. Governors are becoming increasingly self-sufficient in delivering the Meet Your Governor initiatives following the withdrawal of their administrative support resources.	Approval to proceed with external audit tender process. Approval of NEDs' appraisal outcomes and objectives. Approval of the reappointment of Barbara Brady and Manjeet Gill for a further term of one year.

Comments on effectiveness of the meeting
The meeting was well-structured and covered a broad range of statutory, strategic, and operational matters. Despite concerns over NED attendance, the meeting was effectively chaired and demonstrated strong engagement from governors and executive attendees.
Items recommended for consideration by other Committees
Consideration by the Audit and Assurance Committee of the external audit procurement process and evaluation criteria. Consideration by the Risk Committee of ongoing estate-related risks (radiology reception environment). Consideration by the People Committee of governor engagement in digital systems and workforce planning.
Progress with Actions
Number of actions considered at the meeting - 7 Number of actions closed at the meeting – 6 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.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	2nd Oct 2025
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Dr David Selwyn, Acting Chief Executive		

Purpose

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

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

A&E = Accident and Emergency
BAF = Board Assurance Framework
BMA = British Medical Association
CDC = Community Diagnostic Centre
COPD = Chronic Obstructive Pulmonary Disease
ED = Emergency Department
FY1 = First Year
MOU = Memorandum of Understanding
MOU = Memorandum of Understanding
NHS = National Health Service
NOF = National Oversight Framework
NTU = Nottingham Trent University
OPEL = Operational Pressures Escalation Level
PCNs = Primary Care Networks
PIFU = Patient Initiated Follow Up
PTL = Patient Tracking List
RTT = Referral to Treatment

Executive Summary

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

Operational update

Sherwood ranked East Midlands' second-highest acute trust in NHS England National Oversight Framework (NOF)

In September 2025, NHS England published its new National Oversight Framework (NOF) which ranks every trust in England against a number of standards, from their performance in urgent and emergency care departments to how quickly they can progress elective operations, their cancer performance, and even the experiences that patients share each year in the *NHS National Staff Survey*.

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

The framework places trusts into four performance segments, with the first, segment one, representing the best-performing trusts and the fourth segment showing the most challenged. Separate league tables are published for acute, non-acute and ambulance trusts.

For us here at Sherwood, the league tables see us ranked in 48th place out of 134 acute trusts in the country and the second-highest ranking trust of our kind anywhere in the East Midlands.

That framework also places us into the third of the four segments, recognising that any trust working in financial deficit cannot climb any higher than segment three.

The publication of the National Oversight Framework makes clear that trusts who cannot balance their books will lose their freedoms to run independently, something that would be incredibly damaging to what we have built together here at Sherwood.

Significant and sustained effort has continued to drive improvements in financial and operational performance over recent weeks, as the Trust works towards its commitments of saving £45.8million this financial year.

Overview of operational performance

We have had a challenging July and August across several areas of the Trust. In July, we saw high patient demand within our Urgent and Emergency Care services, which I have provided more details about below. Those challenges were compounded by the industrial action we saw at the end of July.

We experienced a seasonal ease in Urgent and Emergency Care demand in August, although this was not to the extent that we saw in 2024.

We have seen discharge delays increase significantly over the summer period reaching levels not seen since early 2024. This largely relates to increased numbers of pathway one discharge patients waiting to leave hospital, which concerns patients being discharged with a package of care from our hospitals.

The challenge of discharging patients in a timely manner drove increased patient length of stay and flow issues into and through our hospitals. The delays in admitting patients due to a lack of beds, resulted in our Emergency Department frequently being overcrowded, leading to increased waiting times which can increase the risk of delay-related harm.

Our headline A&E (Accident and Emergency) four-hour performance metric deteriorated to 68.8% in August, falling well below our operational plan and much lower than the 82% we saw last year.

This performance challenge was also apparent in our Emergency Department (ED) 12-hour length of stay performance and in our 30-minute ambulance handover performance.

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

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 0.97% of the total patient tracking list (PTL) 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 deteriorated to 61.3% in August. While the Trust continues to benchmark well nationally, we have fallen further from our plan to deliver a mandated 5% improvement on November 2024 performance. 18-week first appointment performance has also deteriorated and our total PTL size is growing.

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 (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 as we look to improve performance to meet our plan by December 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, closing in July 2025 at 89%. 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 increased in recent weeks, though recovery plans are in place across several tumour sites.

Our Integrated Performance Report (IPR) provides more detail on areas of strong and challenged performance together, along with key actions we are taking to improve the timeliness of care we offer to patients.

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

Reflecting on the impact of July's industrial action

July saw the return of national industrial action, as resident doctors chose to take strike action as part of their ongoing dispute with the government over pay and conditions.

Resident doctors (formerly known as junior doctors) make-up around half the medical workforce in England, which led to significant disruption during the action which took place between 7am on Friday 25th July and 7am on Wednesday 30th July 2025.

Trust data shows that a total of 639 outpatient appointments, 16 inpatient procedures and 53 day-case procedures were postponed as a result of that industrial action, with those having now been rescheduled.

While much emphasis is placed on the activity that was postponed during that time, the Trust continued to deliver 7,625 outpatient appointments, 23 elective operations and 496 day-case procedures during the same period. Huge credit for that belongs to our Trust colleagues for their dedication to our patients during that time.

In addition to the impact on our patients, this latest period of industrial action cost the Trust £0.4million through the cost of covering shifts and loss of income. This cost will be incurred as a cost pressure to the Trust, with no additional NHS England support being provided for this.

While there is no confirmed industrial action due to take place over the coming months at the time of writing, the British Medical Association (BMA) is currently running a ballot for industrial action for doctors in England in their first year (FY1) of employment. That ballot is due to close on Monday 6th October 2025.

Partnership updates

Securing funding for an integrated neighbourhood respiratory health service

As part of a wider Mid Nottinghamshire collaborative, we have been successful in securing £215k for the development of an integrated neighbourhood respiratory health service. The Trust led on the proposal, which is a joint plan with Nottinghamshire Healthcare Trust, our six Primary Care Networks (PCNs), and the Integrated Care Board.

Respiratory disease is a leading cause of premature death and avoidable admissions in Nottinghamshire, with COPD and asthma prevalence exceeding the national average. The programme's aim is to create a scalable, community-based approach that meets our population's health needs and tackles health inequalities.

The programme will start in two PCNs increasing access to early and accurate diagnosis of COPD and asthma and moving specialist care closer to communities. The new ways of working will be embedded within the new integrated neighbourhood teams, allowing closer working and support from community and voluntary sector partners and public health teams.

The new service is due to mobilise during October.

Trust signs landmark Memorandum of Understanding with Nottingham Trent University

Sherwood Forest Hospitals has signed a Memorandum of Understanding (MoU) with Nottingham Trent University (NTU) to formalise the two organisations' strategic partnership aimed at enhancing healthcare education, research, and innovation across Nottinghamshire and the wider region.

The MoU sets out a shared commitment to collaborate across key areas including clinical and non-clinical placements, workforce development and digital transformation. The partnership will focus on improving the health and wellbeing of local communities while supporting the recruitment, education, and retention of high-quality healthcare professionals.

Initial areas of focus include expanding placement opportunities for NTU students, developing joint research initiatives, and creating pathways for employment and education in both clinical and non-clinical roles.

As a Trust, we are committed to improving lives across the communities we serve and this partnership with Nottingham Trent University is another brilliant example of how we work with other local organisations to do just that.

Caption: Dr David Selwyn and NTU's Vice-Chancellor and President, Steve Denton

This exciting partnership will help our local hospitals to explore research and innovation opportunities with our local education providers, helping our local NHS to access the cutting-edge facilities and thinking that our universities have to offer.

Crucially, this commitment will also create more opportunities for local people to step into the NHS to learn and work locally – helping to meet the needs of our local communities, both now and for many years to come.

The shared commitment also builds upon both institutions' individual partnerships with West Nottinghamshire College.

The partnership will also extend to the University, College and Trust working together to design university healthcare courses that will prepare local people for working in the local health and care sector.

County-wide NHS partnership wins forces Health and Wellbeing Award

We are incredibly proud to announce that at the recent Boots and Beret ceremony, Sherwood won the Health and Wellbeing award jointly with Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust.

Winning this award brings pride and joy and represents the dedication, commitment, and perseverance that made it possible from our Armed Forces Network.

The awards, run by Nottinghamshire County Council, honour the dedication, commitment, and support for our Armed Forces community in Nottinghamshire.

Other Trust updates

Mansfield Community Diagnostic Centre begins offering additional lung tests

The Mansfield Community Diagnostic Centre has begun offering additional respiratory lung health tests for asthma, 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.

The new site, once built, 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.

Sherwood Forest Hospitals re-awarded the Carer Friendly Employer Quality Mark

For the fourth consecutive year, Sherwood Forest Hospitals has been awarded the Carer Friendly Employer Quality Mark by Nottinghamshire Carers Association. This recognition reflects our ongoing commitment to supporting colleagues who have caring responsibilities outside of work.

Trust neonatal team receives Bliss Baby Charter accreditation

The Neonatal team at Sherwood Forest Hospitals Trust has recently received their Neonatal Bliss silver award accreditation from the Bliss Baby Charter.

The charter provides support and guidance for neonatal teams to help them develop good relationships with parents. While working toward the accreditation, members of the unit have developed several initiatives and tools to aid families during their journey in the unit.

These include developing a virtual tour to make a visit to the unit less daunting for families, a counsellor for the unit, a playroom for siblings and a mandatory study day for staff on the unit, among other things.

The charter supports Neonatal teams to build the foundations of Family-integrated care on the unit, which means ensuring that parents are actively involved in their baby's care alongside healthcare professionals.

This partnership between parents and the healthcare team empowers parents to become confident and knowledgeable when giving care to their children, who quite often have additional needs.

The Baby Bliss Charter consists of seven simple principles that sum-up the care, respect and support that vulnerable babies should receive and cover.

These principles are social, developmental and emotional needs, decision making, specialist services and staff, benchmarking, unit information and support for families, feeding and discharge.

The Emily Harris Foundation continuously supports the neonatal unit to enhance the experience of patients and families. The Foundation has provided families with access to a counsellor service and aided the playroom in addition to the day-to-day support they already provide.

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. Committee members also received the full BAF for assurance of the review process.

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

Board of Directors in Public - Cover Sheet

Subject:	Maternity and Neonatal (Perinatal Services) Safety Champions Report- July 2025	**Date:**	2 October 2025
Prepared By:	Sarah Ayre, Head of Midwifery, and Rachael Giles, Deputy Divisional Director of Nursing, Women's and Children's Division		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women's and Children's, Philip Bolton, Executive Chief Nurse		

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	Insufficient financial resources available to support the delivery of services	
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

- MNDIP Maternity and Neonatal Digital Improvement Programme
- MNVP Maternity and Neonatal Voice Champion

- PAC Perinatal Assurance Committee
- LMNS Local Maternity and Neonatal System
- NICU Neonatal Intensive Care Unit
- HoM Head of Midwifery
- SBLCBV3 Saving Babies' Lives Version Three: A care bundle for reducing perinatal mortality

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 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 practice 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, providing assurance on progress against our safety, quality, and cultural improvement priorities.

Maternity and Neonatal (Perinatal Services) Safety Champion (MNSC) oversight

July 2025 data

1. Staff Engagement

1.1 Safety Champion Walkaround

On 4th August 2025, Paula Shore, Director of Midwifery/Divisional Director of Nursing, Shantell Miles, Director of Nursing/ Deputy Chief Nurse and Neil McDonald, Non-Executive Director took time as our named Safety Champions to walk around the acute maternity areas. They spent time talking to staff within both the maternity ward and birthing unit about the changes made, specifically around staffing and models and received positive feedback about all. Teams were aware of the plans to over recruit within the service and how this would further positively impact. For future walk rounds the champions are planning a focus upon the neonatal unit and community midwifery.

1.2 Perinatal Services Forum

The Perinatal Forum on 9th July 2025, chaired by Director of Midwifery, Paula Shore, was well attended and highlighted both challenges and achievements. Staff raised concerns about the impact of staffing pressures, parental behaviours, and the emotional strain of limited opportunities for newly qualified midwives, while welcoming the Quad +3 forum as a positive way to strengthen their voice and leadership support. Recent successes included strong interest in Band 3 Maternity Support Worker recruitment, the appointment of a neonatal clinical educator, and the neonatal unit achieving Bliss Silver Accreditation. Staff emphasised the importance of visible leadership, better communication with families, and assurance that quality and safety will remain protected despite financial pressures.

1.3 Perinatal Services Staff Council

No escalations received this month. Positive feedback around early Christmas request communication and a fair/consistent approach to allocating 'red' and 'green' shifts.

2. Quality Improvements

2.1 Outpatient Clinic Transformation

We are pleased to welcome Lisa Foster as the Matron for Outpatient Services, providing senior leadership and oversight across maternity outpatients. Lisa will be supported by Amy Worsley our new externally recruited Band 7 Outpatient Lead Midwife, and our newly recruited experienced Band 6 midwife, Judy Graham, who brings significant clinical expertise to the team.

Together with Samantha Barlow, Speciality General Manager, and our Consultant Obstetricians, this strengthened leadership team has established a dedicated MDT steering group to review and overhaul antenatal clinic capacity and flow. The group's focus is on ensuring safe, efficient, and sustainable outpatient pathways while improving both staff and patient experience.

This work is already shaping a refreshed model of service delivery, designed to balance demand and capacity, reduce waiting times, and provide assurance on the quality and safety of care.

2.2 Consultant Midwife

Following the recent recruitment process for the Consultant Midwife (Clinical Effectiveness and Innovation), we can confirm the appointment of Samuel Todd. Samuel is an experienced midwife who brings a strong background in education, leadership, and clinical practice to this key post. Samuel's career has spanned both clinical and academic settings, where he has established a track record of excellence in midwifery education and lecturing, alongside significant leadership roles. He has demonstrated clinical credibility through sustained frontline practice and is recognised for his ability to blend evidence-based practice with innovation in care delivery. His expertise in shaping and delivering midwifery education programmes will support the development of our workforce, strengthen clinical governance, and enhance the Trust's academic partnerships.

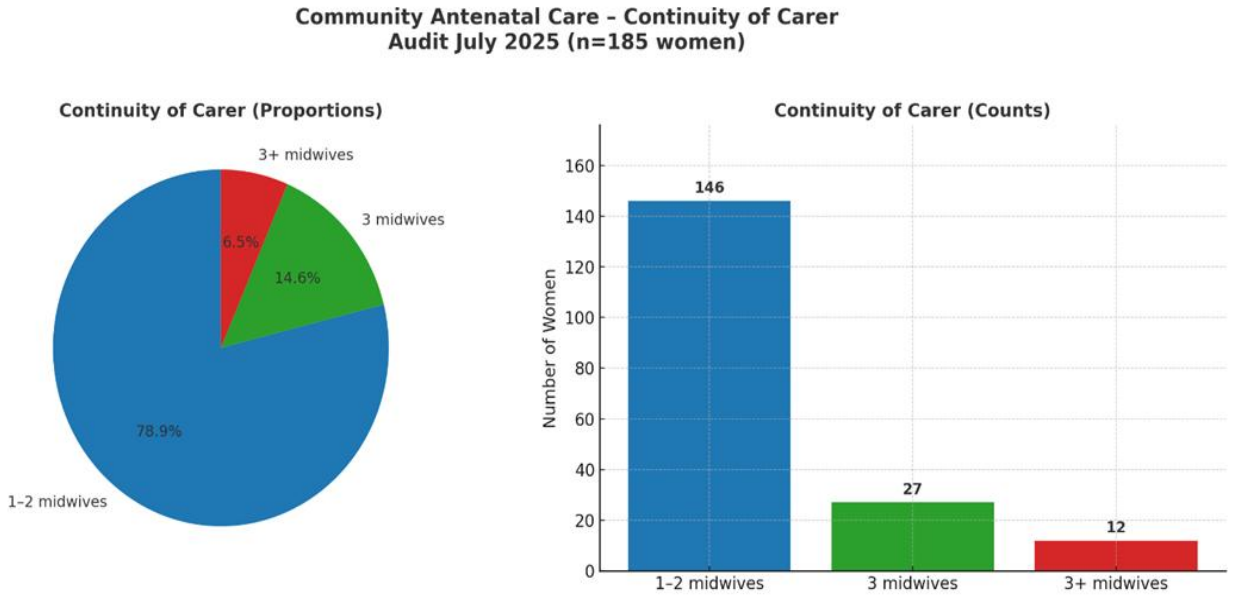
The appointment of Samuel Todd provides assurance to the Board that we have secured a highly capable leader who will support the delivery of our safer staffing priorities, the national maternity transformation agenda, and local ambitions for clinical effectiveness and service improvement. His role will be pivotal in ensuring midwifery practice across Sherwood Forest Hospitals NHS Foundation Trust continues to be evidence-led, responsive to feedback from women, birthing individuals and their families, and aligned with national policy and regulatory expectations. Samuel is expected to take up post on 3rd November 2025 and we will provide further updates on his induction and early priorities in subsequent reports.

2.3. Recognition for Kings Mill Hospital Obstetric & Gynaecology Department

Kings Mill Hospital's Obstetrics and Gynaecology department has been recognised nationally by the Royal College of Obstetricians and Gynaecologists (RCOG) for excellence in training and professional development. Out of 167 units assessed through trainee feedback, our service received high commendations in three of the four award categories: Best in Gynaecology Training, Best in Professional Development, and Best Overall Performance. This achievement reflects the commitment and expertise of our clinical educators, the dedication of colleagues across the department, and the strong support of our Business Support Unit and Postgraduate Educational

Leadership team. It is a clear demonstration of the Trust's commitment to developing future clinicians while maintaining the highest standards of patient care.

2.4 Community Care – Continuity at its Core



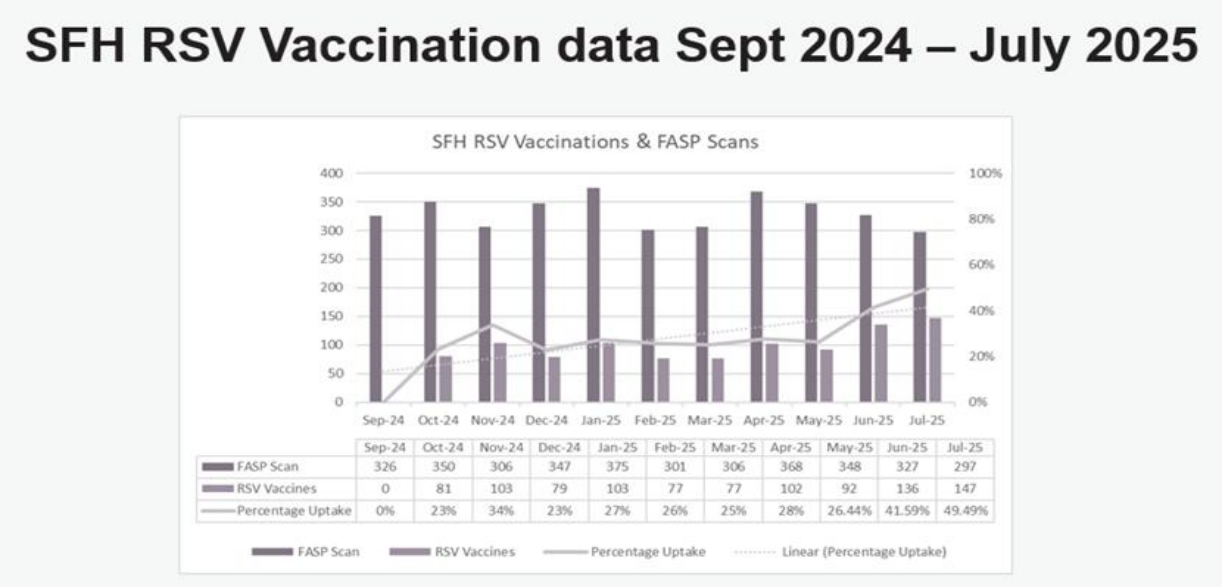
78.9% of our women and birthing individuals received complete continuity of care in the antenatal period.

The audit of 185 women/birthing people demonstrates a high standard of continuity of antenatal care, with 79% receiving care from just one or two midwives and a further 15% from three. This reflects strong relational continuity, recognised nationally for improving outcomes, enhancing satisfaction, and supporting more personalised care. The small number of cases where continuity was disrupted were linked to predictable workforce changes such as maternity leave, secondments, and retirement, rather than systemic service gaps. The findings provide assurance that the majority of families are receiving consistent, high-quality antenatal care, supported by robust systems to maintain continuity. Quarterly audits will ensure trends are monitored and learning is embedded, helping to sustain this positive performance and highlight opportunities for further improvement.

2.5 Vaccinations in Pregnancy

At Sherwood Forest Hospitals we provide birthing women with vaccinations during their pregnancy for RSV, Pertussis and during the winter period Influenza. There are two Band 5 vaccinators (1.74 WTE) externally funded by NHS England who provide vaccinations. Since the second vaccinator has been in post in May there has been a clear increase in number of vaccinations provided. Influenza Vaccination is set to commence in September 2025.

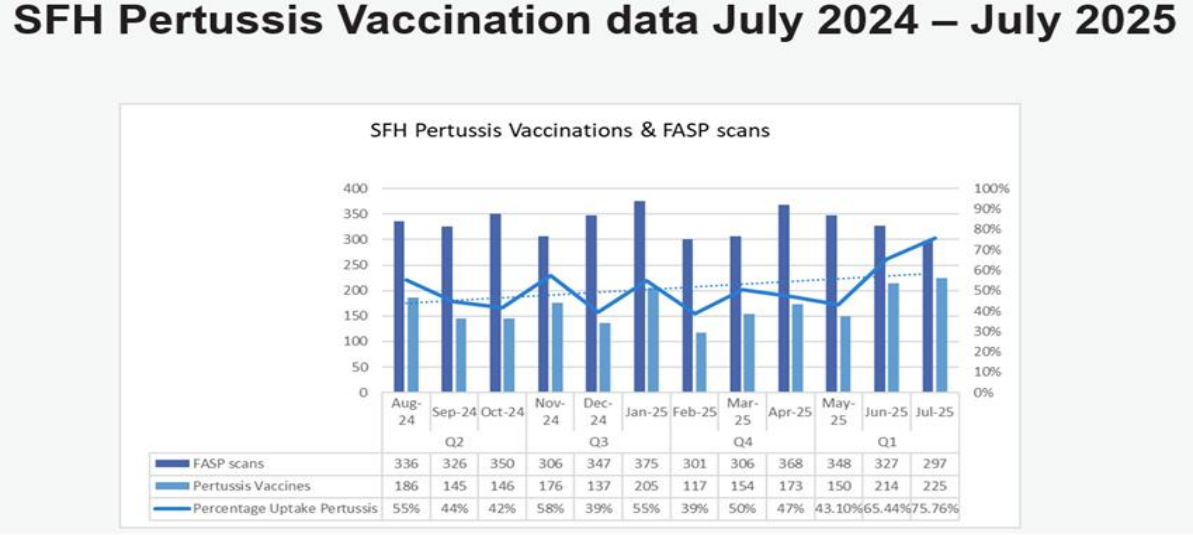
RSV Vaccination Data:



	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
FASP Scan	326	350	306	347	375	301	306	368	348	327	297
RSV Vaccines	0	81	103	79	103	77	77	102	92	136	147
Percentage Uptake	0%	23%	34%	23%	27%	26%	25%	28%	26.44%	41.59%	49.49%

Increase from 26.44% in May to 49.49% July 2025

Pertussis Vaccination Data:



	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	Q2			Q3			Q4			Q1		
FASP scans	336	326	350	306	347	375	301	306	368	348	327	297
Pertussis Vaccines	186	145	146	176	137	205	117	154	173	150	214	225
Percentage Uptake Pertussis	55%	44%	42%	58%	39%	55%	39%	50%	47%	43.10%	65.44%	75.76%

Increase from 43.10% in May to 75.76% July 2025.

3. Quad+3 Perinatal Services Culture Programme

3.1 Staff Survey
Through June and July 2025, the SLT was supported by Jacob Minihan, OD & Engagement Partner, with weekly face-to-face staff engagement sessions. These sessions allowed all our teams to contribute to the action planning to address the themes identified. The new plan will be overseen and owned by the Quad+3, and the Staff Council will receive a monthly update on progress at their next meeting. A paper will be presented at PAC in November with a full overview.

3.2 Exemplar Accreditation 2026
Sherwood Forest Hospitals (SFH) Exemplar Accreditation Programme aims to provide a set of tools to enable a comprehensive assessment of the quality of care at ward, unit, department, and team levels. It does this by bringing all key measures together into one overarching framework so that all aspects of care can be evaluated and the quality of care can genuinely be measured:

continuously learning, improving, and supporting the delivery of outstanding care to our patients (NHS England 2019).

4. National Programmes

4.1 NHSE Perinatal Culture and Leadership Programme (QUAD+3)
The formal programme concluded on 15th March 2025, and a paper outlining its achievements top date was shared at PAC in July 2025. Ongoing work will now focus on relaunching the Maternity Forum as the Perinatal Services Forum, embedding open and transparent communication channels from Ward to Board and Board to Ward across our MDT and leading the action plan devised from the most recent staff survey results. The Quad+3 will also be working on a dedicated programme to support NICU with culture and staff experience improvements.

4.2 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.

4.3 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 the Head of Midwifery. Once the LMNS formally requests our evidence for meeting the 4 main themes, we will fix an agenda item at PAC to share our status and provide assurance against the plan.

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.

Following the onsite ICB Insight Visit planned for 6th June 2025, we will be able to provide a more system-wide update to PAC in July 2025.

4.4 NHSR
Specialty General Manager Sam Barlow will lead the collation of our evidence once again, with safety action owners assigned as per below. As per the previous process, Sam will report via PAC.

Safety Action 1 PMRT	Lead Sarah Sarjant
Safety Action 2 MSDS	Lead Lisa Butler
Safety Action 3 Transitional Care	Lead Rachael Giles
Safety Action 4 Clinical Workforce	Lead Samantha Barlow
Safety Action 5 Midwifery Workforce	Lead Lisa Butler
Safety Action 6 Saving Babies Lives	Lead Sarah Sarjant
Safety Action 7 Listening to service users	Lead Sarah Ayre

Safety Action 8 Training	Lead Lisa Butler
Safety Action 9 Board Assurance	Lead Sarah Ayre
Safety Action 10 MNSI	Lead Sarah Sarjant

4.5 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. The plan is to revisit the maternity self-assessment tool created by NHSE in May 2025, led by HoM Sarah Ayre, to be presented at PAC once completed.

4.6 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.

4.7 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 Hannah Lewis is currently benchmarking against the report, and her updates will be shared via PAC once completed.

4.8 10 Year Health Plan
The newly published "Fit for the Future: 10-Year Health Plan for England" outlines three transformational shifts for the NHS:

> From hospital to community: introducing Neighbourhood Health Services for integrated, locally based care.
>
> From analogue to digital: harnessing AI, digital records, and data systems for proactive, predictive, and patient-controlled care.
>
> From sickness to prevention: shifting towards early intervention, public health, and genomic and population health services.

Specific Impacts on Maternity and Neonatal Services:

> A national independent investigation into maternity and neonatal services will be launched, including urgent reviews of up to ten trusts, and will inform a new maternity and neonatal action plan, led by a new Taskforce chaired by the Secretary of State.
>
> From November, a new Maternity Outcomes Signal System (MOSS) will utilise near-real time data and AI to flag early signs of elevated stillbirth, neonatal death, and brain injury rates, enabling rapid response and intervention.
>
> The Plan commits to co-producing a national maternity & neonatal action plan with bereaved families, aiming to improve equity, safety, and oversight across services.
>
> There is a renewed focus on developing quality metrics for maternity care, including patient-reported outcome and experience measures (PROMs and PREMs), to ensure services deliver safe, personalised, and equitable care.
>
> Expanded Family Hubs and Start for Life services are supported, designed to integrate perinatal mental health support and community engagement into maternity services.

The 10-Year Plan positions maternity and neonatal services prominently within the NHS reform trajectory, emphasising safety, equity, and innovation. However, it pivots away from specific, immediate clinical detail, relying instead on the forthcoming action plan and investigative findings to translate broad vision into tangible service improvements. Continued focus on workforce resilience, community infrastructure, and measurable outcomes will be vital to deliver on the promise of safer and more responsive care for mothers, babies, and families.

4.9 Summary of the Thirlwall Inquiry

The Thirlwall Inquiry, chaired by Lady Justice Thirlwall, is a statutory public examination into the events at the Countess of Chester Hospital following the convictions of neonatal nurse Lucy Letby for the murder and attempted murder of babies. It formally commenced in September 2024. A key preliminary report was produced by the Nuffield Trust, which analysed questionnaire responses from 120 NHS trusts with maternity and neonatal units. Distribution occurred in November 2023, and the report summarises recurring themes and issues revealed across the NHS.

The Inquiry's terms of reference focus on critically evaluating the care and communication processes affecting impacted families. It examines what parents were told about their baby's condition, how deteriorations were explained, access to medical records, the handling of raised concerns, and the disclosure of Letby's conduct

Preliminary thematic evidence has already indicated:

Gaps in safeguarding and risk reporting, including failure to escalate serious concerns and weak investigation of unusual clinical events

Cultural and structural issues, such as "cultural entrapment" where normalized behaviours prevented escalation, and disjointed governance between maternity and neonatal services

Anticipated Recommendations

While the final report has not yet been published, based on emerging thematic evidence and issues identified, anticipated recommendations include:

Enhanced incident reporting and governance protocols: Clearer, mandatory escalation pathways for unexpected or concerning neonatal or maternal events.

Strengthened risk culture and safeguarding: Measures to address cultural entrapment and ensure staff feel safe and empowered to raise concerns.

Integrated oversight structures: Unified governance spanning maternity and neonatal services to avoid siloed decision-making and promote a mother-baby centric approach.

Improved transparency and family communication: Robust policies on timely, compassionate, and accurate communication with families, including access to records and disclosure of clinical concerns.

Mandated training and workforce clarity: Clear delineation of roles, responsibilities, and required competencies across leadership and frontline teams.

Board-level accountability: Boards to take proactive oversight of safety concerns, ensuring they are informed and challenge appropriately.

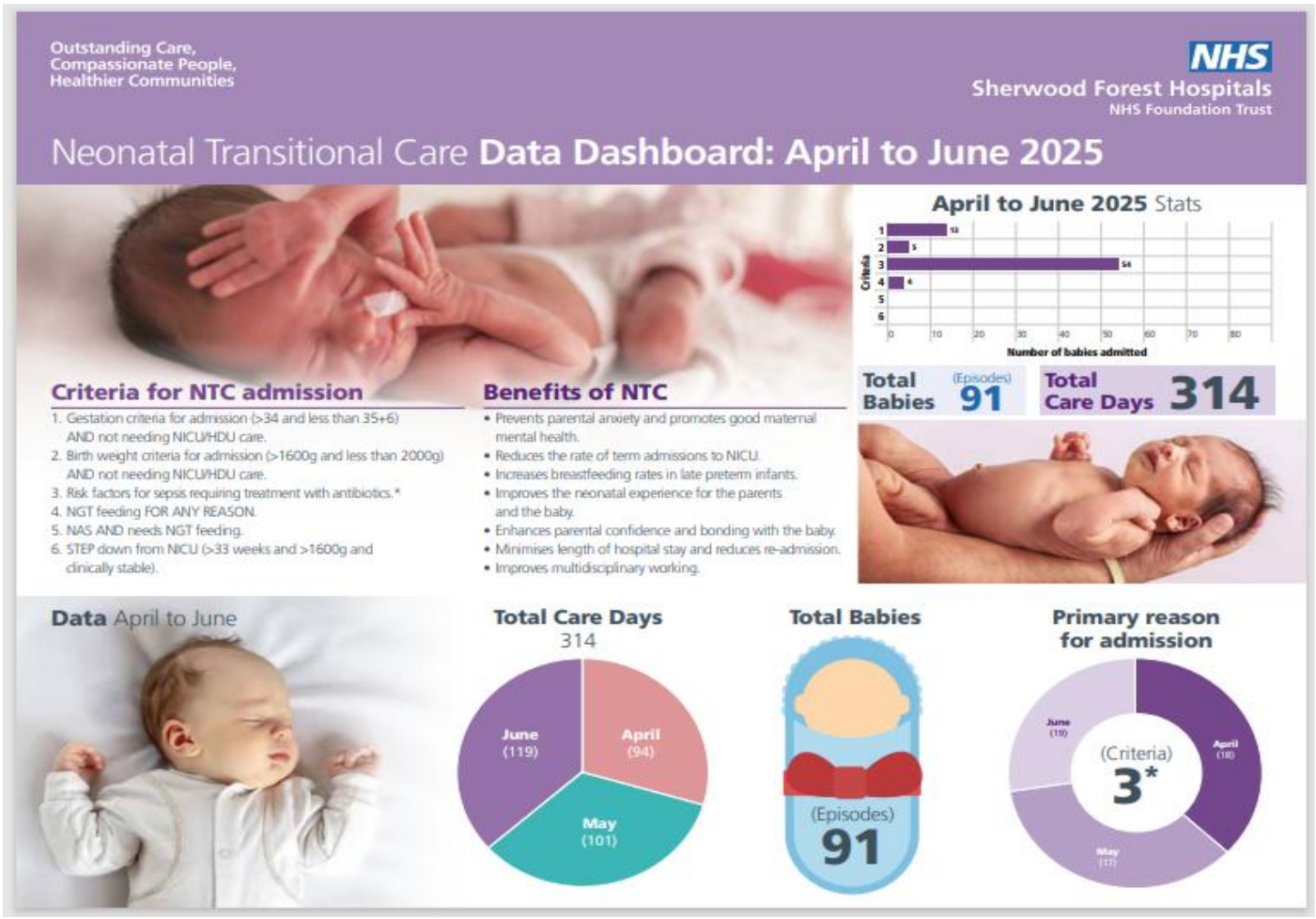
Forward Assurance for the Board

The Thirlwall Inquiry is charting fundamental systemic and cultural learning for maternity and neonatal services across the NHS. Its subsequent recommendations are likely to shape future governance, safeguarding, staff support, and family engagement frameworks. We will continue monitoring developments closely and will prepare to integrate any actionable recommendations into our quality and safety strategies as soon as they are published.

5. Neonatal Intensive Care Unit (NICU)

We would like to extend our sincere thanks to Band 7 nurse Sarah Bray for her dedication and leadership during her time as Ward Sister for NICU. Sarah has made a significant contribution to the service, and we wish her every success as she moves on to her new role. Interviews for the Ward Sister post will take place during the week commencing 1st September 2025, ensuring continuity of leadership within the team.
We are also delighted to formally welcome Sarah to her new position as substantive Matron for Children and Young People, following her successful interview earlier this month, and look forward to the positive impact her leadership will continue to bring.

6. Neonatal Transitional Care



.

7. Perinatal Quality Surveillance Scorecard July 2025 – highlights

The latest scorecard demonstrates encouraging progress in several key quality indicators. Notably, the rate of 3rd and 4th degree perineal tears reduced to 1.3% in July, an improvement

from the year-to-date average of 2.2%. This positive change aligns with the focused relaunch of the OASI care bundle, supporting safer birth outcomes and enhancing maternal experience.

Other indicators remain stable, with postnatal community feedback maintaining 100% positive responses for July, reflecting excellent communication and support. While stillbirths and postpartum haemorrhage continue to be closely monitored through case reviews, no emerging themes of concern have been identified.

The data provides assurance that active improvement work, targeted recruitment, and strengthened clinical oversight are contributing to safer staffing and improved outcomes across maternity and neonatal services. Further monitoring will confirm whether the improvement in perineal trauma rates is sustained in the coming months.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal (Perinatal Services) Safety Champions Report – August 2025	**Date:**	2 October 2025
Prepared By:	Sarah Ayre, Head of Midwifery, and Rachael Giles, Deputy Divisional Director of Nursing, Women's and Children's Division		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women's and Children's, Philip Bolton, Executive Chief Nurse		

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	Insufficient financial resources available to support the delivery of services.	
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)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Assurance Committee (PAC)
- Local Maternity and Neonatal System (LMNS)
- Neonatal Intensive Care Unit (NICU)
- 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)

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 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 practice 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, providing assurance on progress against our safety, quality, and cultural improvement priorities.

Maternity and Neonatal (Perinatal Services) Safety Champion (MNSC) oversight

August 2025 data

1. Staff Engagement

1.1 Safety Champion Walkaround

As detailed in the July paper a safety champion walkaround took place on 4th August 2025. In line with the NHS England Maternity and Neonatal Safety Champion model, our Safety Champions will focus primarily on visiting NICU and Triage over the coming months. Their role is to ensure the priorities of the national maternity and neonatal safety improvement programme are embedded, and act as a direct link between frontline teams and the Trust Board. By listening to staff, service users and families, the Champions help surface concerns, share learning, and support quality improvement initiatives. Their regular presence reinforces psychological safety and ensures that staff voices are heard at the executive level, with feedback directly influencing decision-making and assurance on patient safety.

1.2 Perinatal Services Forum

The staff forum on 6 August 2025, chaired by Chief Nurse Phil Bolton, provided updates on national, regional, and local developments in maternity and neonatal services. Nationally, staff were briefed on the independent maternity review commissioned by Westminster, involving ten trusts, which will undoubtedly showcase both strong practice and areas for improvement. Approval for over-recruitment was welcomed as a pragmatic response to high parental leave rates and reliance on temporary staffing; staff highlighted future risks for workforce planning and student intakes once vacancies are reduced. Recruitment successes were celebrated, including the new consultant midwife, alongside appointments of twelve newly qualified midwives, two community midwives, and two maternity support workers, all due in post by the end of the year. Quality and safety remain central, with ongoing Safety Champion walkarounds praised, including a September focus on community midwifery. In neonatal services, the impact of leadership changes was noted, pride was expressed in the Bliss Silver accreditation, the appointment of a new education support role, and the launch of a virtual NICU tour.

Operational concerns included issues with the new uniforms, the importance of clear communication over the Divisional structure changes, and alignment of financial decisions with clinical priorities. Staff also valued the redesigned scan card holder and the opportunity to provide input through the Divisional FIP Programme. Overall, the forum reflected strong staff engagement, with positivity about recruitment, innovation, and leadership balanced by candid recognition of ongoing challenges in sustainable workforce planning, student placement capacity, and maintaining safe, high-quality care.

2. Service User Voice

2.1 Perinatal Services Oversight Group

PSOG was well attended on 4th September 2025 A full update of themes and escalations will be reported to PAC in November 2025. However, two priorities were identified: translation and translating patient information and surveys, alongside discharge discussions in the community to ensure appropriate Birth Afterthought referrals and support for all women and birthing individuals.

3. Quality Improvements

3.1 Perinatal Services – Portfolio and Leadership update

Proposed changes to senior leadership portfolios within the Women and Children's Division are designed to support the development of integrated Perinatal Services, aligning our local leadership structure with national ambitions to strengthen continuity, safety, and quality across the full maternity and neonatal pathway. These changes will also advance the Trust's ambition to deliver consistently excellent patient experience, reduce unwarranted variation, and embed shared learning across services. Throughout September, there will be a focused programme of collaborative engagement with all relevant stakeholders before the final plan is agreed, communicated, and embedded.

3.2 Baby Tagging

To address the risk identified on the Divisional risk registers regarding infant security, we are progressing with a formal tender process for the procurement of a baby-tagging system. This will ensure that our services are aligned with national expectations and best practices in safeguarding newborns. The tender process will be managed through the Division's business unit. A market engagement exercise will be undertaken to identify suitable suppliers and systems, followed by an options appraisal paper, which will be presented to the relevant committees for approval. The appraisal will include a cost–benefit analysis, review of system functionality, assessment of implementation requirements, and consideration of ongoing maintenance.

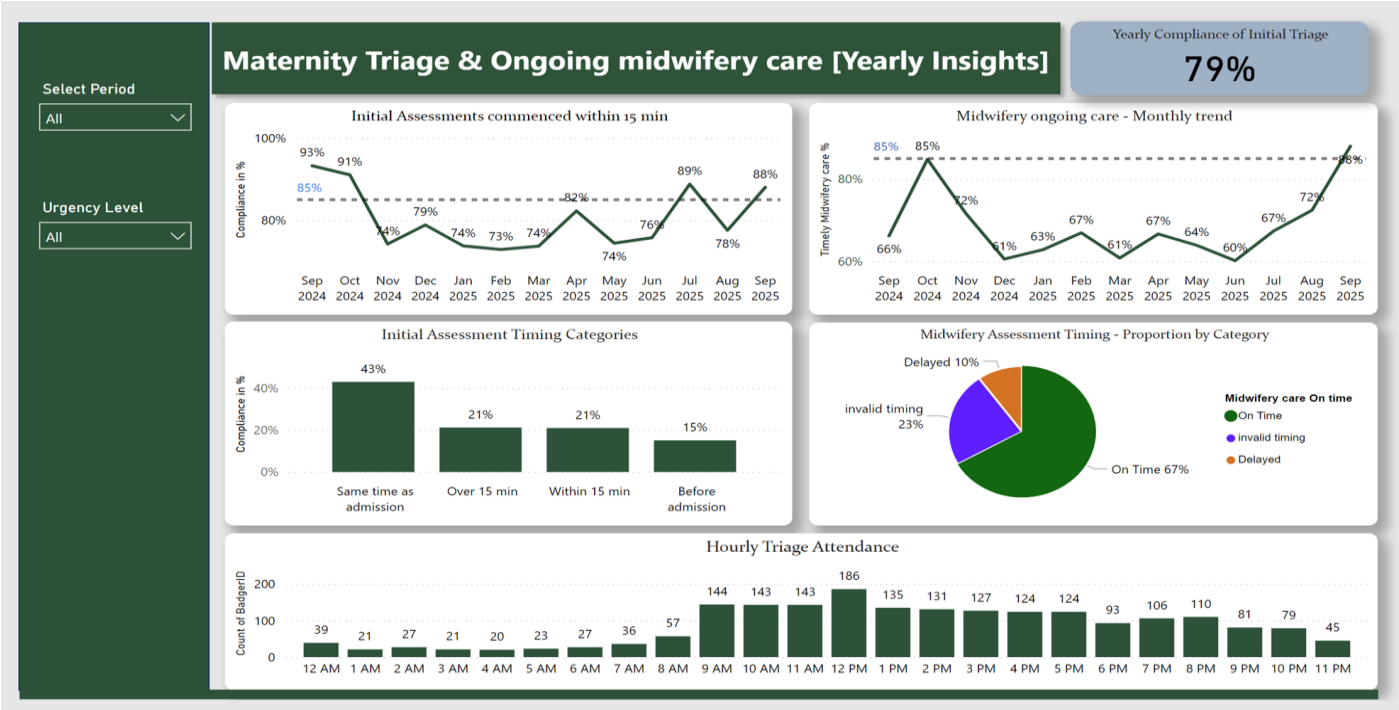
Our ambition is to finalise a preferred option in early 2026 with implementation from 1 April 2026, aligning with the new financial year. While these longer-term mitigations are being established, all recent incidents relating to infant security have been managed appropriately through the Datix process. Each case has been subject to multi-disciplinary review, with feedback shared with staff, actions implemented promptly, and learning communicated divisionally to ensure transparency and assurance. This proactive approach demonstrates that, while the residual risk remains live, robust immediate controls are in place to safeguard babies and reassure families.

3.3 Relocation of Triage

The relocation of the Maternity Triage service has been developed following robust risk assessment, coroner's case recommendations, and comprehensive stakeholder engagement. Recent national and local learning has emphasised the need for timely assessment, safe escalation, and a designated clinical environment that supports both privacy and efficiency in emergency presentations. The proposed relocation directly addresses these recommendations by providing an improved physical footprint, co-located clinical support, and enhanced visibility of women and birthing individuals presenting with urgent needs. A full risk analysis and Quality Impact Assessment (QIA) have been undertaken to ensure that patient safety, clinical quality, and workforce sustainability remain at the centre of the change. Identified risks have been mitigated through the design of the new triage pathway, with consideration given to staffing models, escalation processes, and the interface with emergency obstetrics and gynaecology services.

3.4 Triage Live Dashboard

Following a period of engagement and design, supported by our BI Team, we have launched the live Triage Data dashboard. Data to support evidence of how we are meeting the metrics that demonstrate quality, and safety will now be available in real time and will be reported at PAC. The data goes back to September 2024 and so can present a yearly as well as a monthly overview.



The data shows improvements in both the commencement of initial assessments within 15 minutes and the provision of ongoing midwifery care. When reviewed across the year, it also highlights that peak activity consistently occurs between midday and 3 pm. These insights will inform workforce redesign and planning considerations ahead of the planned relocation in December.

4. Quad+3 Perinatal Services Culture Programme (SA9, MIS Yr7)

4.1 NICU

The proposed portfolio realignment represents a strategic transformation within NICU, serving not only as an operational adjustment but as a foundational enabler of the Quad+3 culture programme. This initiative is designed to embed cultural excellence and leadership accountability at every level of the service.

Staff feedback has consistently highlighted the need for visible senior leadership, authentic role modelling, and a culture of accountability. The Quad+3 framework responds to this by focusing on four core pillars, Voice, Leadership, Learning, and Wellbeing, supported by three critical enablers: Governance, Data, and Communication. This programme will foster psychologically safe environments where staff feel empowered to speak up, ensure wellbeing initiatives are both meaningful and accessible, and establish consistent communication pathways that reinforce how every role contributes to safer, more compassionate care.

4.2 Positivitea Trolley

The Divisional leadership team continues to conduct the monthly Positivitea Trolley, and these are catching on across the Trust, with Surgery looking to ‘adopt’ the idea. CAU and W25 had first dibs on the cake and snacks supplied by the leadership team this month.

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 SS 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 the Head of Midwifery. Once the LMNS formally requests our evidence for meeting the 4 main themes, we will fix an agenda item at PAC to share our status and provide assurance against the plan.

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

Specialty General Manager Samantha Barlow will lead the collation of our evidence once again, with safety action owners assigned as per below. As per the previous process, Samantha will report via PAC.

Safety Action 1 PMRT	Lead	Sarah Sarjant
Safety Action 2 MSDS	Lead	Lisa Butler
Safety Action 3 Transitional Care	Lead	Rachael Giles
Safety Action 4 Clinical Workforce	Lead	Samantha Barlow
Safety Action 5 Midwifery Workforce	Lead	Lisa Butler
Safety Action 6 Saving Babies Lives	Lead	Sarah Sarjant
Safety Action 7 Listening to service users	Lead	Sarah Ayre
Safety Action 8 Training	Lead	Lisa Butler
Safety Action 9 Board Assurance	Lead	Sarah Ayre
Safety Action 10 MNSI	Lead	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. 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. Delivery will depend on translating national vision into practical local action, underpinned by workforce resilience, community infrastructure, and robust outcome measures.

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. The introduction of MOSS will require robust local data governance and clinical engagement to ensure accurate, timely reporting and effective response. Anticipated national investigations and the new action plan will place additional scrutiny on governance, workforce resilience and community integration, with an expectation that Trusts demonstrate visible leadership, measurable quality outcomes and meaningful family engagement.

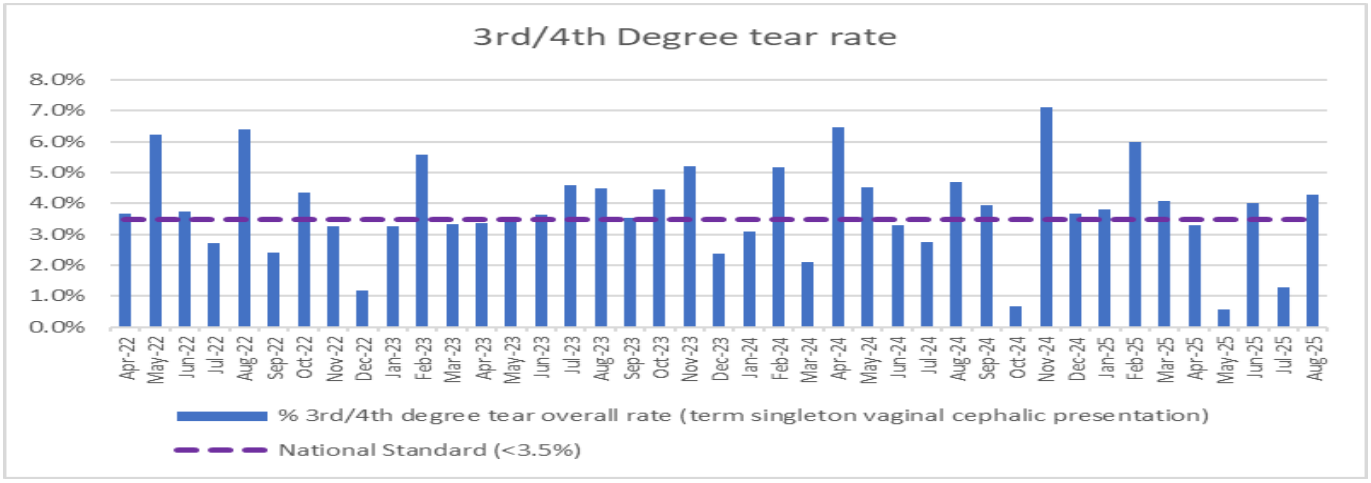
SFH is well placed to respond, building on recent progress in safer staffing models, family engagement initiatives, and the Quad+3 cultural programme, but sustained investment in workforce planning, digital readiness and community pathways will be critical to deliver on these national ambitions.

6. Maternity Perinatal Quality Surveillance scorecard August 2025 data

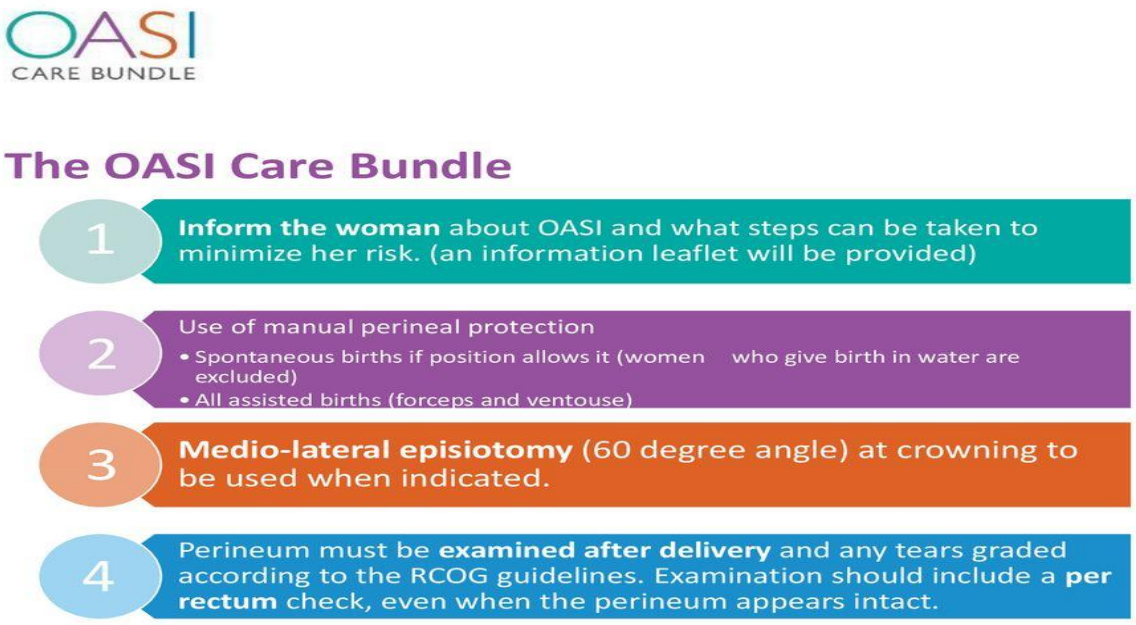
The August 2025 quality surveillance data show continued monitoring of key safety outcomes, including 3rd/4th degree perineal trauma and stillbirths.

6.1 3rd/4th degree perineal trauma

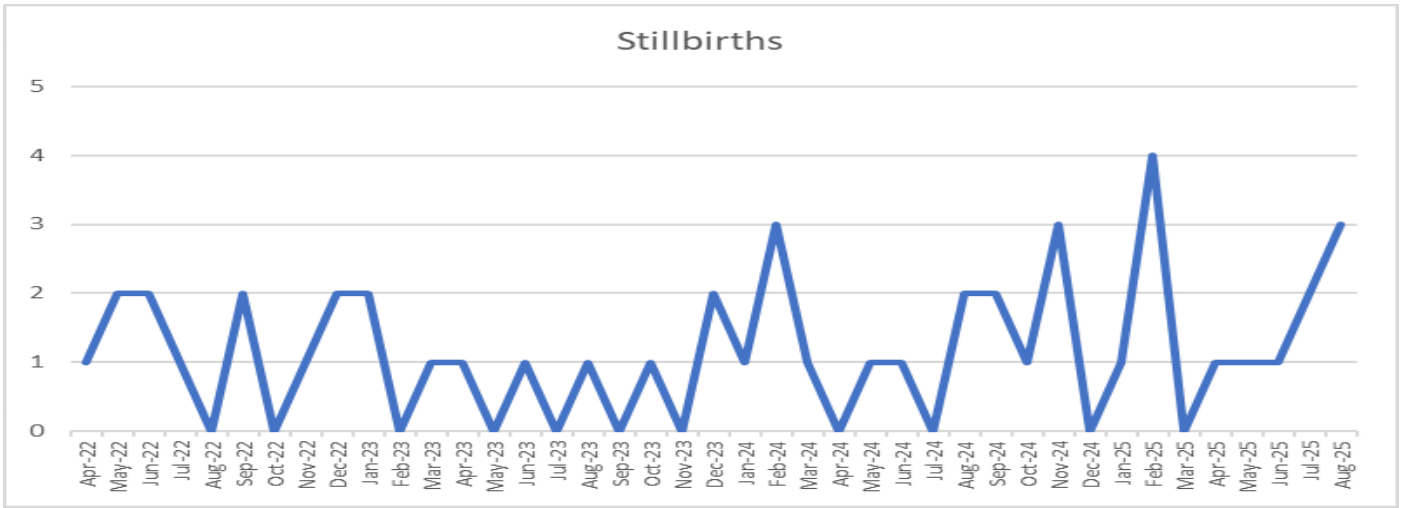
Our 3rd/4th degree tear rate remains within expected national thresholds, supporting assurance that evidence-based intrapartum practices and timely escalation pathways are being embedded.



A quality improvement project is ongoing to fully embed all four elements of the OASI Care Bundle, with a particular focus on Element One, which aims to strengthen antenatal education and support informed decision-making.



6.2 Stillbirth – year to date 5.5% (national benchmark 4.4 stillbirths in 1000 births)



6.3 Saving Babies Lives Care Bundle Version 3 (SBLCBv3) (SA 6, MIS Yr 7) 94% complaint

The SBLCBv3, published in July 2023, is a national programme designed to reduce perinatal mortality and address inequalities. It brings together six evidence-based elements of maternity care:

- **Reducing smoking in pregnancy** through universal tobacco dependence treatment services.
- **Fetal growth surveillance** – enhanced risk assessment, monitoring and management of fetal growth restriction.
- **Awareness of reduced fetal movement (RFM)** – consistent information and timely response pathways.
- **Fetal monitoring in labour** – ensuring staff training, competency and escalation.
- **Reducing preterm birth and optimising perinatal care** – prediction, prevention and preparation strategies.
- **Management of pre-existing diabetes in pregnancy** – added in Version 3 to reduce adverse outcomes.

SBLCBv3 aligns with NICE, RCOG, and national maternity safety ambitions, providing a standardised framework for Trusts to monitor compliance, benchmark performance, and drive improvements in safety, quality and equity of maternity care.

Our overall compliance is on target; however, a change in compliance was noted for element 1 – Smoking in Pregnancy. The guideline & SOPs: The SFH Guideline Tobacco Dependence Treatment in Maternity Services (REF1.1E) and associated SOPs for Tobacco Dependence Treatment (REF1.5B) and Nicotine Replacement Therapy (REF1.5C) are due for update, current version V3.1, all to be amended to V3.2 and smoking status recorded at every antenatal appointment with CO reading has impacted this month's compliance:

Indicator 1. a.i. – 89% compliance (below standard).
Indicator 1.a. iv. – 68% compliance (significant gap).
Indicator 1.b – 75% compliance (below target).

7. Neonatal Transitional Care

As part of the development of an integrated Perinatal Services model, Transitional Care (TC) has been aligned under the leadership of the Inpatient Services Matron. This change strengthens the connection between postnatal, neonatal, and transitional care pathways, ensuring consistent oversight of care for babies requiring additional support alongside their mothers. Previously, TC sat outside of the core inpatient portfolio, creating challenges in terms of operational oversight, workforce alignment, and governance reporting. By bringing TC under the Inpatient Services Matron, we are embedding clearer accountability, more consistent staffing models, and stronger integration of family-centred care principles across the perinatal pathway.

This alignment also enables more effective use of workforce resources, closer collaboration between neonatal and maternity teams, and enhanced assurance that care standards meet national recommendations (including BAPM and GIRFT guidance). From a family perspective, it ensures smoother transitions of care, minimises unnecessary separation of mothers and babies, and supports the Trust's ambition to deliver a truly joined-up perinatal service.
The inclusion of TC within the Inpatient Services Matron's portfolio is therefore a key enabler of the perinatal services plan, supporting continuity, visibility of leadership, and the delivery of safe, compassionate, and coordinated care for women, babies, and their families.

8. Neonatal Intensive Care Unit (NICU)

8.1 Recruitment

Ward Sister Sarah Bray leaves the organisation on 12 September 2025, and we extend our best wishes for her future endeavours. The first round of recruitment for this post was unsuccessful; therefore, the senior divisional team is taking this opportunity to review best practices in leadership models to ensure the role is structured to provide maximum impact and sustainability.

8.2 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. A preliminary report from the Nuffield Trust, based on responses from 120 NHS trusts, highlighted recurring national themes including gaps in safeguarding and escalation, weak investigation of unusual clinical events, and cultural barriers to raising concerns.

Emerging evidence points towards anticipated recommendations for strengthened governance and escalation protocols, improved safeguarding and risk culture, integrated oversight across maternity and neonatal services, clearer family communication policies, mandatory training and competency frameworks, and stronger board-level accountability.
The Inquiry is expected to drive significant systemic and cultural change across maternity and neonatal services. For SFH, proactive monitoring of the Inquiry's findings and readiness to integrate recommendations into governance, safeguarding and family engagement processes will be key to assuring safety and quality.

Implications for SFH:
For Sherwood Forest Hospitals, 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. SFH's ongoing focus on safer staffing, Quad+3 culture work, and family engagement places the Trust in a strong position, but early preparation to adopt the Inquiry's recommendations will be essential to demonstrate proactive assurance and alignment with national expectations.

8.3 British Association of Perinatal Medicine (BAPM) Update

The 2025 BAPM Annual Conference and AGM, held on 8th and 9th September in Cardiff and online, centred on "Transition: leading together to improve newborn care."

The conference featured sessions across critical and emerging topics from early feeding and neurodevelopmental care to data-enabled planning for extremely preterm infants, POCUS application, safety culture, IVH management, neuroprotection, and surgical advances like spina bifida repair and FETO. The AGM incorporated key governance elements and celebrated achievements through the Gopi Menon Awards, acknowledging outstanding contributions in perinatal medicine.

Implications for SFH:
Incorporate BAPM AGM themes into the development of the Perinatal Services Integration Plan, particularly around seamless transition between neonatal and paediatric care, alongside transitional care.

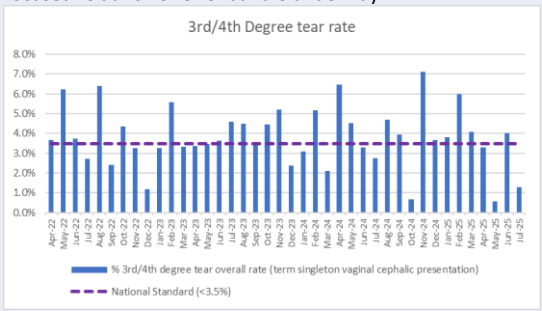
Perinatal Quality Surveillance Model for August 2025 (July 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

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

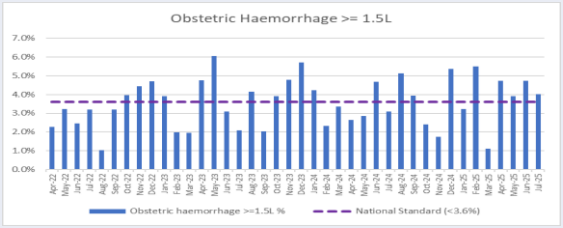
3rd/4th Degree Tear 1.30% (July 2025) 2.2% YTD

Focused relaunch of OASI bundle underway



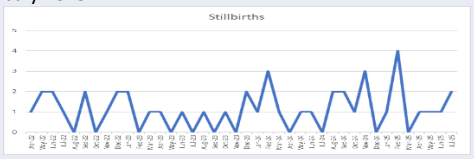
Postpartum Haemorrhage 4.0% (July 2025) 4.3% YTD

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



Stillbirth Rate 3.4% YTD (July 2025)

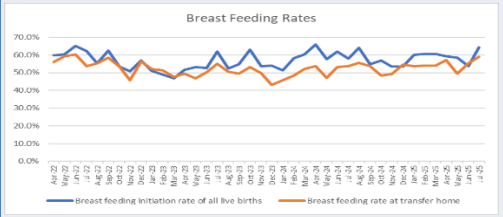
2 stillbirths in July
Cluster review complete – report presented to PAC July 2025



Patient Experience: 100% postnatal community (July 25)

FFT Feedback remains at 100% positive for June. The theme for feedback in July remains excellent communication and support from community teams in the postnatal period. PLAN – to review ECoC plan and ensure we meet national ask

Quality Improvements – BREAST FEEDING RATES



Workforce (July 2025)

Maternity

Midwifery B6 vacancy filled, B5 vacancy part filled, remainder out to advert

Maternity Support Workers – B3 vacancy out to advert – 2.5 WTE vacancy

Consultant Midwife APPOINTED – starts 3rd November

Perinatal Services Matron – to be advertised

Neonatal

Significant nursing challenges remain – clear oversight and a recruitment plan in place – HIGH MATERNITY LEAVE ANTICIPATED over 2025/2026

B8a Matron C&YP APPOINTED

NICU B7 WARD SISTER interviews w/c 01.09.25

No Neonatal Consultant vacancy.

Staffing Red Flags (July 2025)

4 Homebirths in July 2025, no suspension in service since 24/04/25

- **Divert of services**

02.07.25 – acuity NO WOMEN DIVERTED

19.07.25 – acuity 1 WOMAN DIVERETD

25.07.25 – acuity – 3 WOMEN DIVERTED

Review of Birthrate Plus Safe Staffing Tool has reflected that the acuity on all occasions was high and presented a negative staffing balance therefore appropriate use of escalation guidance and diversion of services.

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

All women/birthing individuals who were diverted to other Units were sent a letter of acknowledgement/apology from the DOM.

Saving Babies Lives Care Bundle (SBLCB v3) predicted 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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	91%	CNST Met

Perinatal Assurance

NHSR	National Reporting
• Year 6 MIS achieved • Planning for Year 7 underway – monthly assurance meetings underway	• Ockenden - Initial 7 IEA- 100% compliant • 3 yr. Delivery plan – delivery plan overseen by ICB • 10-year Plan launched 03.07.25

Incidents reported June: 74 (73 low harm, 1 moderate or above)

MDT reviews	Comments
Triggers x 14 Rapid Review x4	No themes identified

MOD HARM:

23.07.25 DW226765 intrapartum stillbirth.

Perinatal Quality Surveillance scorecard August 2025 (July 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		

Quality Metric	Standard	Running Total/ average YTD	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	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			46%	48%	46%	44%	54%	51%	52%	51%	48%	49%	52%	49%	52%	
3rd/4th degree tear overall rate	<3.5%	3.50%	2.80%	4.70%	3.90%	0.70%	7.10%	3.70%	3.80%	6.00%	4.10%	3.30%	0.60%	4.00%	1.30%	
3rd/4th degree tear overall number			4	7	6	1	12	6	6	6	6	5	1	6	2	
Obstetric haemorrhage >1.5L number			9	15	12	7	5	16	9	14	3	13	12	13	11	
Obstetric haemorrhage >1.5L rate	<3.5%		3.10%	5.10%	3.90%	2.40%	1.70%	5.40%	3.20%	5.50%	1.10%	4.70%	3.90%	4.70%	4.00%	
Term admissions to NICU	<6%		4.70%	4.00%	3.90%	3.60%	3.30%	1.90%	1.10%	1.95%	2.32%	3.90%	4.10%	2.18%	2.35%	
Stillbirth number			0	2	2	1	3	0	1	4	0	1	1	1	2	
Stillbirth rate	<4.4/1000				4.4			4.5			4.3			3.5		
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:22	1:22	1:23	1:22.18	1.22.10	1.22.10	1.22.10	1.19.53	1:20.59	1:19.50	1:21.63	1:19.03	1:17.91	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:23	1:23	1:24	1:22.75	1:22.18	1.22.10	1.22.18	1.19.85	1:20.42	1:21.30	1:23.74	1:21.02	1:20.07	
Number of compliments (PET) as reported on DATIX					1	2	1	1	2	3	2	2	3	1	12	
Number of concerns (PET) as reported on DATIX					4	0	1	0	0	1	0	0	0	0	2	
Complaints (PET) as reported on DATIX					0	0	0	0	0	0	1	0	1	1	2	
FFT recommendation rate - COMMUNITY POSTNATAL	>93%												78%	100%	100%	
FFT recommendation rate - MATERNITY WARD	>93%												87%	71%	81%	
FFT recommendation rate - SBU	>93%												97%	90%	89%	

External Reporting	Standard	Running Total/ average	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	Trend
Maternity incidents no harm/low harm			125	169	115	159	142	131	89	107	107	89	124	131	74	
Maternity incidents moderate harm & above			2	1	0	0	0	0	2	0	0	0	1	2	1	
MNSI/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	N	1	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	1	0	0	0	0	0	0	0	0	0	0	0	N	
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	Jul-25	No themes identified in month
Findings of review all cases eligible for referral to MNSI	Jul-25	Factual accuracy review on going for 1 live report, awaiting parental consent for referal for recent SB (Aug)
Service user voice feedback	Jul-25	PSOG and MNVP reports/updates form Perinatal Services governance structure
Staff feedback from Safety Champions and walk-abouts	Jul-25	Triage staff report positively on current Telephone system - plan to meet with community next month

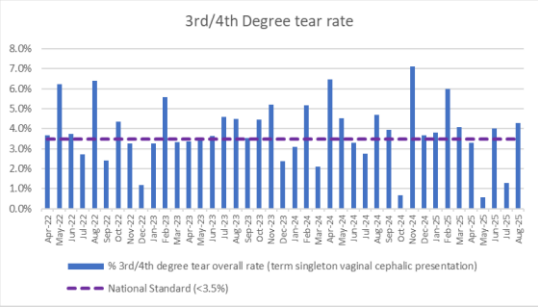
Perinatal Quality Surveillance Model for Sept 2025 (August 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

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

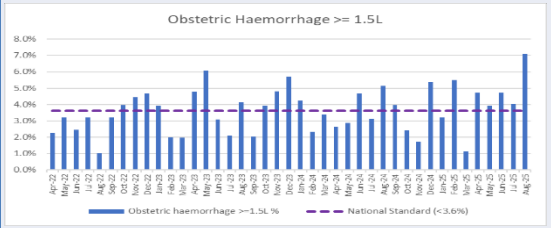
3rd/4th Degree Tear 4.3% (August 2025)

Focused relaunch of OASI bundle underway



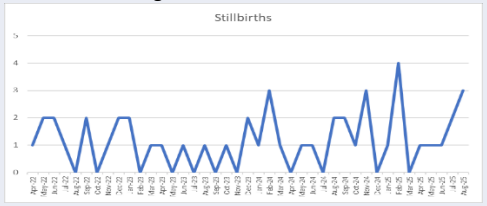
Postpartum Haemorrhage 7.1% (August 2025) 4.9% YTD

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



Stillbirth Rate 5.5% YTD

3 stillbirths in August: No themes identified



Patient Experience: (August 25)

Working with MNVP and Lead Advocate Sarah Seddon to translate the FFT so that our non-English speaking families can share valuable feedback. Agenda item and action through PSOG

Triage Relocation

A Working Group will commence in the week of 15/09/25 to oversee relocation planning, including the completion of a robust QIA and risk assessments. Given the scale and complexity of this project, it is not reasonable to expect clinical-facing leaders to deliver this in isolation. Faculty support is therefore requested to ensure the program is managed effectively and that clinical leaders can remain focused on the safe delivery of patient care.

Workforce (August 2025)

Maternity

Midwifery B6 advert active

B5 vacancy part filled, remainder out to advert

Maternity Support Workers – B3 vacancy out to advert – 2.5 WTE vacancy

Consultant Midwife APPOINTED – starts 3rd November

Neonatal

Significant nursing challenges remain – clear oversight and a recruitment plan in place – HIGH MATERNITY LEAVE ANTICIPATED over 2025/2026

B8a Matron C&YP APPOINTED

NICU B7 WARD SISTER interviews w/c 01.09.25

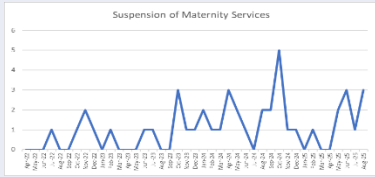
No Neonatal Consultant vacancy.

Staffing Red Flags (August 2025)

2 Homebirths in August 2025, no suspension in service since 24/04/25

- **Divert of services**

3 diverts in August – all based on acuity



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

All women/birthing individuals who were diverted to other Units were sent a letter of acknowledgement/apology from the DOM.

Saving Babies Lives Care Bundle (SBLCB v3) predicted 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	National Reporting
• Year 6 MIS achieved • Planning for Year 7 underway – monthly assurance meetings underway	• Ockenden - Initial 7 IEA- 100% compliant • 3 yr. Delivery plan – delivery plan overseen by ICB • 10-year Plan launched

Incidents reported August: 105 (103 low harm, 2 moderate or above)

MDT reviews	Comments
Triggers x 10 Rapid Review x 3	No themes identified

MOD HARM:

DW227616 – birth injury

DW228226 – neonatal admission concerns

Perinatal Quality Surveillance scorecard September 2025 (August 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		

Quality Metric	Standard	Running Total/ average YTD	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	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			48%	46%	44%	54%	51%	52%	51%	48%	49%	52%	49%	52%	49.5%	
3rd/4th degree tear overall rate	<3.5%	3.50%	4.70%	3.90%	0.70%	7.10%	3.70%	3.80%	6.00%	4.10%	3.30%	0.60%	4.00%	1.30%	4.36%	
3rd/4th degree tear overall number			7	6	1	12	6	6	6	6	5	1	6	2	7	
Obstetric haemorrhage >1.5L number			15	12	7	5	16	9	14	3	13	12	13	11	21	
Obstetric haemorrhage >1.5L rate	<3.5%		5.10%	3.90%	2.40%	1.70%	5.40%	3.20%	5.50%	1.10%	4.70%	3.90%	4.70%	4.00%	7.10%	
Term admissions to NICU	<6%		4.00%	3.90%	3.60%	3.30%	1.90%	1.10%	1.95%	2.32%	3.90%	4.10%	2.18%	2.35%	4.95%	
Stillbirth number			2	2	1	3	0	1	4	0	1	1	1	2	3	
Stillbirth rate	<4.4/1000			4.4			4.5			4.3			3.5			
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:22	1:23	1:22.18	1.22.10	1.22.10	1.22.10	1.19.53	1:20.59	1:19.50	1:21.63	1:19.03	1:17.91	1.19.06	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:23	1:24	1:22.75	1:22.18	1.22.10	1.22.18	1.19.85	1:20.42	1:21.30	1:23.74	1:21.02	1:20.07	1.21.17	
Number of compliments (PET) as reported on DATIX				1	2	1	1	2	3	2	2	3	1	12	8	
Number of concerns (PET) as reported on DATIX				4	0	1	0	0	1	0	0	0	0	2	1	
Complaints (PET) as reported on DATIX				0	0	0	0	0	0	1	0	1	1	2	0	
FFT recommendation rate - COMMUNITY POSTNATAL touch point 4	>93%											78%	100%	100%	100%	
FFT recommendation rate - MATERNITY WARD touch point 3	>93%											87%	71%	81%	72.73%	
FFT recommendation rate - SBU touch point 2	>93%											97%	90%	89%	89%	

External Reporting	Standard	Running Total/ average	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	Trend
Maternity incidents no harm/low harm			169	115	159	142	131	89	107	107	89	124	131	74	105	
Maternity incidents moderate harm & above			1	0	0	0	0	2	0	0	0	1	2	2	4	
MNSI/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	1	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	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	Aug-25	No themes identified in month
Findings of review all cases eligible for referral to MNSI	Aug-25	MI-039331 - factual accuracy report completed and returned to MNSI - awaiting their response
Service user voice feedback	Aug-25	Q4 Themeing report shared at PAC September 25
Staff feedback from Safety Champions and walk-abouts	Aug-25	Community Teams to be visited in September. Relocating Triage remains a focus

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Learning from Deaths (LfD)	**Date:**	02/10/2025
Prepared By:	Dr Nigel Marshall (Chair- Learning from Deaths Group)		
Approved By:	Dr Simon Roe (Chief Medical Officer)		
Presented By:	Dr Simon Roe / Dr Nigel Marshall		

Purpose		
To provide a summary of mortality intelligence reviewed by the Learning from Deaths group and ongoing work to respond to and improve that intelligence and enhance organisational and wider learning.	**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**

Principal Risk		
PR1	Significant deterioration in standards of safety and care	**X**
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	**X**
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

Learning from Death Highlight Reports are presented at Patient Safety Committee (PSC) quarterly

Acronyms

- **HSMR -** Hospital Standardised Mortality Ratio
- **HSMR+** - Hospital Standardised Mortality Ratio "Plus" (Telstra's new metric)
- **SFH(T) -** Sherwood Forest Hospitals (Trust)
- **SMR+ –** Standardised Mortality Ratio
- **SHMI -** Summary Hospital-Level Mortality Indicator
- **CUSUM -** Cumulative Sum
- **SJR-** Structured Judgement Review
- **LfD –** Learning from Deaths (Committee)
- **SPC-** Specialist Palliative Care
- **EOL-** End of Life
- **ReSPECT -** Recommended Summary Plan for Emergency Care and Treatment
- **PSIRG-** Patient Safety Incident Response Group
- **ICB/S-** Integrated Care Board / System
- **LMC**- Local Medical Council
- **LD / LeDeR** Learning Disabilities / Learning Disabilities Mortality Review
- **ICB / ICS-** Integrated Care Board / System

Executive Summary

Summary:
This report provides an overview of mortality intelligence reviewed by the Learning from Deaths Group for Q1 and Q2 of 2025-26. It seeks assurance on current performance (and process) alongside outlining future intentions and priorities for the group and wider trust.

Key Metrics: (Values as of 20.9.25)

- **SHMI** (Summary Hospital-Level Mortality Indicator): **106.86 ("as expected")**
  - SHMI is the key mortality metric referenced in the "NHS performance framework".
- **HSMR+** (Hospital Standardised Mortality Ratio+): **104.01 ("within expected")**
  - A move from Hospital Standardised Mortality Ratio (HSMR) to the new Telstra reporting methodology, HSMR+ (plus), has been in place since November 2024. Since that time, the Trust has seen a markedly reduced value for HSMR+, when compared to the previous HSMR, with SFHT consistently reporting "within expected" and in a stable position when compared to peers and National benchmarking. A similar pattern and trend is seen when considering SMR

The report highlights key areas of work, including:

- Mortality intelligence and focused divisional / speciality mortality reporting
- Themes of focus and learning- accuracy of documentation, communication and coding
- Updates to Mortality benchmarking provider and In-House mortality intelligence capacity

Clinical Reviews and Learning:

- Previous Outlier Diagnosis Groups:
  - Deficiency (anaemia), Intestinal Infection, Soft tissue injury / contusion.
- End of Life (EOL) Audit completion
- Structured Judgement Reviews (SJRs):
  - 59 raised (716 total deaths) = 8.2%
  - New platform for data and re-design of approach to governance
- LeDeR Reviews:
  - 8 reviews received; LD nurse supports system-wide learning
- Coronial Cases (Q1):
  - 11 inquests heard and concluded with improvements / learning identified

The Board is asked to note:

- Focus on clinical engagement with an emphasis on communication and clinical documentation, leading to and supporting:
  - Timely and effective diagnosis and patient-centred management
  - Accurate coding and reflection of activity.

- Awaiting completion of arrangements / contracts for mortality benchmarking provision, aligning best value to Trust with improvements to ICB partnership working.

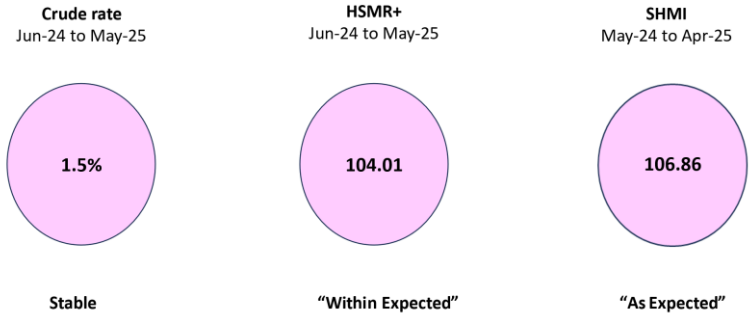
- Pro-active approach with increased divisional / speciality ownership and clinically-led learning and actions, supported by in-house analytics and intelligence for data provision

- Highlighted "key themes" for individual specialities but also sharing learning across Trust and wider forums.

Mortality Surveillance

1.1 Crude and adjusted mortality rates

Latest formal Telstra reporting June 24 - May 25 (September 2025 report into LfD Meeting)



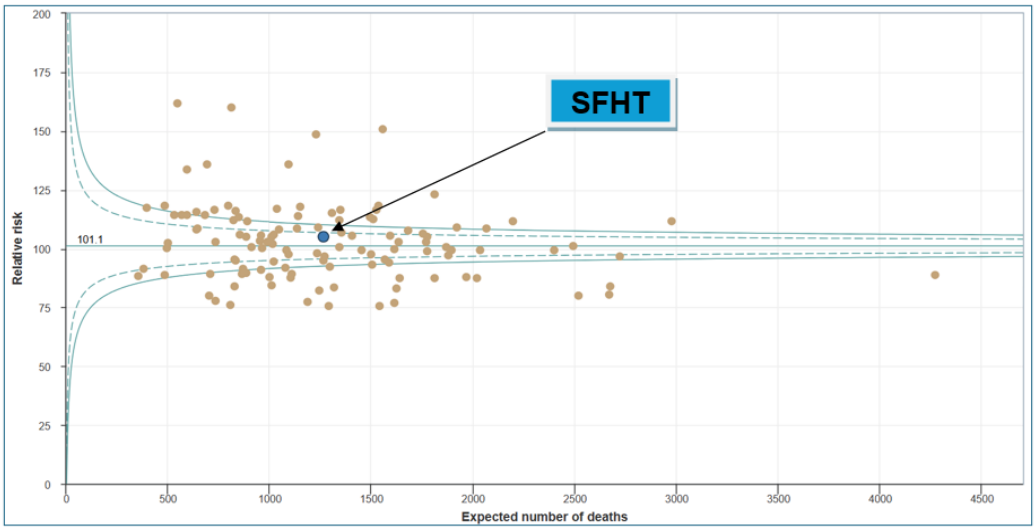
- The Trust currently reports being "as- (or within-) expected" values for the reporting metrices SHMI, HSMR+ and SMR.
- SHMI value has seen a small increase but initial reflection with Telstra was for this to be unsurprising, considering the HSMR+ trend previously seen over that reporting month.

A small number of outliers trigger across the various models but in latest reporting (September), none are triangulating across all three metrics (HSMR+, CUSUM and SHMI).
Different models for adjusted mortality are available and much work has been undertaken to help provide, what we feel is, a more robust approach to understanding the data and reporting metrics. However, common to all these is a reliance on accurate and relevant data being provided; factors which play into this include clear documentation, correct and consistent alignment to coding and timely and accurate diagnosis, all these helping to accurately reflect the complexity of the patient and provide a more-true picture of activity being undertaken.
Current triangulation, to support understanding and focus, includes review of HSMR(+), CUSUM alerts and SHMI.
Telstra's September report indicated no fresh concerns or significant highlights to bring to the Trust's attention.

HSMR+ National Peer comparison (Last 12 months)

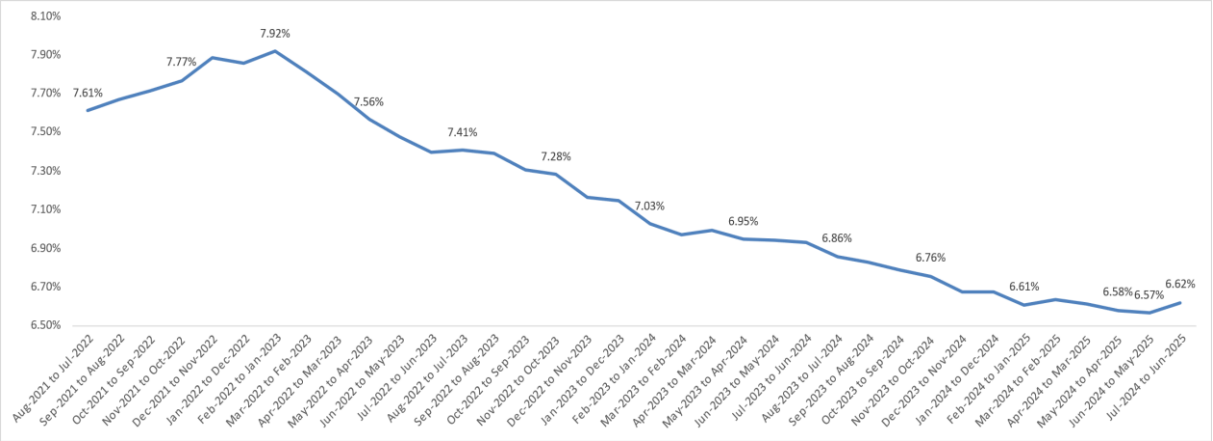
Peer relative analysis continues to see SFHT within the middle of the funnel-plot distribution.

(SFH = blue; national peers = brown)

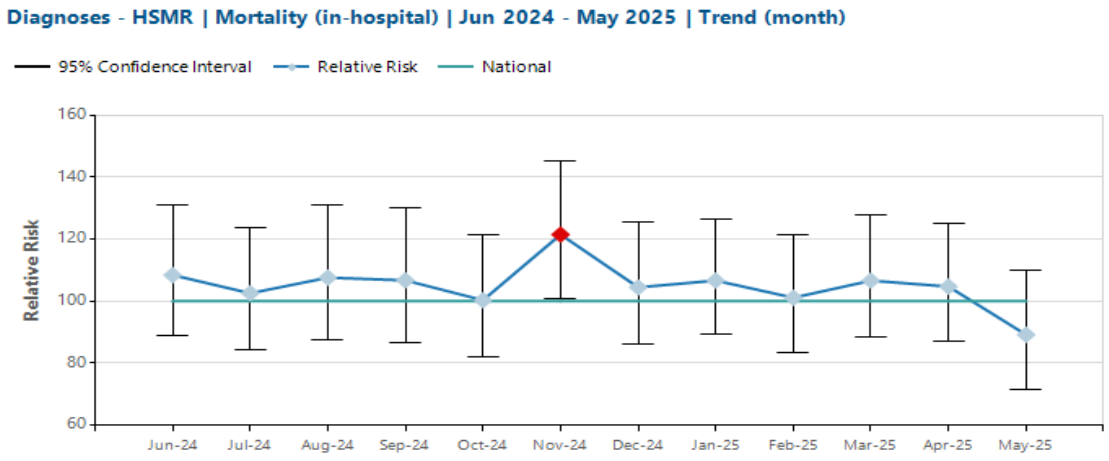


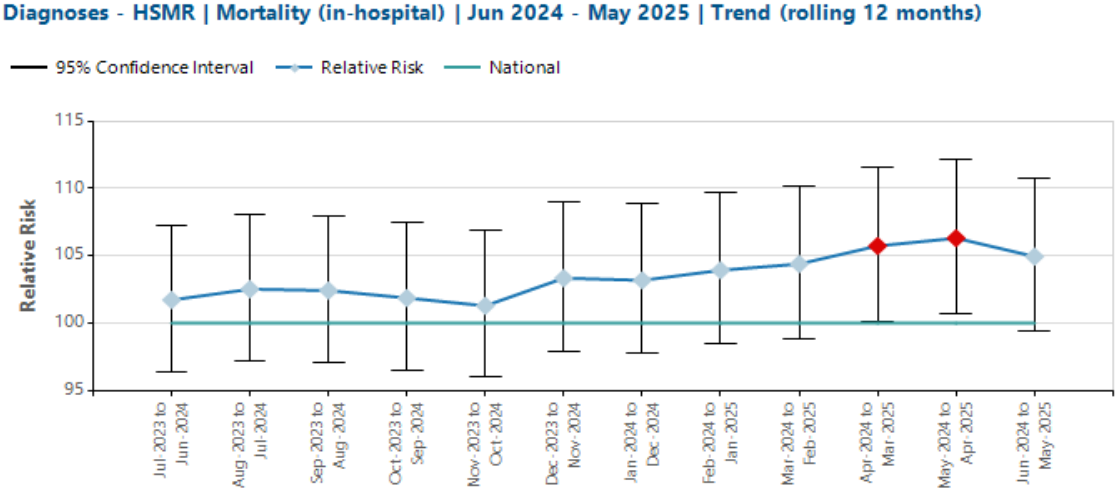
A focus over the past 36 months has been that of the importance of accurate and timely documentation and how this impacts coding; a marker of this includes the recording of diagnoses, as opposed to symptoms and signs, where we continue to see an overall improved picture.
A strong educational focus continues through forums such as Grand Round, internal Governance meetings and Clinical Leadership meetings, where the expectation is to share learning and understanding.

Percentage of Spells in Symptom and Signs Chapter (Rolling Trend)

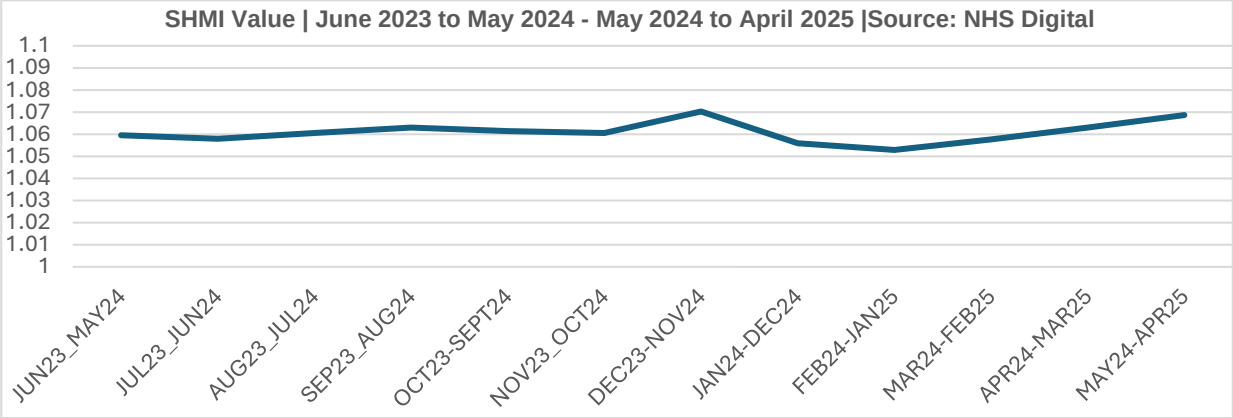


HSMR+ Trends:

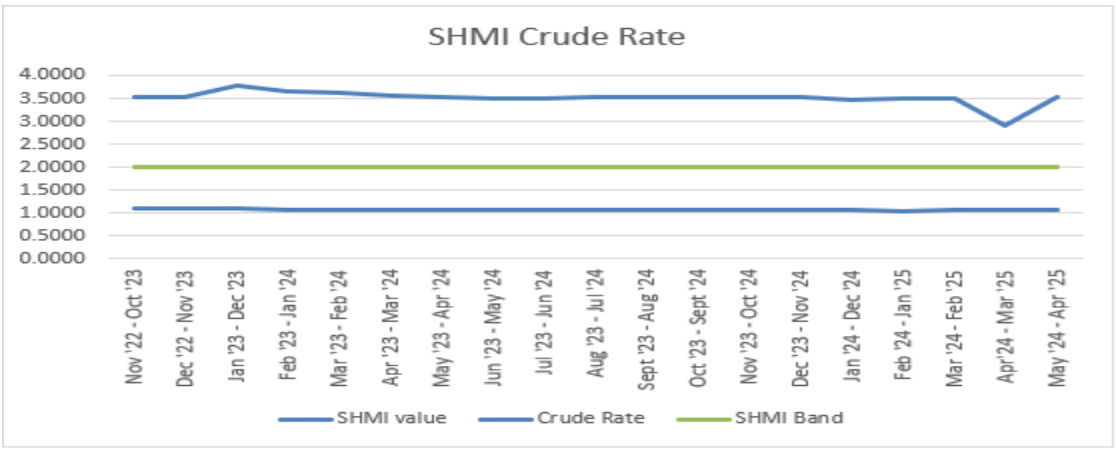




SHMI Value



SHMI Crude Rate



Outlier Areas:

CUSUM alerts derive from cumulative sum statistical process control charts, which plots patients' actual outcomes against their expected outcomes sequentially over time; a breach triggers an alert.
The latest mortality report from Telstra indicates previously highlighted areas have largely normalised with no change in the CUSUM alerts triggering at the max (99.9%) threshold; any prior alerts will persist until the 12-month rolling period expires.
There are NO reported new diagnosis groups alerting when triangulating across HSMR+, CUSUM and SHMI methodologies.

- Anaemia:
  - HSMR alert Mar 24
  - CUSUM alert Jul 2024 (99.9%).
  - A clinical coding review, since the last report, did not appear to reveal any major concerns but it was felt the diagnosis was largely driven by symptoms and signs of anaemia related to underlying conditions.
- Intestinal Infection:
  - HSMR alert Mar 2025
  - Last CUSUM alerts Aug 22 (99.9%), Jan 23 (99%)
  - There have been no further CUSUM alerts in this diagnosis group over the latest reporting period.
  - Previous clinical review highlighted alternative diagnoses, potentially non-infective, but presenting as non-specific abdominal symptoms.

- Superficial Injury and Contusion:
    - HSMR alert Dec 2022
    - The last CUSUM alerts were Aug 24 (99.9%) and Jan 25 (99%).
    - Initial coding review highlighted accuracy and good adherence to coding rules, thereby reflecting presentation diagnosis / symptoms.
- Other Non-traumatic joint disorders:
    - HSMR alert Nov 24
    - CUSUM alert Nov 24 (99%)
    - This is understood to be a relatively low-risk diagnosis group and potentially sensitive to variance. Monitoring continues but early forecast indicates this alert will no longer exist within the coming 1-2 months.

"Aortic, peripheral and visceral artery aneurysm" has been highlighted as a single diagnosis group by triangulation but not on CUSUM; the metric appears to report "higher" for cumulative 12-month HSMR+ but not on any single month; Telstra are looking into this data to ascertain whether likely common cause variation or determine the need for focused / targeted review.

- Early review identifies 9 deaths with 3 occurring in July 24; the alert may therefore disappear from the dashboard within the next couple of months.
- Discussion with Telstra indicates this to likely be a higher risk group with wider comorbidity scoring and acuity; the data does not appear to highlight any major concerns at this time and the advice is to monitor.

A projected small monthly increase in HSMR was seen in July reporting with SHMI remaining stable. Data revealed lower average age, comorbidity coding and average frailty score.
Frailty, being one of the key metrics reported through Telstra, has an impact on overall risk and mortality scoring. The coding team have worked closely with the clinical teams to understand the rules and establish an approach to documentation and capture.

In addition to this, an increase in 4hr+ Emergency Department (ED) waits was noted. Further analysis on major admissions and 12hr waits did not highlight any obvious strong corelation with a prior HSMR spike but further analysis is being undertaken to understand any trends / patterns or underlying links between long waits and mortality rates.

End of Life Care (EoLC):

Due to the nature of strict criteria and previous inclusion within metrics, the Trust has historically been reported as an outlier in terms of "Specialist Palliative Care" coding. Monitoring continues despite this not being a part of formal HSMR+ reporting.
The Service had a CQC visit in February 2025 that was positive, being particularly pleased with the development of EOL care delivery within the Trust in the last 2 years.

The last quarterly report highlighted:

- 4 EOL related complaints in Q1 relating to nutrition, care, and discharge with most being communication related. The team are continually offering specific training and seeking enhanced ways to reach individuals and teams.
- 2 EOL related compliments.
- The Amber care bundle, for patients where outcome is uncertain but death a possibility, continues to be rolled-out with a facilitators network launched May 2025.
- A focus on ReSPECT includes daily nursing metrics and has been reported "green" across these areas; a ReSPECT text box is now live on the clinical discharge summary to support information sharing and wider completion.
- EOL care team were nominated finalists in the Integrated Care Systems Award category of the National palliative Care Awards, the only acute Trust in the finalist's line-up.

Work continues on trying to ensure effective identification of patients who are deteriorating or approaching end of life, with a focus on advanced care planning, documentation such as ReSPECT, and “sticker notification” for Specialist Palliative Care involvement / awareness.

EOL Audit:

- The EOL Care Team has completed an audit of 120 deaths within the first 48hrs of admission to ED.
- Highlighted areas included the importance of accurate diagnosis, opportunities to improve communication and documentation of EOL status of patient, alongside the need to ensure completion of assessment tools (e.g. frailty score) and ReSPECT documentation.
- The report has been submitted in draft form and is to be formally presented at PSC, alongside the regional LfD forum.

Mortality Benchmarking Provider:

Following a 1-year extension to the contract with Telstra (Dr Foster), the decision has been made, with Quality Committee agreement, to not renew the contract but align, where able, with colleagues in the ICS (i.e. NUH) and consider alternative provision for benchmarking data. Although we have developed a strong relationship with our designated Telstra analyst / consultant, the change provides financial benefit and the use of local trust data and enhanced analytics, is thought, will enable more up-to-date information than either HSMR+ or SHMI alone. The main focus will now be SHMI, this being the key metric highlighted in the Performance Framework report.

Local Trust Data:

The longer term strategy is to have a more pro-active and clinically driven approach, where teams and individuals, through greater ownership of their data, will highlight areas for further review / analysis, as a result of early signals and trends. It is felt this is a good opportunity to make changes as a result of our relatively stable mortality position with SHMI and HSMR+.
The Trust has been placing focus and a great deal of work in developing their internal Power BI mortality dashboard, bringing together Trust data in one easy-to-access place, being delivered at speciality level, and including information around patient quality and safety metrics. This has the potential advantage of presenting more up-to-date data and trends.

Wider learning, accountability and collaboration:

A Regional / ICB Learning from Deaths forum is in early development but hoped will allow greater sharing of information between stakeholders and peers, rich discussion and provide a foundation for wider accountability. This forum should enable challenge and enhanced understanding of the factors and inter-dependencies which contribute to ensuring a high quality approach to system working.

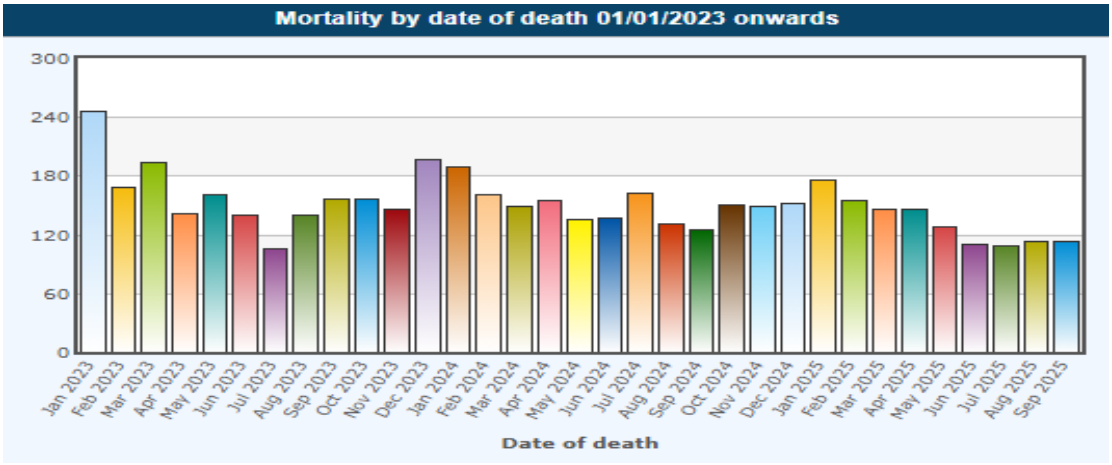
The Mid-Notts “Interface Workstream” includes Primary and Secondary Care, alongside involvement from Local Medical Council (LMC) and ICB colleagues; the purpose is to identify challenges at the “interface”, facilitate (and undertake) focused project work, support improvements to working and consider system-wide understanding.

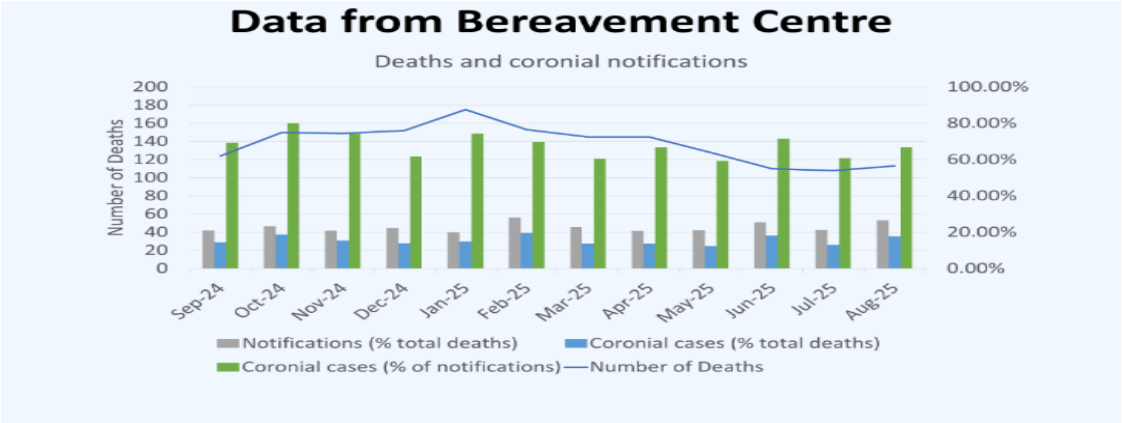
Independent review of Learning from Deaths has recently been commissioned through 360 Assurance; this piece of validation is envisaged will produce comment around areas for improvement whilst providing assurance as to governance and process. It is intended to bring the summary findings of the review as part of the next Learning from Deaths submission.

Review of deaths and SJRs

The Datix IQ mortality review tool has now been live for almost a year. Mortality reviews are requested and managed via this platform and include Structured Judgement Reviews (SJRs), avoidability assessments and other learning outcomes. Training on this tool and completion of the review continues in-house, in an attempt to meet the standards for quality assurance and provide consistency in the Trusts approach to mortality reviews and wider learning.

Data from the Medical Examiner Service:





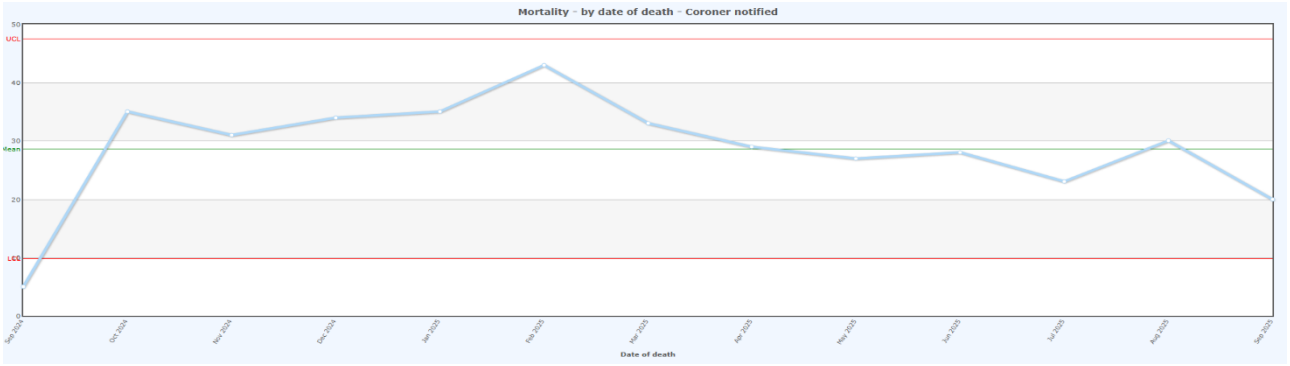
Legislative changes to the process of Death Certification and role of the Medical Examiner have been in place since September 2024. The Medical Examiner Service works hard to meet 100% scrutiny target for cases.

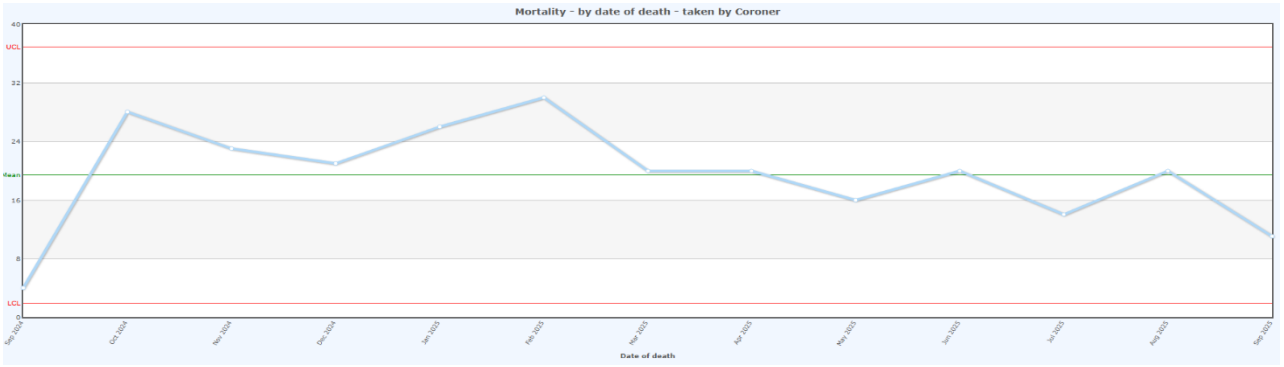
Reporting from the ME and Bereavement service focused on Q1 data, although it was recognised that figures held by the service may be slightly different to those held within the Trust dashboard due to timings (of referral and data capture).

- Q1 data from ME service for acute deaths presented, 373 adult deaths, 3 child deaths.
- Adult cases resulting in 290 x direct MCCD issued, 83 x referred to Coroner, 54 of these cases taken over. Child cases resulting in 3 x cases taken for Post-mortem.
- This quarter has included 3 bank holiday periods which impacts on timelines.

A reduced proportion of cases being referred to the Coroner has been seen compared to the previous year with an increased percentage of these cases being taken by the Coroner. Discussion continues in how to ensure timely and effective preparation and undertaking for any matters requiring detailed review and reports, including the role of FROE (Factual Recollection of Events) documentation and feeding into patient safety investigations.

Mortality- Coroner Notifications and Taken by Coroner:





Structured Judgement Reviews

The Trust continues to approach case-note review methodology in the form of Structured Judgement Reviews (SJRs) as its approach for further investigation and learning.
SJR reporting as part of the Quarterly LfD update highlights:

- Migration of SJRs onto the Datix IQ platform is now mobilised.
- Individual SJR methodology and Datix user training has been delivered to 20 Speciality and Divisional Mortality or Governance leads, alongside additional group sessions with Urgent and Emergency Care and General Internal Medicine.
- Data from completed SJRs are available on the Power BI dashboard.
- At the time of data enquiry (09/02/2025) 92.86% SJRs had been requested through the Medical Examiner with 25% of these being related to LD cases.
- Of those requested, more than half have been closed (complete) with improvements in “time to completion” being seen. Consultants no longer score their own care anymore, providing increased objectivity.
- Good completion of “overall phase of care” review is reported; the predominant rating is that of “good”, aligning with our overall picture of CQC rating. Leads are being encouraged to ensure timely completion and sign off so as to ensure the system is as up-to-date as possible.
- The focus, moving forwards, is to encourage thematic review using specific problem types and feeding into Divisional Mortality meetings for wider discussion.

The number of SJRs requested saw an increase in Q1 25/26 with 46 requests including mandatory cases such as Learning Disability or patients detained under the Mental Health Act.

Q2 reporting is awaiting month-end numbers for completion and data validation; in addition, it is understood not all SJRs were captured on Datix IQ for Q2 due to the TGR (Trust Governance Review) approach being trialled over this period. SJRs have reverted to being recorded on Datix IQ and, along with retrospective entry of the SJRs previously coming within the TGR envelope, should be reflected in future reporting. SJR requests for Q1 account for 12.01% of total deaths.

For reference, since 9 September 2024, Medical Examiners in England have referred 7 to 8% of deaths in acute trusts for case record review or equivalent, and 5 to 6% of all deaths for some form of clinical governance review (National Medical Examiner report 2024- published Sept 25).

Q1 2025/26	APR	MAY	JUN
Total Deaths	145	128	110
Deaths / Quarter	383		
Coroner Notified	30	27	29
Taken by Coroner	19	16	19
SJR (Monthly)	17	8	21
SJR (Quarter)	46		
SJR (Quarter) %	12.01%		

SJRs outstanding from the previous DATIX web platform have been discussed within Medicine Division Morbidity / Mortality meetings and subsequently signed off.

Learning Disabilities (LD)- Feedback from LeDeR Reviews:

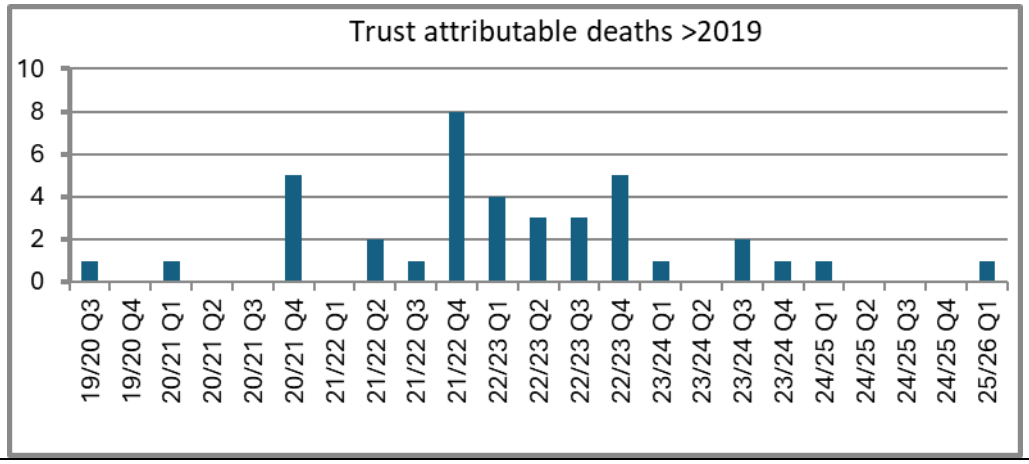
Since the previous LeDeR report in April 2025 there have been eight deaths in patients with learning disabilities in the Trust. Three of these were female and five were male.

The LD nurse receives data shared from the LeDeR reviews relating to patients who have died whilst at Sherwood Forest Hospitals. The aim of this is to look for themes and trends which can support learning across the organisation.
During this reporting period there have been three new LeDeR reviews shared from deaths at Kingsmill hospitals.
The LD Nurse attends the LeDeR working group meetings on a monthly basis and continues to support the ICB LeDeR reviewers with additional information and opportunities to review the paper records if and when required.
The three redacted reviews received during this reporting period focus on the flagging of LD within notes, communication, responding to family requests and management at EOL.

Feedback and Serious Incident Investigations from Coroner:

There is a requirement to report to board an estimate of deaths where a problem in care has been felt to contribute to a death. STEIS and PSII are felt to provide insight into these cases, with these being regularly taken for coronial investigation. Investigations and inquests can take months to conclude and report; however, learning will be reported as becomes available. Numbers over the past 5 years appear small.

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



The last report to Learning from Deaths highlighted the following:
Q1 Summary:

- 16 inquests and 25 investigations have opened in relation to new coronial matters.
- 25 investigations have closed without inquest
- 11 inquests have been heard and concluded with outcomes including accident / misadventure, industrial disease, narrative conclusion and natural causes.
- No regulation 28 notifications (the report highlighted it is over a year since receiving the last Reg 28)
- Highlighted areas included post operative complications (bleeding and urosepsis) and death as a consequence of an extremely rare but recognised condition, more likely than not triggered by a reaction to appropriately prescribed medication.
- The single case referenced under "attributable death" in 25/6 Q1 is undergoing a PSII (also coronial) so this is not confirmed.

Q2 Provisional Conclusions:

- Died from an ischaemic bowel against a backdrop of a stroke as a consequence of which the use of blood thinning medication had been temporarily paused.
- Died from the effects of the spinal cord injury caused when patient's wheelchair tipped during transportation.
- Died from metastatic lung cancer. On balance, the lack of referral by the GP surgery to the respiratory team for further investigation and management was considered to have made a more than minimal, negligible, or trivial contribution to death.

Inquest feedback from 2 cases was brought to the Learning from Deaths group (July 2025) for information, discussion and further communication.
The newly implemented "BIG 5" communication was also used to support wider sharing.
Recommendations were focused on:

- Remembering differential diagnoses for agitation and aggression, including alcohol withdrawal, acute hypoxia
- Importance of early EOL recognition, thinking about patient comfort and informing family members early
- Ensuring continuity in the written record, to help accurately reflect a person's clinical picture.

This communication and learning formed part of a wider action through PSIRG (Patient Safety Incident Response Group) and included development of a patient safety alert for sharing across the Trust as an *"iCare"* alert. (**see *Appendix 1***)

Approaches to improving sharing of learning has been a theme of discussion, with opportunities including Grand Round planned to ensure a broader spread of information sharing.

Learning from Deaths (LfD) Meetings:

Monthly meetings have strong and engaged trust-wide multi-disciplinary representation, alongside valuable involvement from community stakeholders (e.g. Palliative Care) and ICB.
Divisional areas feed into the LfD Group by way of quarterly reports, with discussion and wider intelligence being supported through involvement of the Clinical Coding team, Business Intelligence / Analytics colleagues and triangulation with Medical Examiner intelligence to help identify thematic learning.
Monthly focus meeting with our Telstra data analytics consultant and their formal mortality intelligence report supports understanding and provides focus.
The forum continues to act as a vehicle for discussion and review of mortality trends and outliers, from Trust and specialty-specific perspectives.

Discussion of mortality metrics help identify areas for deeper dive or targeted review to help understand outlier data and draw themes for learning and trust opportunities for improvement. The latest Power BI platform, using SHMI data, has been shared amongst the group with access and training made available.

A recent change in LfD Chair has led to review of processes and considerations for wider learning opportunities with an emphasis on capturing themes and an intentional shift to focus on aspects of "good" care and performance (safety II).
Newly implemented initiatives to aid consistency in reporting include:

- A standardised reporting template (to highlight themes and learning actions)
- "BIG 5" communication sent out to triumvirates (as a summary of key themes).

Standardised Divisional Reporting Template:

Learning from Deaths – Divisional Summary Report (2025/26)			Sherwood Forest Hospitals NHS NHS Foundation Trust	
REPORTING PERIOD		Standard Quarterly LfD Report		
DIVISION		Targeted Review (Diagnosis Group)		
DIVISION LEAD		Other		

SUMMARY OVERVIEW				
Total Deaths in period			Number of cases with potential sub -optimal care	
SJRs Undertaken			Please confirm ALL /any cases with highlighted issues or themes felt contributory to (or to have had any impact on) death have been escalated / managed appropriately	
Coroner referrals				

KEY THEMES AND LEARNING (Summarise recurring / pertinent themes- e.g. communication, documentation, pathways.....)
1:
2:
3:

AREAS / EXAMPLES OF GOOD CARE:	AREAS OF SUB-OPTIMAL CARE / EXAMPLES FOR IMPROVEMENT:
1:	1:
2:	2:

ACTIONS IDENTIFIED:	RESPONSIBILITY	DUE DATE	PROGRESS
1.			
2.			
3.			

IMPACT OF LEARNING (Measurable outcomes / changes)	FEEDBACK (How has learning been shared?)
1:	1:
2:	2:

OTHER INFORMATION (for reporting / sharing):

The BIG 5 (Example- July 25):

Learning from Deaths – "The BIG 5"

Learning Themes for July 2025

Sherwood Forest Hospitals NHS Foundation Trust

1. **Effective documentation and communication:**
   - Make sure your notes are clear and accurate
   - Remember the patient in your communication
2. **Complete tasks:**
   - E.g. Sepsis screening, VTE risk assessment
3. **Follow through with plans, including tests, imaging and requests….**
   - Take responsibility for ordering, chasing results and actions.
4. **Coding-**
   - THINK- importance of Primary diagnosis (what you are treating) and co -morbidities
5. **Wider discussion / external recommendations:**
   - Remember differential diagnoses for agitation and aggression, including alcohol withdrawal, acute hypoxia
   - Importance of early EOL recognition; think about patient comfort and inform family members early
   - Ensure continuity in the written record, to help accurately reflect a person's clinical picture.

Dedicated to Outstanding care

Divisional reporting has highlighted recurring / aligned themes related to communication, ceilings of care, early recognition of EOL and specialist palliative provision.

There is a focus on trying to ensure themes and any key-learning are shared Trust-wide and, if applicable, beyond.

LfD Terms of Reference

- Currently undergoing initial review from 360 Assurance with feedback awaited and improvement plan to ensure clear process and strong governance.

Reflections on Q1&2 2025/26

Original Plans:

- Continue to work with clinical colleagues to improve accuracy of clinical documentation to enable effective diagnosis, treatment and coding.
- Agree arrangements for provision of benchmarking and analysis which will be of best value to the Trust.
- Continue to work towards pivoting to clinically-led, closer to real time learning supported by quantitative and qualitative data.

Summary of Key Themes:

- Frailty is recognised to be a key metric and felt to have direct impact on mortality reporting; the coding team has worked closely with clinical colleagues to establish rules and agree a coding approach. Communication and wider learning, in the form of Grand Round and other teaching forums help emphasise the importance of coding (through timely and accurate documentation) and providing a true reflection of activity.
- EOL Care- identification of deteriorating patient; early recognition and escalation.
- Communication, coding and documentation remain key themes with an emphasis on supporting divisional and mortality leads to better understand the importance, relevance and impact in quality outcomes.

Benchmarking / Mortality Intelligence:

- Agreement is in place to focus on SHMI as the key mortality metric for benchmarking, this being the measure identified in the Performance Framework. At the same time, an alternative provision for benchmarking data is being considered to better align with colleagues in the ICS (i.e. including NUH).
- Internal development of the Trust Power BI dashboard provides, what is hoped to be, comprehensive data sets to improve understanding and access to information at a local and speciality level; this is accessible to speciality and divisional mortality leads, with information in one place alongside key essential data (including SJRs) and wider national benchmarking metrics.

Plans for Q3/4

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

Appendix 1: iCare Safety Alert

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

SAFETY ALERT

Please share this safety alert with your staff and colleagues as appropriate. Consider forwarding this e-mail, reading this alert out at briefings and handovers, printing a copy of for staff rooms and offices or displaying it on notice boards. All Safety Alerts can all be found on the Patient Safety intranet page.

Differential Diagnoses For Agitation And Aggression

1 What happened?

There has been a recent incident involving a patient with Chronic Obstructive Pulmonary Disease (COPD), and Obesity Hypoventilation Syndrome (OHS).

The patient was not tolerating the prescribed Non-Invasive Ventilation (NIV) and became increasingly agitated due to hypoxia.

The patient also had a history of alcohol misuse but hadn't had a drink for a while.

2 What should have happened?

There are differential diagnoses for agitation and aggression, these include alcohol withdrawal, but also acute hypoxia.

Where patients have a history of alcohol misuse and who also have a current respiratory diagnosis, please consider whether hypoxia is the cause of the agitation.

Clinical staff can then implement the most appropriate treatment plans to manage cause of the agitation.

3 What can be learned?

The etiology of agitation is multifactorial, encompassing acute medical illnesses such as infections, metabolic disturbances, or pain, substance intoxication or withdrawal, delirium, and a spectrum of psychiatric disorders including mood, psychotic, and personality disorders.

Early identification and a systematic evaluation to determine underlying causes are critical, as agitation of unknown origin should be presumed to have a medical cause until proven otherwise, particularly in populations such as the elderly or those without a prior psychiatric history.

4 What are we doing to stop this happening again?

Effective management relies on a combination of non-pharmacological de-escalation strategies and, when necessary, targeted pharmacological interventions, always prioritizing the safety of all involved.

Clinicians should document the differential diagnosis and the management plan implemented in the patient records. This will support the identification of the correct causative factor and the evaluation of the effectiveness of the treatment.

	Doctor	Nurse/AHP	Admin	All Staff
Trustwide	√	√		
Division				
Specialty				

002809

Trust Board

Subject:	**Nursing, Midwifery, and Allied Health Professional Bi-annual Staffing Report.**	**Date:**	October 2025
Prepared By:	Rebecca Herring (Associate Director of Nursing - Workforce) Sarah Ayre (Head of Midwifery) Kate Wright (Chief Allied Health Professional)		
Approved By:	Phil Bolton, Chief Nurse & Paula Shore, Director of Midwifery.		
Presented By:	Rebecca Herring (Associate Director of Nursing - Workforce)		

Purpose

This report aims to provide the Board of Directors with an overview of nursing, midwifery, and allied health professional (AHP) staffing capacity within Sherwood Forest Hospitals Foundation NHS Trust (SFH). It is also to assure our compliance with the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance, National Quality Board (NQB) Standards, and the NHS Improvement (NHSI) Developing Workforce Safeguards.	**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 well-being within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X	**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	**X**
PR4	Failure to achieve the Trust's financial strategy	
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

Nursing, Midwifery & Allied Health Professional Committee Sept 2025
People, Culture &Improvement Committee Sept 2025

Acronyms

Executive Summary

Background

This report provides an overview of the nursing, midwifery, and allied health professional (NMAHP) workforce at SFH. It evaluates compliance with national guidance, including NICE (2014), NQB (2016), and NHSI (2018), while also presenting the ongoing workforce developments. The overarching aim remains to ensure that the Trust has the right number of staff, with the right skills, delivering high-quality care at the right time and in the right place.

NQB EXPECTATION 1: RIGHT STAFF

Since the last reporting period, the Trust has continued to strengthen its evidence-based workforce planning. Two 30-day Safer Nursing Care Tool (SNCT) data collection cycles were completed in September 2024 and March 2025, ensuring continued alignment with national safe staffing requirements. A Birthrate Plus® review is currently underway to provide assurance on maternity workforce requirements, with early findings indicating rising complexity of care and increased safeguarding needs. Establishment reviews for allied health professionals are also progressing well, with therapy services completed and radiology underway, although safe staffing for AHPs remains an evolving national agenda.

Workforce benchmarking demonstrates that the Trust's Care Hours Per Patient Day (CHPPD) currently stands at 8.4 compared to a peer median of 9.1, indicating that staffing levels are broadly comparable while also highlighting efficiency in deployment. However, Datix reporting and workload return submissions continue to show pressures linked to therapeutic observation requirements and short-notice staff absences. In response, the phased roll-out of SafeCare, an electronic workforce deployment tool, is improving real-time visibility of staffing and patient acuity to support safer decision-making.

NQB EXPECTATION 2: RIGHT SKILLS

Recruitment and retention remain a priority across the Trust. Nursing vacancies are below the national benchmark, though Band 5 posts remain more challenging. Over 35 newly qualified nurses are due to join in the coming months, alongside targeted recruitment initiatives aimed at reducing our reliance on temporary staffing. In maternity, support workers have transitioned to Band 3 roles in line with the Health Education England (HEE) Framework, and the service will shortly welcome a Consultant Midwife and Lead Advocate to strengthen divisional governance and service-user voice. Neonatal services continue to move forward with qualification in speciality (QIS) attainment, with 85% of staff expected to be QIS-trained by September 2025.

AHP recruitment is broadly strong, with progress across occupational therapy, physiotherapy, radiography, and orthotics, although sonography remains a significant challenge, and MRI staffing pressures are anticipated at the Clinical Diagnostic Centre. Mitigations include new trainee pipelines, hybrid posts, and apprenticeship routes. Stability has also been achieved in Speech and Language Therapy, with substantive recruitment eliminating agency spend. Overall, the workforce position is improving, though ongoing risks in key specialities require continued focus

NQB EXPECTATION 3: RIGHT PLACE & TIME

Despite ongoing workforce pressures, staffing fill rates have remained stable and consistently above 95% for day shifts and 93% for night shifts, ensuring minimum safe thresholds are maintained. However, it is recognised that there have been multiple occasions where the optimum staffing levels haven't been reached, and this has had an impact on patient care and staff experience. Agency usage has reduced by 28% compared with the same period last year, with no escalated rate shifts required for eight consecutive months, reflecting strengthened controls and grip on temporary staffing. The SafeCare workforce deployment tool is now being rolled out across inpatient areas, providing real-time oversight of patient acuity and dependency to support daily safer deployment decisions. The Surgical Division has successfully completed the pilot phase, with positive feedback and reassuring compliance data. The Urgent and Emergency Care Division is next to go live, with training underway, and full implementation across all areas is expected by January 2026.

Recommendation

Overall, the Trust demonstrates good compliance with the NHSI Developing Workforce Safeguards, and the Chief Nurse and Chief Medical Officer have confirmed that nursing, midwifery and AHP staffing is safe, effective, and sustainable. The People Committee is therefore asked to receive this report, note the progress being made across nursing, midwifery, and AHP workforce planning, and acknowledge compliance with the Developing Workforce Safeguards.

Report Title:	Nursing, Perinatal, and Allied Health Professional Bi-annual Staffing Report
Date:	September 2025
Author:	Rebecca Herring (Associate Director of Nursing - Workforce) Sarah Ayre (Head of Midwifery) Kate Wright (Associate Chief Allied Health Professional)
Executive Sponsor:	Phil Bolton (Chief Nurse) Paula Shore (Director of Midwifery)

Purpose

2.0 The purpose of this report is to provide an overview of the nursing, midwifery, and AHP workforce to ensure we have the right number of staff, with the right skills, delivering high-quality care at the right time and in the right place.

2.1 The report will also analyse the Trust compliance with the NICE (2014) safe staffing guidance, NQB (2016) expectations, and the NHSI (2018) Developing Workforce Safeguards recommendations as well as discuss the recommendations put forward from the NMAHP establishment reviews.

Nursing & Midwifery Overview

NQB EXPECTATION 1: RIGHT STAFF

3.0 Evidence-Based Workforce Planning

3.1 Since our last report, regular cycles of nursing acuity and dependency data have been collected and analysed using the Safer Nursing Care Tool (SNCT). This objective, evidence-based nursing tool provides insight into patient acuity and dependency, which, when triangulated with nurse-sensitive indicators and professional judgement, informs the Trust's establishment-setting process.

3.2 In line with the Imperial licensing agreement, two 30-day SNCT data collection cycles were completed in September 2024 and March 2025. This ensures our continued compliance with the SNCT methodology, as endorsed by NICE in their 2014 safe staffing guidance and aligns with the recommendations outlined in the Developing Workforce Safeguards (2018) guidance.

Figure 1: Imperial Licences

SNCT License	RENEWAL DATE
Emergency Department SNCT	✓ July 2027
Adult Inpatient Area SNCT	✓ July 2027
Adult Assessment Area SNCT	✓ October 2025 (Renewal in progress)
Children & Young People SNCT	✓ October 2025 (Renewal in progress)

3.3 Analysis and recommendations reports have been shared with the Deputy Chief Nurse and Divisional Directors of Nursing and will continue to inform the establishment review process. Confirm and challenge reviews will be led by the Deputy Chief Nurse and Associate Director of Nursing Workforce in November, with Trust management team approval sought in December and Board approval in February.

3.4 Evidence-based maternity workforce requirements are outlined by NICE (2014), who recognise the use of Birthrate Plus® as a workforce tool to inform maternity staffing decisions, with the Royal

College of Midwives and the Royal College of Obstetricians and Gynaecologists endorsing the use of Birthrate Plus® (BR+). BR+ calculates the overall midwifery workforce needed across hospital and community services to safely manage the needs of women, birthing individuals and babies.

3.5 The Trust has commissioned an independent review with BR+ to provide assurance when to aligning staffing models and recommendations with front-line clinical practice, with the recommendations expected in the coming weeks. Early insights already highlight increased complexity of care, a rise in out-of-area activity, and a greater proportion of women and birthing individuals requiring enhanced high-risk care and safeguarding support. These trends are compounded by the ongoing effects of social deprivation across our local population, as reflected in the latest COREPPLUS25 data. The BR+ findings will therefore be pivotal for informing our next round of reviews scheduled in November 2025.

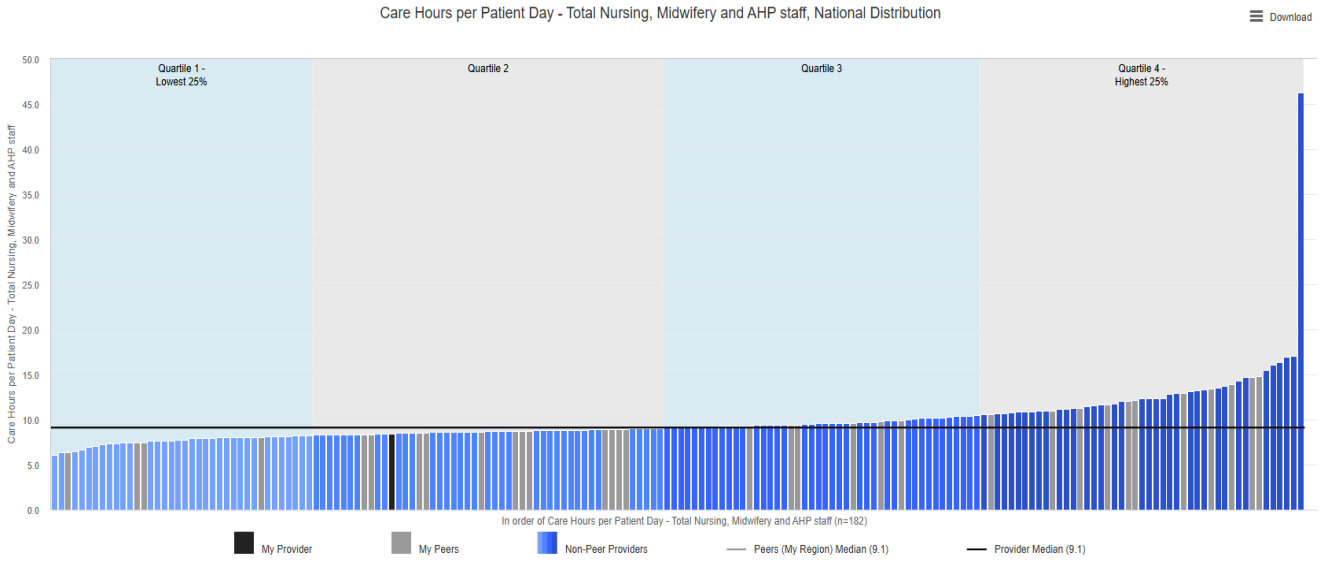
4.0 Benchmarking

4.1 Continuing with NQBs '*right staff* 'expectation, Trust must compare staffing with peers. Care Hours Per Patient Day (CHPPD) is a nationally reported metric used to quantify the average number of care hours provided to each inpatient over 24 hours. It combines the hours worked by both registered nurses and healthcare support staff and is calculated by dividing the total number of actual care hours by the number of inpatients at midnight.

4.2 CHPPD supports safer staffing by offering a consistent measure to assess and compare workforce deployment across wards, Trusts, and peer organisations. While it should not be considered in isolation, it is a valuable indicator for identifying variation, informing workforce planning, and ensuring that care delivery remains aligned with patient needs.

4.3 Figure 4 illustrates CHPPD at the Trust level, showing an improved position of 8.4 care hours per patient per day**,** compared to a peer median of 9.1**.** Although CHPPD is one of several metrics used to assess staffing effectiveness, this data indicates that our staffing levels are broadly comparable with similarly sized NHS Trusts and are not an outlier in terms of efficiency or variation.

Figure 2: Trust Level CHPPD



Data Source: Model Hospital, May 2025

5.0 Measure & Improve

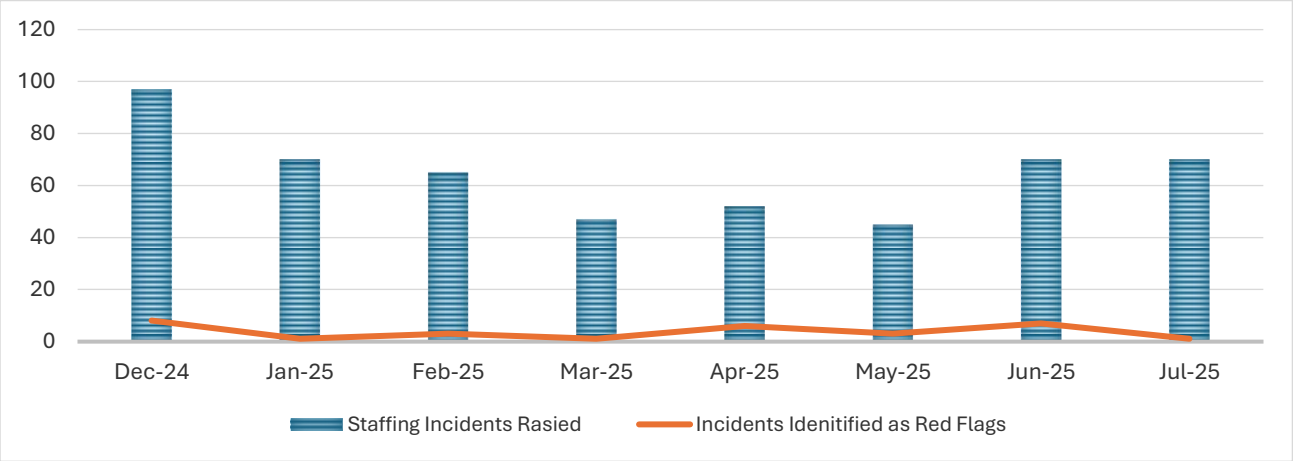
5.1 Datix remains the primary governance system for reporting staffing incidents at SFH, and through these reports, we can identify red flag events as outlined in the NICE guidance (2014). However, we are also scoping additional reporting mechanisms to complement our existing escalation and governance processes through the implementation of SafeCare. SafeCare is an electronic workforce management system used to monitor and manage staffing levels in real-time across clinical areas.

It enables ward managers and leadership teams to align staffing with patient acuity and dependency, supporting the delivery of safe and effective care.

5.2 As noted in our previous report, heightened activity and stretched workforce capacity continue to be identified as key underlying factors in reported staffing-related incidents. These challenges are further compounded by increased requests for additional resources to support enhanced therapeutic observations**.** This remains a consistent theme in instances where red flag delays in care are reported and often linked to short-notice staff absences. In response, clinical teams have implemented risk-based deployment strategies to ensure that minimum safe staffing levels are maintained.

5.3 In response to the growing national demand for enhanced therapeutic observation and care, NHS England has established a dedicated key workstream to promote shared learning through regular case reviews and system-wide collaboration**.** SFH remains an active participant in this workstream and continues to meet compliance requirements, including timely monthly submissions to the Patient Workload Return.

Figure 4: Staffing Incidents



Data Source: DATIX Reporting System.

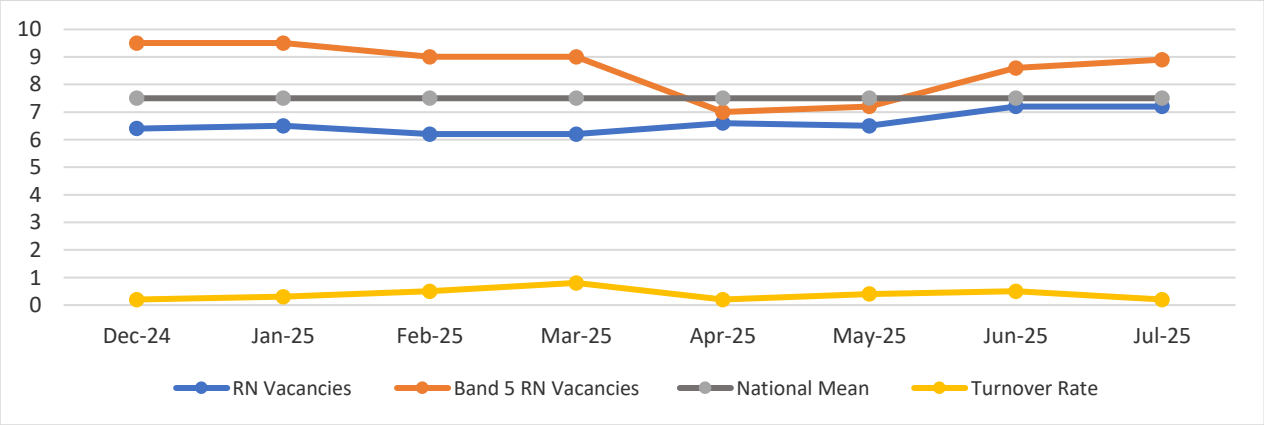
NQB EXPECTATION 2: RIGHT SKILLS

6.0 Recruitment, Retention & Education

6.1 Nursing vacancies continue to present a significant challenge across the NHS, with the most recent data indicating approximately 25,600 unfilled nursing positions in England, reflecting a vacancy rate of around 7.5%. Although this marks some progress compared to previous years, national vacancy levels remain above optimal thresholds and continue to place pressure on workforce capacity and care delivery.

6.2 SFH remains fully committed to addressing our nursing vacancies to ensure the delivery of safe, effective, and sustainable care across the organisation. Collective nursing and midwifery vacancies at SFH remain slightly below the national benchmark of 7.5%. However, Band 5 nursing vacancies continue to exceed this level. As the Band 5 cohort represents one of the largest segments of our registered workforce, steady progress is being made to reduce these vacancies. With over 35 newly qualified recruits joining the organisation over the coming months, and our consistently low turnover rate, we are optimistic that tangible improvements in our Band 5 vacancy rate will be realised.

Figure 3: Nursing and Midwifery Vacancy Position



Data Source: Workforce Informatics July 2025

6.3 At SFH, Nursing Associates (NAs) play a vital role in strengthening nursing teams and enhancing patient care. Acting as a bridge between Healthcare Support Workers and Registered Nurses, NAs provide essential support by delivering direct patient care, assisting with clinical tasks, and contributing to the planning and coordination of care. Their role helps improve the overall efficiency and effectiveness of the nursing team, ensuring high-quality and compassionate care. As we approach the final months of the SNA programme, the Trust will support our final cohort of 14 students in transitioning into qualified NAs posts across the five divisions.

6.4 A bespoke recruitment bank transfer event for Nursing Care Support Workers (CSWs) was held in May, with representation from across all divisions of the Trust. The event successfully generated 38 offers, resulting in the recruitment of 24 whole-time equivalent (WTE) vacancies. This positive outcome is expected to reduce reliance on bank and agency staff, helping to drive down the vacancy factor, support workforce stability, and support cost efficiencies across the Trust. Building on this success, the Medical and Urgent Care Division have adopted the same approach and scheduled a similar recruitment event targeted specifically at filling vacancies within the division, which is planned for early September. Based on previous recruitment activities, strong engagement is anticipated.

6.5 Advanced practice continues to grow across SFH, with 14 qualified ACPs and 18 trainee ACPs in posts across 8 different specialities. Since 2023, we have partnered with the University of Nottingham as our training provider for the MSc Advanced Clinical Practice and have utilised the apprenticeship levy to access their degree apprenticeship. Our first ACP apprentices at SFH are due to qualify this autumn.

6.6 The current financial climate has determined that there will be no local trainee ACP recruitment in the organisation for 25/26. In addition to this, in May, the government announced plans to abolish level 7 apprenticeships. However, a recent review by NHSE and the DfE undertaken in August has pledged to protect apprenticeship funding until April 2029 for the following five pathways, which are directly aligned to the 10-year health plan, with ACPs being one of those protected.

6.7 In line with Ockenden's call for system-wide funded workforce plans, our focus is on ensuring a sustainable, skilled workforce across midwifery, obstetrics, anaesthetics, neonatal and wider perinatal services. From November, the division will welcome the recently appointed Consultant Midwife, who will lead a portfolio of education, research, innovation, and health inequalities, with the overall aim to improve perinatal pastoral care.

6.8 All Maternity Support Workers (MSWs) within the acute service have now successfully completed the in-house training and are fully aligned to the HEE Band 3 Competency Framework. As a result, the acute establishment no longer includes Band 2 roles, ensuring a consistent Band 3 skill set across the service. Going forward, all future MSW recruitment will require new employees to have achieved the Care Certificate as a minimum, with training pathways in place to maintain and further develop competence. This updated pathway shift provides assurance of a standardised skilled workforce, aligned with national mandates.

6.9 Maternity Services have recently introduced the Lead Advocate role, a unique position within the service designed to ensure that the voice of women, birthing individuals, and families is heard. The role provides dedicated leadership to strengthen how service user feedback is captured, triangulated, and acted upon across all pathways. The Lead Advocate chairs the Perinatal Service Oversight Group (PSOG), which brings together feedback from multiple sources, including Maternity Voices Partnership, Friends and Family Test, complaints and compliments, and patient stories. This role is considered an exemplar of good practice, providing a clear and structured mechanism to integrate the lived experience of families into governance and improvement processes. It is envisaged that this model will be presented nationally as a benchmark for "what good looks like" in embedding service user voice at the heart of perinatal care.

6.10 The NICU team has successfully appointed a Clinical Educator, who is being funded for 22.5 hours per week by the Operational Delivery Network (ODN) for 12 months. This role is focused on supporting current and upcoming QIS students and will be managed by the NICU Practice Development Lead. Following positive engagement, the ODN has extended funding for a second year, with a review scheduled before the funding period concludes. Additionally, the ODN has provided further support by offering extra places on the QIS course, and the Trust has committed to supporting two staff per cohort (four per year). The division has put forward a bid to support with additional funding for training allocations.

6.11 Currently, 70% of the registered NICU workforce are QIS-trained, not including staff working in home care and NTC. Forecasts indicate that this will rise to 81% by March 2025 and to 85% by September 2025, with an additional 8 QIS-trained staff across the neonatal footprint who are not included in the daily safer staffing figures, as they are not substantively recruited against the NICU establishment. They do, however, work flexibly to support QIS compliance and staffing resilience.

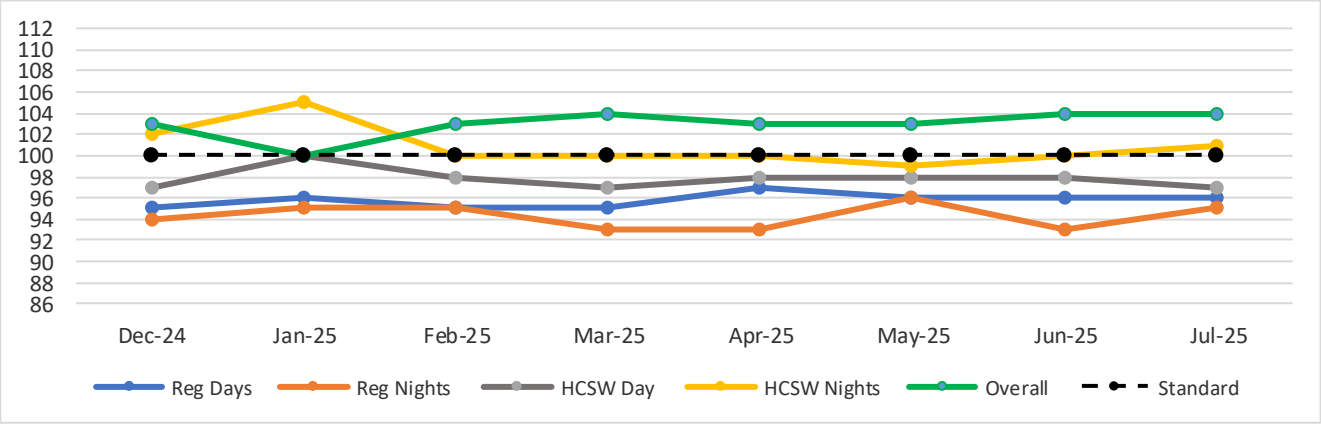
6.12 The NTC service is now fully recruited, with all staff having completed their induction. The service is expected to now operate at full capacity and within its allocated budget, contributing to improved continuity of care and stability in the wider neonatal workforce model.

NQB EXPECTATION 3: RIGHT PLACE & TIME

7.0 Productive Working, Deployment & Minimising Agency

7.1 Since our last report, maintaining safe staffing levels across services has continued to present significant challenges**,** driven by a combination of sustained elevated patient activity and ongoing workforce pressures**.** Patient attendance and acuity remain consistently high, leading to multiple activations of the Full Capacity Protocol during the reporting period.

Figure 5: Planned vs Actual Fill Rates



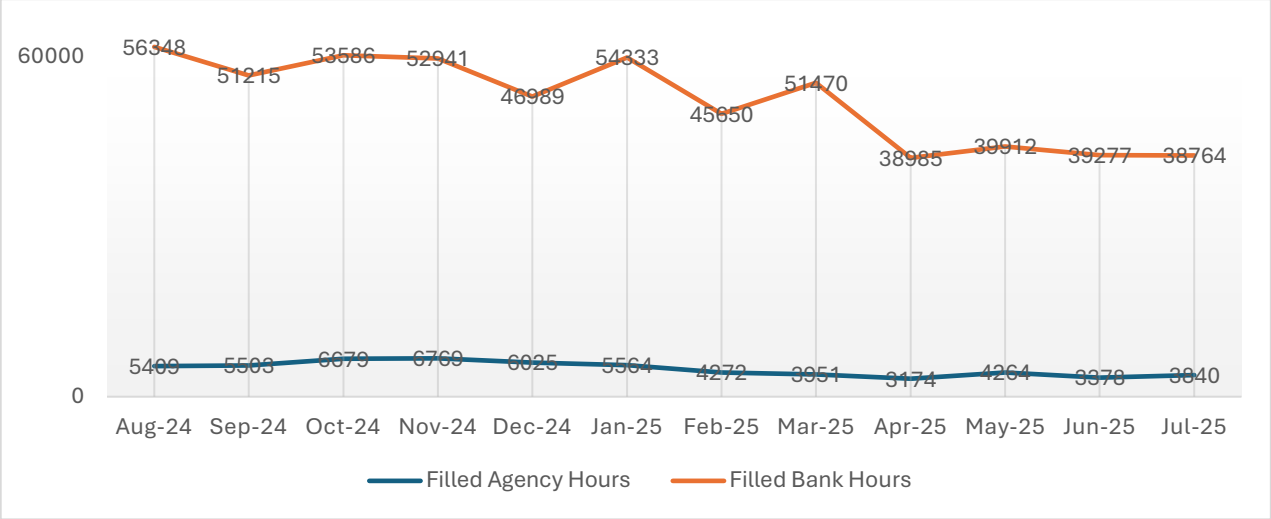
Data Source: Strategic Data Submission NHSE 2025.

7.2 Despite these pressures, clinical leaders have conducted regular risk assessments and implemented strategic deployment of available resources to ensure that minimum safe staffing thresholds are

maintained. The Trust has consistently achieved staffing fill rates above 95% for registered staff on day shifts and 93% for night shifts, demonstrating robust workforce planning. However, it is acknowledged that, while minimum staffing levels were met, there were multiple occasions where optimal staffing was not achieved, which may have impacted both the quality of patient care and the experience of frontline staff**.**

7.3 A continued reliance on agency and bank staff is being driven by multiple factors highlighted throughout this report. However, agency usage at escalated rates remains under tight scrutiny, with continued positive progress evidenced by zero shifts being required at escalated rates for the eighth consecutive month. When compared to July of the previous year, there has been a 28% reduction in overall agency usage, highlighting the effectiveness of the grip and control measures implemented to manage escalations. This ongoing trajectory of improvement is expected to continue as we move forward with the cost efficiency plans.

Figure 6: Agency and Bank Usage (Hours)



Data Source: Temporary Staffing Office, July 2025.

7.4 The Neonatal Unit has experienced a challenging year, with significant levels of long-term sickness absence continuing to impact bank and agency spend, as well as compliance with BAPM (British Association of Perinatal Medicine) safer staffing standards. Despite these pressures, staff have worked collaboratively to maintain safety and service continuity. To mitigate staffing shortfalls and support service resilience, nurses assigned to Neonatal Transitional Care (NTC) have been redeployed into the core Neonatal Unit with immediate effect. This measure has enabled the team to maintain safe staffing levels through escalations, while ensuring the continued delivery of high-quality neonatal care.

7.5 As mentioned previously within this report, the SafeCare Workforce Deployment Tool is being rolled out across the inpatient areas. This will support our risk assessments when deploying staff due to having oversight of real-time patient acuity and dependency. The surgical division has now completed its pilot phase of the project rollout, and initial feedback indicates it has gone well, with compliance data being reassuring. Current staffing escalation processes will continue as normal until all areas have successfully completed the implementation phase. The second division scheduled to go live is UEC, and training is currently underway. It is anticipated that all areas within scope will be live by January 2026.

NQB EXPECTATION 1: RIGHT STAFF

8.0 Evidence-Based Workforce Planning

8.1 There is currently no national safe staffing tool or guidance for AHPs. Safe staffing decisions therefore rely on demand and activity data, patient acuity levels, job planning, staff rostering and establishment setting. To mitigate shortfalls, AHP teams flex staffing within professional boundaries and skill mix, although this can result in reduced capacity in other areas. Professional judgement is applied daily to prioritise workload, with smaller specialities experiencing increased pressures during periods of escalation, such as activation of the Full Capacity Protocol.

8.2 Recent establishment reviews have progressed the development of minimum staffing levels for therapy professions, including physiotherapy, occupational therapy, dietetics, speech and language therapy, and orthotics. Reports have been drafted and will be presented at the SFH AHP establishment review in December 2025. Radiology reviews are also underway.

8.4 Whilst good progress is being made to determine what safe looks like for our AHP services here at SFH, further work and information are still required. At a national level, widespread variation is recognised across the specialities and membership of the regional AHP community of practices in being progressed to help inform our own agenda for AHP safe staffing.

8.5 Electronic job planning for AHPs has paused temporarily due to secondment capacity and licence availability. All Band 5 AHPs currently have electronic job plans in place, and additional licences are being sought through the renewal contract with Allocate to extend coverage across the workforce. This will provide greater visibility of direct clinical care capacity.

NQB EXPECTATION 2: RIGHT SKILLS

9.0 AHP Recruitment

9.1 Recruitment of Operating Department Practitioners remains a challenge, but despite this, vacancies are reducing, and apprenticeship routes are supporting workforce growth. Orthoptist posts are substantively filled, but the small team continues to face disruption due to sickness absence; however, approval has been secured to convert variable pay into a substantive Band 5 role to strengthen resilience. Orthotics is now fully established with no vacancies for the first time in 19 months.

9.2 Paramedic practitioners remain embedded across urgent and emergency care, Newark Hospital urgent treatment centre, and critical care. Physiotherapy recruitment remains strong, with all posts filled, including a previously vacant Band 7 neurology role, which has been successfully recruited via a progression pathway.

9.3 In radiography, five Band 5 vacancies have been recruited with new graduates starting shortly. Sonography, however, continues to present significant recruitment difficulties, compounded by long-term sickness absence. Three trainees are nearing completion, and two recruits have been secured, but further recruitment will be required to meet service demand. The Clinical Diagnostic Centre is expected to face similar challenges, with MRI staffing a particular pressure; hybrid rotational posts are currently out to recruitment, and further business planning is underway.

9.4 Speech and Language Therapy has successfully recruited to four substantive posts and secured the transfer of an agency Band 8a into a permanent role, eliminating agency costs in the Head and Neck service.

10.0 Productive Working, Deployment & Minimising Agency

10.1 AHP bank, agency costs and working arrangements for additional hours and weekend working continue to be monitored via the NMAHP transformation programme. AHP agency costs continue to reduce, with Sonography remaining the highest usage required. Bank and agency staffing are required in speech & language therapies, orthotics, and physiotherapy have reduced following the successful appointment into previously 'hard to recruit' roles.

10.11 Therapy teams have now transferred onto the electronic roster system, providing improved visibility of staffing and supporting flexible working arrangements to better meet service needs. While this represents good progress in defining what safe looks like for AHP services, further work is required.

National Compliance

11.0 The Developing Workforce Safeguards published by NHSI in 2018 were designed to support effective workforce planning and staff deployment. Trusts are assessed for compliance with the triangulated approach to deciding staff requirements described within the NQB guidance. This approach combines evidence-based tools with professional judgement and patient outcomes to ensure the right staff with the right skills are in the right place at the right time.

11.1 Appendix One details the Trust's compliance with the nursing and midwifery elements of the Developing Workforce Safeguards recommendations. The recommendation from the Chief Nurse and Chief Medical Officer is that there is good compliance with the Developing Workforce Safeguards.

11.2 The Chief Nurse and Chief Medical Officer are satisfied that nursing, midwifery and AHP staffing is safe, effective, and sustainable.

Recommendations

12.0 The Board are asked to receive this report and note the ongoing plans to provide safe staffing levels across nursing, midwifery, and AHP disciplines.

12.1 The Board is asked to note the ongoing recruitment plans to support each service.

12.2 The Board is asked to note the Developing Workforce Safeguards compliance standards.

13.0 Appendix One: Developing Workforce Safeguards Compliance Standards

Recommendation:	Compliance:
Recommendation 1: Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	**Compliant** ✓ SNCT has been embedded within adult in-patient areas, paediatric in-patient areas, and the Emergency Department. ✓ BR+ is embedded with Maternity services and a refresh of training has been undertaken. ✓ Monthly, Biannual and annual reporting to Trust Board
Recommendation 2: Trust must ensure the three components are used in their safe staffing process.	**Compliant** ✓ SNCT and BirthRate are in use at the Trust and provide an evidence-based benchmark for our establishment setting process. Nurse-sensitive indicators information is aligned to each establishment review and professional judgement is always considered.
Recommendation 3 & 4: Assessment will be based on a review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.	**Compliant** ✓ Confirmation is included in the annual governance statement that our staffing governance processes are safe and sustainable.
Recommendation 5: As part of the yearly assessment, assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes.	**Compliant** ✓ Data is reviewed and collated every month for a range of workforce metrics, quality indicators, and productivity measures – as a whole and not in isolation from each other.
Recommendation 6: As part of the safe staffing review, the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable.	**Compliant** ✓ Biannual and Annual Nursing, Midwifery, and Allied Health Professional Staffing Report.
Recommendation 7: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.	**Compliant** ✓ Annual submission to NHS England, ICB & ICS. Led by the People Directorate.
Recommendation 8: They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	**Compliant** ✓ Monthly Safe Staffing Reports for Nursing and Midwifery and staffing dashboard triangulates this information.
Recommendation 9: An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	**Compliant** ✓ A bi-annual review for nursing using SNCT is completed across all services; establishments are reviewed on an annual basis. An annual and bi-annual staffing report is presented to the Nursing, Midwifery and Allied Health Professional Committee, People, Culture and Improvement Committee, and the Board of Directors.
Recommendation 10: There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	**Compliant** ✓ SNCT and BR+ are in use as per full license agreements.
Recommendation 11 & 12: As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	**Compliant** ✓ Completed as part of the establishment setting process and any changes in service provision. These are monitored by the Nursing, Midwifery, and Allied Health Committee.
Recommendation 13 & 14: Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	**Compliant** ✓ Staffing resource is also discussed at the flow and capacity meetings throughout the day. ✓ Staffing escalation process via Matron and Bronze on call. ✓ Safe Staffing Standard Operating Procedure. Perinatal Assurance Committee. ✓ Monthly Safe Staffing Report for Nursing and the Monthly Safe Staffing Report for Midwifery.

Developing Workforce Safeguards (NHSI, 2018

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Guardian of Safe Working Report	**Date:**	2nd October 2025
Prepared By:	Rebecca Freeman – Head of Medical Workforce Jayne Cresswell – Medical Workforce Specialist		
Approved By:	Dr Simon Roe – Chief Medical Officer		
Presented By:	Dr Simon Roe – Chief Medical Officer		

Purpose		
The paper provides the Board of Directors with an update on the exception reports received from Resident Doctors between 1st May 2025 to 31st July 2025	**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**		

Principal Risk		
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	Failure to achieve the Trust's financial strategy	
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

Joint Local Negotiating Committee and People Committee

Acronyms

ED – Emergency Department
CT – Core Trainee
ST – Specialty Trainee
NHSE – National Health Service – England
LTFT – Less than Full Time
PA – Programmed Activity
WTE – Whole Time Equivalent
TOIL – Time off in Lieu
FY1 – Foundation Year 1 Doctor

Executive Summary

The Board of Directors are asked to take assurance from the following:

- The number of exception reports are increasing year on year.
- The largest number of exception reports have been received from resident doctors in Diabetes & Endocrinology which incorporates General Internal Medicine.
- Most Exception reports are being received from CT & ST 1 & 2 doctors and Clinical Fellows

- The number of exception reports being received from ST3+ doctors is still quite low.
- The concerns that have been raised regarding incivility in ED and the action that has been taken.
- The changes to the Exception Reporting Process nationally have been delayed.

Guardian of Safe Working Report covering the period from 1st May 2025 until 31st July 2025.

Introduction

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

As can be seen from the data below, 236 (228.6 wte) resident doctors have been allocated to the Trust by NHSE. The Trust has an establishment of 272 resident doctor posts, so this rotation, there are 36 vacant resident doctor posts. This is due to NHSE not being able to fill these posts for a variety of reasons, including doctors being on maternity leave, unanticipated lack of training progress (not passing their exams), doctors leaving the training programme early, or there not being enough trainees following a particular training pathway to fill the posts across the country. The Trust isn't always informed of the reasons for the vacant posts and as can be seen from previous reports, these vacancy numbers fluctuate for each rotation. It is generally the first rotation of the year where there are the least number of vacancies and the last rotation from April where there are the highest number of vacancies and this is evidenced above. Further information is included in the vacancies section.

High level data as of 31st July 2025

Established resident doctor posts:	272		
Established trust grade doctor posts:	117		
	Posts	**Heads**	**WTE**
Number of resident doctors in post:	236	241	228.6
Number of vacant resident doctor posts:	36	-	43.4
Number of unfilled resident doctor posts filled by a trust grade doctor:	13	-	12.8
Number of trust grade doctors in post:	102	107	104.8
Number of vacant trust grade doctor posts:	15	-	12.2

High level data from previous quarter (as of 30th April 2025)

Established resident doctor posts:	272		
Established trust grade doctor posts:	117		
	Posts	**Heads**	**WTE**
Number of resident doctors in post:	239	245	233.6
Number of vacant resident doctor posts:	31	-	36.4
Number of unfilled resident doctor posts filled by a trust grade doctor:	10	-	9.8
Number of trust grade doctors in post:	106	112	109.4
Number of vacant trust grade doctor posts:	11	-	7.6

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

Exception reports from 1st May 2025 (with regard to working hours)

The data from 1st May 2025 to 31st July 2025 shows there have been 53 exception reports in total.

Of the 53 exception reports from the resident doctors, two were categorised as an immediate safety concern.

By month there were 13 exception reports in May 2025, 25 in June 2025 and 15 in July 2025.

Of the 53 exception reports 45 were due to working additional hours, 5 were due to missing natural breaks, 2 were educational and one was relating to service support.

Of the total 53 exception reports, all have been closed.

For the exception reports where there has been an initial meeting with the supervisor the median time to the first meeting is 8 days. The time to the first meeting has stayed the same as the previous report.

Recommendations are that the initial meeting with the supervisor should be within 7 days of the exception report. In total 30 (57%) of all exception reports either had an initial meeting beyond 7 days or have not had an initial meeting, this is lower than the 64% from the last quarter.

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

Where an outcome has been suggested there are 22 (42%) with time off in lieu (TOIL) totalling 20 hours and 33 minutes, 24 (45%) with additional payment totalling 22 hours and 52 minutes at normal hourly rate and 7 hours and 28 minutes at premium rate and 7 (13%) with no further action.

The Allocate software used to raise exception reports and document the outcome does not have the facility to be able to link to the Health Roster system to confirm TOIL has been taken or additional payment received, therefore this is actioned manually by the Medical Workforce Team, a report is completed for the rota coordinators and the Payroll Team to ensure that time off in lieu is added to the doctor's record or any payment is made. This is completed monthly in line with payroll cut off periods. There are development plans to link the two systems in the future, however, there are no timescales for this at this stage.

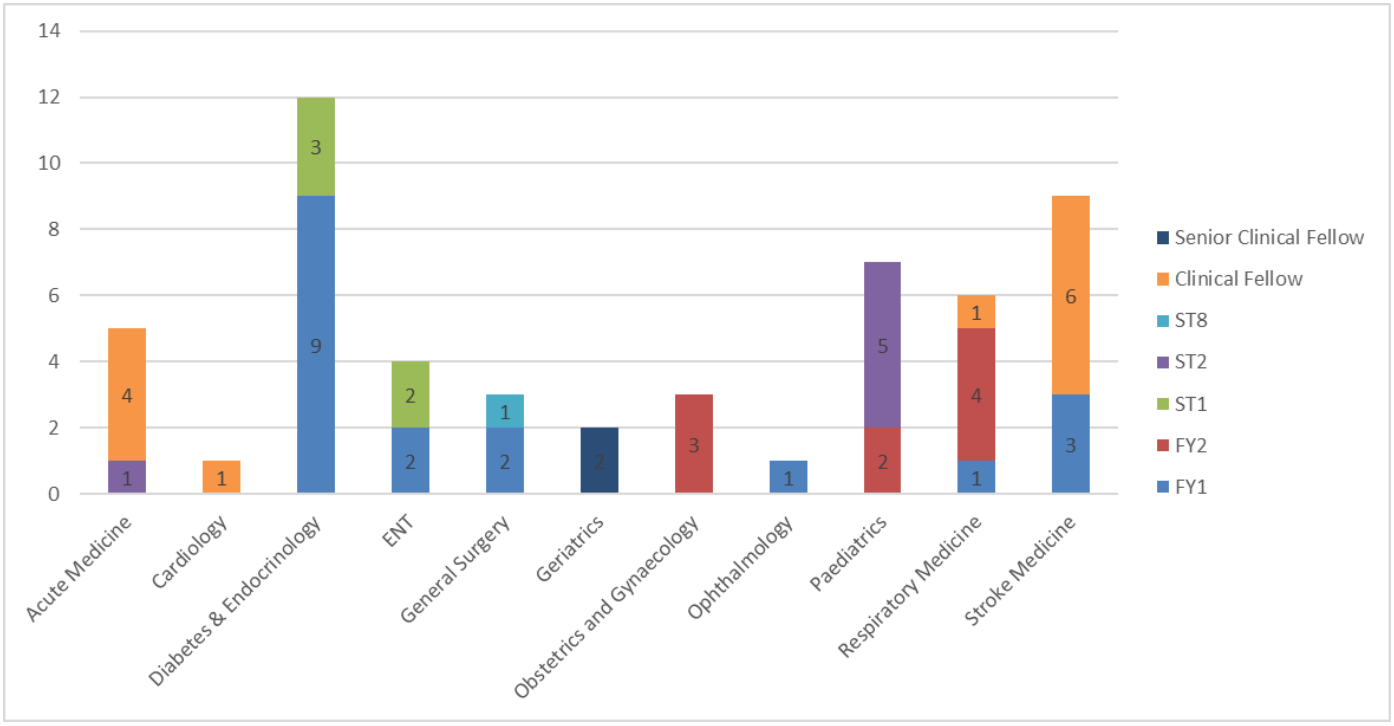


Figure 1. Exception reports submitted by Specialty and Grade.

Figure 1 shows that the majority of the exception reports received during this period - 12 (23%) in total - are from resident doctors working in **Diabetes & Endocrinology** which incorporates **General Internal Medicine.**

On reviewing these exception reports, in most instances the doctors have stayed later than the finishing time for their shift and have raised concerns about support. A separate rota will be fully implemented in November which is currently being recruited to and will provide more support for these specialties.

In total 18 (34%) of the exception reports have come from the Foundation Year 1 doctors, 9 (17%) from the Foundation Year 2 doctors, 23 (43%) from the ST1/2 doctors (including Clinical Fellows) and 3 (6%) from ST3+ doctors (including Senior Clinical Fellows).

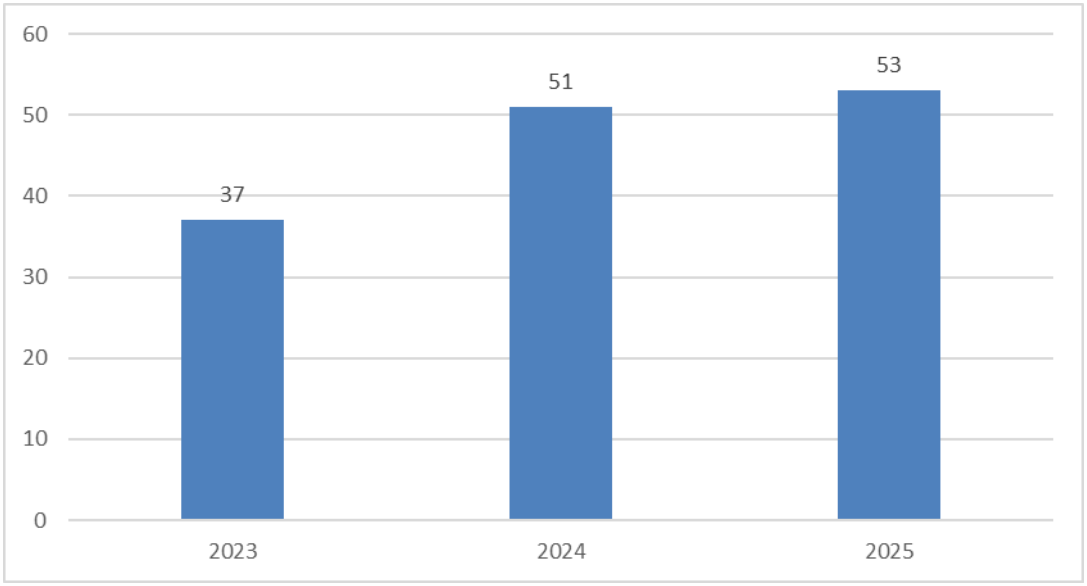


Figure 2. Comparison of number of exception reports for the same quarter between 2023, 2024 and 2025.

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

Date	Grade and Specialty of Doctor	Details of Immediate Safety Concern reported by the Trainee	Action Taken	Status of the Concern
21/05/2025	F2 in paediatrics	Only had 15 minutes break, where BMA suggested 3 x 30 minutes break for shift more than 12 hours	A discussion took place with the resident doctor advising that they should feel empowered to request to take breaks even when wards are busy. SpRs have been asked to consider carrying the bleep if necessary to ensure breaks are achieved. It was also suggested to agree in advance when breaks will be taken and to aim to stick to this schedule provided emergencies allow.	Concern now closed
06/05/2025	CF in Respiratory Medicine	Only 2 resident doctors were present during the ward hours of 09:00 to 14:20. Each Doctor looking after 12 patients the ward was also 1 patient over, therefore being responsible for 13 patients. Concerns expressed by both the	It was confirmed that this was a Tuesday after a bank holiday, therefore there was a commitment to review the staffing levels post bank holiday, given the likelihood of the full capacity protocol being enacted after a bank holiday.	Concern now closed

		doctor and Nurse in charge about patient safety		

Table 1. Immediate Safety Concern Concerns Raised.

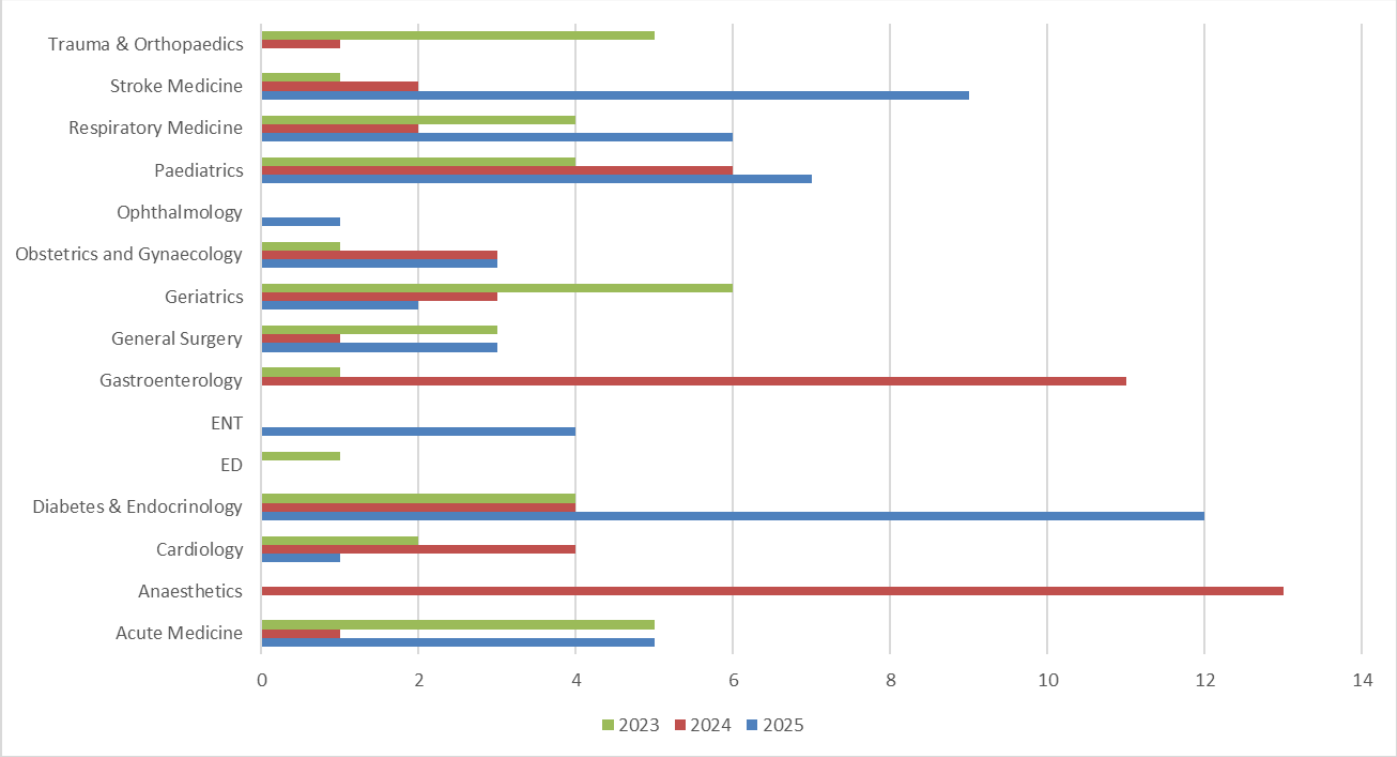


Figure 3. Comparison of number of exception reports submitted by Specialty for the same quarter between 2023, 2024 and 2025.

Figure 3 shows that for this period this year there have been more exception reports from the doctors across some specialties than in previous years, specifically across the Medicine Division.

Work Schedule Reviews

There have been no work schedule reviews during this period.

Fines

There have been no fines.

Vacancies

The Trust currently has 236 resident doctors allocated by NHSE. As mentioned in the introduction, there are 36 vacancies where the Trust has not been allocated resident doctors by NHSE the reasons for these posts not being filled were also mentioned in the introduction, 13 of the vacancies are currently filled by trust grade doctors.

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

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

Qualitative information

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

Date of the Guardian Report	**Number and Percentage of reports <u>not</u> responded to within 7 days**
May 2025 – July 2025	57% of all reports received. 30 reports
February 2025 – April 2025	64% of all reports received. 23 reports
November 2024 – January 2025	24% of all reports received. 8 reports
August 2024 – October 2024	53% of all reports received. 21 reports

Table 3 Exception reports <u>not</u> responded to within 7 days.

<u>Visiting Clinical Areas</u>

The Guardian of Safe Working and the Head of Medical Workforce Walk around the wards every other Wednesday afternoon to talk to doctors about the importance of exception reporting and the role of the Guardian of Safe Working. The Guardian of Safe Working also stays in the foyer of the Education Centre following grand round to be available to talk to doctors Within the last three months the areas that have been visited include Acute Medicine, ED, Paediatrics, Obstetrics and Gynaecology, Trauma & Orthopaedics and Anaesthetics.

Generally, the doctors feel positive about their roles. However, it was clear from the conversations that took place that not all doctors are reporting exceptions. The Guardian of Safe Working encouraged the doctors to ensure that they exception report and explained the benefits of highlighting concerns to him so that they could be addressed and to enable them to receive TOIL or pay for any additional hours worked.

Within Paediatrics, there had previously been concerns raised due to handover being very lengthy which didn't allow the night doctor to leave on time however, this has been addressed by the specialty.

The doctors in ED and Acute Medicine are finding that the specialties are very busy.

There had previously been some concerns raised by the Clinical Fellows particularly relating to behaviours of Senior Medical Staff in ED. These concerns have now been addressed by the Clinical Chair. The doctors have said that whilst it is extremely busy particularly in ED they feel supported.

The feedback from the Anaesthetics doctors was that they feel supported, they do feel that the department would benefit from refurbishment. It was confirmed that there are plans to upgrade the department, however, there are no timescales at present for

Resident Doctor Forums

The final meeting of the Resident Doctor Board took place on 16th July 2025. This was well attended by both the Associate College Tutors and the Trust Executive. The Associate College Tutors all said they had enjoyed undertaking the role for the last year. They said that they had particularly found the leadership training that had been provided beneficial.

Several issues were discussed at the meeting and of note, a concern was raised about the planned rota changes for staff from August onwards in SDEC. The Chief Medical Officer asked for a meeting to take place with the Clinical Chair to discuss the concerns.

National Review of the Exception Reporting Process

The revised Exception Reporting process was due to be implemented on 12th September 2025, it is understood that this implementation date is going to be delayed. However, this has not formally been communicated yet.

Conclusion

The Board of Directors are asked to note the following and the actions planned for the next quarter detailed in Appendix 1.

- The number of exception reports are increasing year on year.
- The largest number of exception reports have been received from resident doctors in Diabetes & Endocrinology which incorporates General Internal Medicine.
- Most Exception reports are being received from CT & ST 1 & 2 doctors and Clinical Fellows
- The number of exception reports being received from St3+ doctors is still quite low.
- The concerns that have been raised regarding incivility in ED and the action that has been taken.
- The changes to the Exception Reporting Process nationally have been delayed.

Appendix 1

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

Action/Issue	**Action Taken (to be taken)**	**Date of completion/Deadline**
National Review of the Exception Reporting Process	Ensure the changes to the process are implemented and communicated to stakeholders prior to the implementation date.	To be confirmed
High number of exception reports from Diabetes & Endocrinology and General Internal Medicine	Guardian of Safe Working and Head of Medical Workforce visit the area and talk to resident doctors	31st August 2025

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Freedom To Speak Up	**Date:**	2nd Oct 2025
Prepared By:	Kerry Bosworth – Freedom To Speak Up Guardian		
Approved By:	Sally Brook Shanahan – Director Of Corporate Affairs		
Presented By:	Kerry Bosworth - Freedom To Speak Up Guardian		

Purpose

The purpose of this paper is to provide the Q1 and Q2 (up to 18/9/25) speaking up data and themes. To provide assurance about the FTSU agenda, visibility and activity of the FTSUG, including developments enacted to improve learning and engagement with FTSU concerns.	**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**		

Principal Risk

PR1	Significant deterioration in standards of safety and care	**x**
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

Acronyms

FTSUG – Freedom To Speak Up Guardian
FTSU – Freedom To Speak Up
NGO – National Guardians Office
OD – Organisational Development
EDI – Equality, Diversity & Inclusivity
AHP – Allied Healthcare Professional
SFH – Sherwood Forest Hospitals
EM – Ethnic Minority
U&EC – Urgent & Emergency Care
CSTO – Clinical Services, Therapies, Outpatients
W&C - Women and Children
OH – Occupational Health
YTD – Year To Date
ER – Employee Relations
GMC – General Medical Council
TMT – Trust Management Team
IEN – Internationally Educated Nurse
DOHSC – Dept of Health & Social Care

Executive Summary

Overview

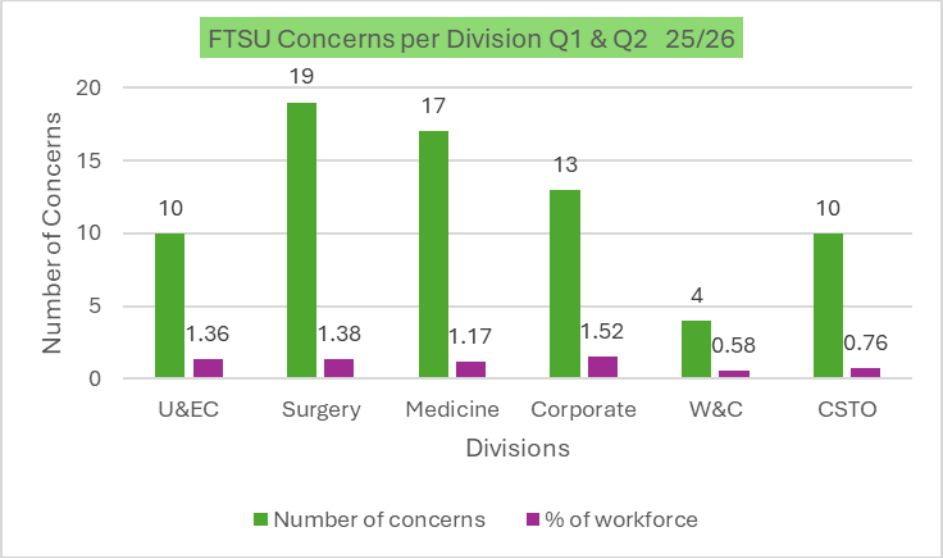
During Q1 there were **41 c**oncerns raised and Q2 to date there were **32** concerns raised with the FTSU Guardian – total **73** concerns to date.

The number of colleagues raising concerns through FTSU continues to demonstrate consistent engagement with FTSU as a route for raising concerns. For this period for 24/25 there were 89 concerns raised. The average quarterly submission number of concerns in the Acute & Acute Community NHS Trust category is 45.9. (NGO Survey of Speaking Up Data to FTSUG 24/25 published Aug 2025)

There is a shift in Q2, that most concerns are raised confidentially not openly, meaning concern raisers are not confident to be known beyond the FTSUG or for the FTSUG to take escalations forward for individual support and resolution.

Out of the 73 concerns raised in Q1 & Q2 of 25/26, 4 are in now in a formal ER process, having not found resolution in the informal stage. There are 20 concerns in informal escalation processes. This highlights the fact that most FTSU escalations are handled informally.

Divisional Representation



All divisions continue to show workers using FTSU.

People Profile

Nursing & Midwifery and Admin/Clerical colleagues continue to raise the most concerns and the majority of concerns are raised from white British females. Of the concerns raised 28% were from an ethnic minority background, mainly in Q2. This is an increase from previous reporting periods. The increase demonstrates improved engagement with FTSU for people who are from an ethnic minority background and could be testament to focused FTSU visibility with this workforce.

Workers with disabilities consistently raise their disability as the theme of the concerns within this group. Themes such as promised support packages not in place, poor local induction aligned to their needs and feeling treated differently or uncompassionately are raised.

Themes from Q1/Q2 - reported as per NGO theme categories.

Worker Safety & Wellbeing – 53 concerns (72.6%)
Bullying & Harassment – 7 concerns (9.6%)
Inappropriate Attitudes & Behaviours – 8 concerns (11%)
Patient Safety and Quality – 5 concerns (6.8%)

Within the report are examples of themes reported per division. This has enabled common themes to be identified.

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

1. Handling of concerns in initial stages and lack of resolution and ownership to commit to bringing to resolution
2. Lack of experience and skill in handling concerns
3. Leadership style and behaviour impacting negatively
4. Lack of support and care and person-centred approach in dealing with situations or processes

Training for leaders is available on the SFH E Learning Academy to assist with equipping line managers with the skills and awareness to promote a healthy speak up culture.

Learning, triangulation and developments from FTSU concerns

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

The FTSUG supports trust wide events to show visibility and opportunity for concerns to be raised- this included the Protection From Harm Conference, collaboration with the Guardian for Safe Working, presence at International Medical Graduates Induction and bespoke listening events.

Consistently evident in the Worker Safety & Wellbeing category is the experience of workers who are in informal stages of raising concerns and have had poor experience, poor engagement and poor communication on ownership and accountability for the informal reviews. In order to progress and learn from these types of concerns, engagement is being built with the divisional triumvirates, following the launch of the FTSU Process & Timescale guidance, which is being cascaded through leadership portfolios. This means the FTSUG will have dedicated time with each division to feed in their themes and trust wide themes for support and ownership.

FTSU Champion numbers have declined this year. Therefore, active recruitment has begun and training of new FTSU Champions is planned for October.

The FTSU Database is now live and provides an improved data management system for FTSU concerns to be logged and tracked. Data is more easily presentable and will enable more visual and relevant data to be shared with the divisions at the 1-1 sessions.

External Well-Led Report

Good progress is being made towards the implementation of the remaining 7 of the 11 FTSU related actions in the Grant Thornton LLP report. The evidence is scheduled for presentation to the Board in December 2025 at which a recommendation to agree their closure is planned to be made.

FTSU Horizon Scan Potential Challenges

1. Particularly in the Q2 concerns there has been a shift from concern raisers raising open concerns, to wanting to raise confidentially. The FTSUG noted from these conversations that the reasons cited fall under potential detriment for speaking up and also futility in speaking up.
2. The FTSUG regularly sees the impact and the emotional distress of concern raisers from living with their concerns and from escalation of their concerns. The FTSUG worked collaboratively and often confidentially with the Clinical Psychology Service and when the service ceases this will impact the support mechanism for concern raisers. The FTSUG also had an ad hoc arrangement for restorative supervision with the psychologist and will now need to explore an alternative arrangement.

National Update

NHSE and the NGO have confirmed that the FTSUG role will remain mandated in the NHS Contract for 2026/2027.

Freedom To Speak Up

SFH Board Report Oct 2025

Kerry Bosworth FTSU Guardian

Sherwood Forest Hospitals NHS Foundation Trust

Purpose

This report provides an overview of speaking up cases for Q1 25/26 and Q2 25/26 to date (18th September 2025), covering the period since the FTSU report was last presented to the SFH Board. Included are developments, improvements and updates from the work of the FTSUG and the wider FTSU agenda, locally and nationally.

Overview

During Q1 there were **41 c**oncerns raised and Q2 to date there were **32** concerns raised with the FTSU Guardian – total **73** concerns to date.

The number of colleagues raising concerns through FTSU continues to demonstrate consistent engagement with FTSU as a route for raising concerns. For this period for 24/25 there were 89 concerns raised. The average quarterly submission number of concerns in the Acute & Acute Community NHS Trust category is 45.9. (NGO Survey of Speaking Up Data to FTSUG 24/25 published Aug 2025)

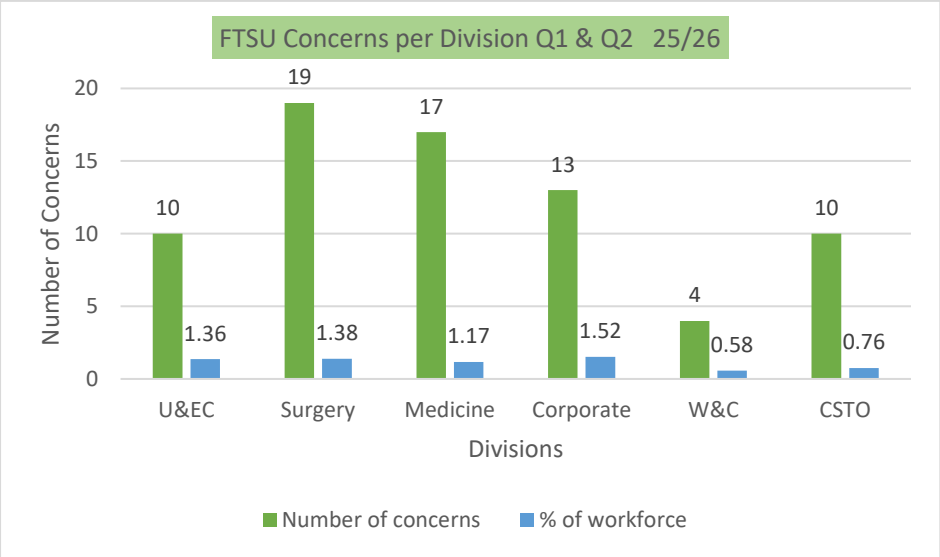
Out of the Q1 41 concerns raised, 33 were raised openly, 7 were raised confidentially (known to FTSUG only) and there was 1 anonymous concern.

Out of the 32 concerns raised in Q2, 14 were raised openly, 17 raised confidentially and 1 anonymous concern.

There is a shift in Q2, that most concerns are raised confidentially not openly, meaning concern raisers are not confident to be known beyond the FTSUG or for the FTSUG to take escalations forward for individual support and resolution.

Currently from 24/25 Q4 there is one case that remains open. Q1 25/26 there are 6 concerns open and Q2 there are 21 concerns that remain open, which means they are awaiting feedback to the FTSUG or to the concern raiser or are in ongoing processes. Out of the 73 concerns raised in Q1 & Q2 of 25/26, 4 are in now in a formal ER process, having not found resolution in the informal stage. There are 20 concerns in informal escalation processes mainly from Q1. This highlights the fact that most FTSU escalations are handled informally. The 24 concerns raised confidentially mean there is no escalation process enabled due to concern raiser request; therefore, the themes of these concerns are planned to be fed into the divisional touch points that are currently being established if they have not been shared via other triangulation routes.

All Divisions continue to be represented in using FTSU, demonstrating awareness of FTSU across the organisation. Divisional numbers are presented below. Due to the variance in workforce numbers within the divisions, cases are also presented as a percentage against the current divisional workforce numbers. Corporate Division are raising the most concerns via FTSU, per workforce percentage.



People Profile

Nursing & Midwifery and Admin/Clerical colleagues continue to raise the most concerns through both quarters of 25/26; also represented are medical, additional clinical services, AHP colleagues and Healthcare Scientists.

The majority of concerns are raised from white British females. Of the concerns raised 28% were from an ethnic minority background, mainly in Q2. This is an increase from previous reporting periods. The FTSU has representation in the Ethnic Minority Staff Network and Champions who are from an ethnic minority background, who focus their support to these workers. The FTSUG has been active in participating in the International Medical Graduate Trust Induction recently and at other engagements to raise the visibility of speaking up for workers with increased barriers for speaking up.

Workers with disabilities consistently raise their disability as the theme of the concerns within this group. Themes such as promised support packages not in place, poor local induction aligned to their needs and feeling treated differently or uncompassionately are raised.

Themes from Q1/Q2 - reported as per NGO theme categories.

Worker Safety & Wellbeing – 53 concerns (72.6%)
Bullying & Harassment – 7 concerns (9.6%)
Inappropriate Attitudes & Behaviours – 8 concerns (11%)
Patient Safety and Quality – 5 concerns (6.8%)

SFH Themes Comparison to National Data

Worker Safety & Wellbeing themes continue to be the prevalent theme of concerns at SFH. Nationally this theme makes up 38.9% of all cases reported to the NGO (72.6% YTD at SFH) and the category that is seeing a significant rise nationally compared to the other themes.

Examples of concerns and themes raised, related to the reported themes per Division:

SURGERY

Patient Safety & Quality

- Out of hours arrangements and enactment of emergency theatre pathway impacting patient care and safety risk
- Resource wasted around on call arrangements not working for the patients or workers
- Non-compliance to national edict and protracted process in achieving compliance
- Unresolved poor behaviour in teams affecting working and efficiency

Bullying & Harassment

- Bullying from colleagues/clique. Failure to manage situation from line management.
- Impact of poor behaviour from colleague not managed appropriately and detrimental effects to team, including cover.
- Fact finds not comprehensive and poor communication with protracted exposure to poor behaviours.

Worker Safety or Wellbeing

- Inconsistent leadership style impacting workers, nepotism, clique behaviour leading to micromanagement of some and impacts of this. Feel treated differently.
- Employee Relation Policies and Processes not followed – impact on workers.
- IEN colleagues feel treated differently and fear speaking up.
- Disability – managers lacking knowledge in Access To Work pathways, poor support and understanding.
- Line managers not receiving concerns in line with the SFH Speaking Up Policy and poor follow up response to FTSU issues raised from FTSUG.
- Cancellation of substantive night shifts at last minute or shortly into the shift, end up owing hours, disruption to family life.

Elements Of Other Inappropriate Attitudes or Behaviours

- Incivility
- Gaslighting behaviours
- Racism – racial slurs between colleagues – said in jest/ banter, not challenged

MEDICINE

Patient Safety & Quality

- Patient record safety and access
- Datix process and lack of feedback on safety and quality issues

Worker Safety & Wellbeing

- Leadership styles and behaviours – clique and nepotistic
- IENs feel treated differently and feel racism in attitudes and behaviours from ward team
- IENs feel speaking up comes with detriment
- Inconsistent approach to ER processes – IENs feel processes enacted quickly for them but not others and feel lack of right to reply
- Line managers not handling speak up concerns compassionately or in line with CARE values
- Bank shift allocation favouritism
- Speaking up not encouraged and made to feel a troublemaker if does

Inappropriate Behaviours & Attitudes

- Car parking favouritism claims – people able to circumnavigate the policy
- Racist attitudes
- Incivility, rude colleagues
- Line managers not adhering to CARE values

URGENT &EMERGENCY CARE

Worker Safety & Wellbeing

- Staff safety – environment. Safety screen in ED reception took 2 months to replace, impact on reception team
- Staff safety – violence and aggression. Support not forthcoming, no updates on actions, not followed up. Feels should be accepting of this as an ED worker
- Traumatic events – no time or process for trauma care following distressing incidents. Traumatised staff straight back into challenging situations and challenging patients.
- Junior workforce struggling, senior staff leaving due to culture and challenge of ED life

WOMEN & CHILDREN

Worker Safety & Wellbeing

- Leadership styles in communication, conflicting information and approaches
- Poor communication in change events and inconsistent style of handling change which impacts on staff
- Staff with disabilities – micromanagement and conflicting styles of leadership support, varying approach in styles

Bullying & Harassment

- Leadership not addressed concerns re behaviour – protracted exposure to poor behaviour
- Poor handling of speaking up relating to behaviour – minimised

CORPORATE

Worker safety & Wellbeing

- Feeling that due to bank admin/leadership being non-clinical, nursing issues are not understood and do not have a clinical mentor / oversight to challenge ward decisions or support development.
- Lack of personal centred approach in decisions re employment via bank e.g. notice of termination of bank contracts, rigid policy
- Lack of disability support for bank workers and lack of person-centred approach, treated differently to substantive – not in keeping with people promise themes.
- Nepotism and favouritism concerns re bank allocation
- Internal Transfer Scheme impacting ability to gain employment from bank employment
- Leadership decisions on patient pathways impacting staff and poorly communicated
- Handling of concerns poor and lack of trust
- Poor psychological safety in team
- Line management failed to resolve poor behaviour in team and incivility

CSTO

Bullying & Harassment

- Team toxicity, hierarchy and nepotism. Poor behaviour to colleagues
- Poor leadership response to sexual safety concern – inappropriate response and failed to support
- Behaviours unchallenged in team

Worker Safety & Wellbeing

- Poor management and communication of change processes.
- Lack of compassionate leadership in process change
- Poor response from raising concerns about behaviour – normalised
- Poor induction into team, lack of training and support
- Lack of support for declared disability and impact on work experience
- Inconsistent style of leadership, treated differently
- Workforce change process poorly enacted and impacts on individuals

The impacts of all the above concerns in the Worker Safety & Wellbeing, category reflect culture which underpins patient safety and can have direct consequences on recruitment and retention, financial costs to service lines, reputation, capacity of OH. It increases demand for the wellbeing services, who the FTSUG regularly triangulates information with and the FTSUG has recognised that it is common for concern raisers to have taken sickness leave or considering it when meeting with the FTSUG.

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

1. Handling of concerns in initial stages and lack of resolution and ownership to commit to bringing to resolution
2. Lack of experience and skill in handling concerns
3. Leadership style and behaviour impacting negatively
4. Lack of support and care and person-centred approach in dealing with situations or processes

Training and upskilling is available to all line managers on handling concerns and reflection of their leadership style to following up concerns. This is via the NGO Speak Up, Listen Up and Follow Up modules on the SFH E-Learning Academy. Currently this is not mandatory at SFH but advisable for senior managers to review their own style of receiving concerns and to assess their line managers skill and experience to handling concerns. This is also important due to the majority of FTSU concerns raised informally and therefore have no People Team oversight.

Learning, triangulation and developments from FTSU concerns

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

Concerns around sexual safety have led to a satisfactory outcome, resulting in addressing inappropriate behaviour and self-reflection of the individual, without having to subject the concern raiser to a formal process.

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

The FTSUG supported the Protection From Harm Conference and provided safe spaces for colleagues attending the day. From these safe spaces, concerns were raised that were taken forward.

Consistently evident in the Worker Safety & Wellbeing category is the experience of workers who are in informal stages of raising concerns and have had poor experience, poor engagement and poor communication on ownership and accountability for the informal reviews. In order to progress and learn from these types of concerns, engagement is being built with the divisional triumvirates, following the launch of the FTSU Process & Timescale guidance, which is being cascaded through leadership portfolios. This means the FTSUG will have dedicated time with each division to feed in their themes and trust wide themes for support and ownership.

The Chief People Officer, the Director of Corporate Affairs (FTSU Executive Lead) and the FTSUG are meeting fortnightly to discuss cases that need assistance to progress and may require senior oversight. These meetings, currently at an early stage in their evolution, are also an opportunity to share information about the themes of FTSU referrals to inform and potentially triangulate aspects of operational people management.

Concerns regarding disabilities and disabled colleagues, specifically around Access to Work have been shared with the EDI team and colleagues connected for further support and action.

The FTSUG and the Guardian for Safe Working plan to hold a joint session on the Medical Grand Round in October to unify approach to raising concerns and further develop working collaboratively.

To increase FTSUG visibility withing the medical workforce, the FTSUG delivered a session to the latest International Medical Graduate Induction. The FTSUG and the East Midlands GMC Regional Advisor collaborated at a workshop on “Having Challenging Conversations” to a medical team from Surgery – giving the opportunity for the FTSUG to have visibility and communicate the role.

FTSU Champion numbers have declined this year. Therefore, active recruitment has begun and training of new FTSU Champions is planned for October. FTSU Champions remain a vital link for visibility of speaking up, so development of this team remains important. The team have had a bespoke session from the NHS Counter Fraud Local Specialist, to upskill their knowledge in this area and a joint session with the Wellbeing Champions is being delivered later this month, to develop collaboration due to the overlap of the nature of the two roles.

The FTSU Database is now live and provides an improved data management system for FTSU concerns to be logged and tracked. Data is more easily presentable and will enable more visual and relevant data to be shared with the divisions at the 1-1 sessions.

The new FTSU Process & Timescale Guidance was shared with divisions prior to its approval by TMT and launch in September 2025. The guidance is designed to assist SFH colleagues in the process of speaking up to raise concerns and to support line

managers or receiving managers, to respond to concerns raised with them and clarify their responsibilities when a FTSU concern is raised. Feedback on its use will be provided in future reports.

Recommendations from the External Well-Led Report

Good progress is being made towards the implementation of the remaining 7 of the 11 FTSU related actions in the Grant Thornton LLP report. The evidence is scheduled for presentation to the Board in December 2025 at which a recommendation to agree their closure is planned to be made.

FTSU Horizon Scan Potential Challenges

Particularly in the Q2 concerns there has been a shift from concern raisers raising open concerns, to wanting to raise confidentially. The FTSUG noted from these conversations that the reasons cited fall under potential detriment for speaking up and also futility in speaking up. In the current climate where financial savings are being driven forward, people fear that speaking up could adversely impact them and make them more vulnerable.

Futility is also raised alongside this as people fear that financial priorities means that there is not capacity or incentive to solve concerns especially where cost is involved or where concerns about behaviour or poor work experiences become low leadership priority.

The FTSUG regularly sees the impact and the emotional distress of concern raisers from living with their concerns and from escalation of their concerns. The FTSUG worked collaboratively and often confidentially with the Clinical Psychology Service to support theses concern raisers, enabling them to move forward, to remain in work or access rapid support. Concern raisers were also signposted into FTSU from the wellbeing services when the cause of their ill health was work related. With the Clinical Psychology service being withdrawn, this will impact the support mechanism for concern raisers.

Psychological support supervision for the FTSUG will be affected as there was an arrangement in place with the service lead for ad hoc supervision for the FTSUG, due to the emotional resilience required to fulfil the FTSUG role.

National Update

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

Recommendation from this report

That the Board:

- receives the report and notes the most recent speaking up data, including the themes and comparisons to national data.
- notes the learning, triangulation and on-going developments arising from FTSU concerns.
- takes assurances from implementation of the new operational process including the new Process & Timescale Guidance and the development of the divisional engagement with the FTSUG.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board - Cover Sheet

Subject:	SFH Staff Flu Vaccination Campaign Plan 2025/26	**Date:**	2nd October 2025
Prepared By:	Adam Grundy – Head of Occupational Health and Wellbeing		
Approved By:	Debbie Kearsley – Deputy Chief People Officer		
Presented By:	Rob Simcox - Chief People Officer		

Purpose		
Plan presented to provide assurance on the Staff Flu Vaccination programme for 2025/26	**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	**X**
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

People Committee – 30th September 2025

Acronyms

HCW – Healthcare Worker
CQUIN – Commissioning for Quality and Innovation
QIVc – Quadrivalent Inactivated Seasonal Influenza Vaccine (Cell Based)
aQIV – Adjuvanted Quadrivalent Inactivated Seasonal Influenza Vaccine
OH – Occupational Health
SFH – Sherwood Forest Hospitals

Executive Summary

This report sets out the plan agreed by the SFH Staff Flu vaccination Group.

The report acknowledges the past achievements of the Trust Staff Flu Vaccination programme and introduces the targets set for the uptake of vaccine in 2025 -2026. The report identifies the difficulties faced during previous flu seasons and barriers to achieving the historically high uptake figures.

There is detailed information on the vaccines chosen this year with the main vaccine being egg free and available for colleagues aged 18 – 64. A vaccine will be available from OH specifically for staff aged 65+.

The approach for this year is set out in the report acknowledging that a more traditional approach will be taken with pop up grab a jab clinics being run as well as support from Peer Vaccinators. The campaign will also aim to target high traffic areas as well as opportunistic events such as mandatory training. Additional onsite bookable appointments will also be offered for staff to access the vaccine at a time of their choosing.

Incentives will be offered again this year and the report details these. Monthly prize draws will be included in the incentive package as well as a new incentive to win an additional days annual leave for staff vaccinate before the end of November.

The end of the report contains the National assurance checklist.

2025/26 season

Healthcare worker (HCW) flu vaccination approach with completed best practice management checklist – for public assurance via Trust boards by November 2025.

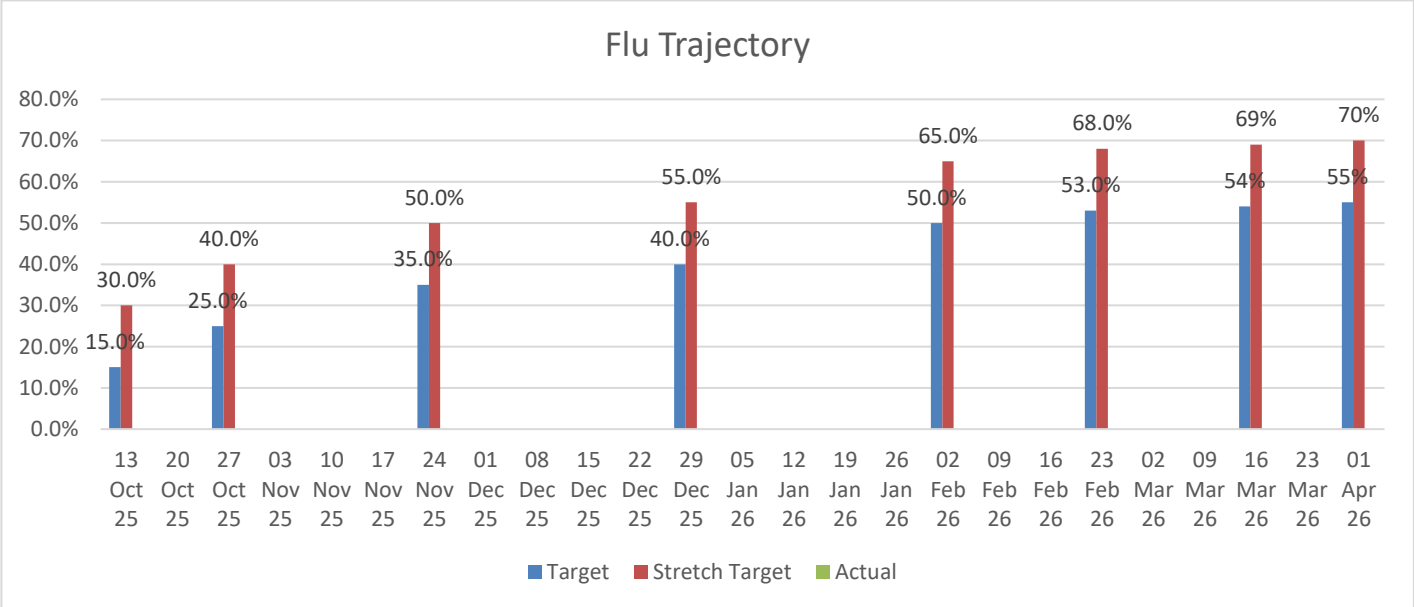
Introduction

The annual flu campaign is firmly embedded within the culture of the Trust, with a track record of front-line staff uptake that is consistently well above the national average year on year.

The 2024/25 HCW flu vaccination campaign resulted in a 50% front line staff uptake – which was in line with the national average and locally in other Nottinghamshire NHS Trusts.

There is no CQUIN target for 2025/26. We have agreed on a target of 55% of front-line staff uptake which is in line with the NHSE directive to improve uptakes by 5% on 2024 – 2025 figures. However, we want every single member of staff to be offered the opportunity to be vaccinated against flu.

The below sets out this year's uptake trajectory and includes a stretch target:



The potential for significant co-circulation of flu and other respiratory viruses could substantially affect the pressure on the NHS from winter 2025. This means that the 2025/26 HCW flu vaccination programme remains a very important priority this year to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may also be managing winter viral infection outbreaks.

Vaccine

5500 cell-culture trivalent (TIVc) vaccines have been ordered as well as 150 adjuvanted trivalent (aTIV) vaccines for over 65's. Both vaccines are manufactured by Seqirus and will not have traditional brand names but be known as how they are described above.

The first flu vaccine delivery is expected to be received in pharmacy week commencing 15th September 2025. Clinics are planned to start on 1st October 2025 as per guidance from the National Flu Immunisation Programme 2025 to 2026 Letter.

TIVc vaccines will be available for peer vaccinators to administer however the vaccine intended for over 65's (aTIV) will only be available via Occupational Health (OH).

Approach for 2025/26 season.

The approach will be based on previous seasons as this has historically proved successful.

- Annual staff flu vaccination programme will be led by OH.
- The organisation and co-ordination of the campaign will be achieved via a Trust HCW flu vaccination group chaired by the Deputy Head of OH.
- The campaign will be supported by a strong and innovative communication strategy which includes using Trust staff in publicity material.
- Efforts will be made to tackle misinformation around flu vaccination in the run up to and during the flu season. A Myth Busting video is planned for all staff to access and drop in Q+A sessions will be offered delivered by colleagues knowledgeable in this area.
- Trained teams of peer vaccinators spread throughout the Trust will proactively vaccinate colleagues. It is proposed that for 2025 – 2026 each ward or unit will commit to train 4-5 peer vaccinators who can proactively vaccinate their own area.
- OH will provide a large number of drop in 'grab a jab' pop up flu clinics in high traffic staff areas.
- OH and peer vaccinators will attend opportunistic events throughout the season to offer vaccination (e.g. mandatory update training for front line staff, Celebrating Excellence).
- Onsite on demand bookable appointments will also be available for staff in the Occupational Health Department.
- Any staff member who attends OH for any reason during the flu season will be offered a flu vaccine.

- The following incentives will be offered:

    - Every staff member who has the jab before Christmas will be entered into a monthly prize draw to win a prize (donated by Unison Dukeries Branch).
    - Ward/peer vaccinators are also incentivised – when they have vaccinated 50 colleagues a £20 high street voucher can be claimed. This will be limited to remaining vouchers from the previous season and once those are used no more will be purchased.
    - Every staff member who has the jab by the end of November 2025 will be entered into a prize draw to win an extra day of annual leave (maximum of 5 people can win on days extra leave)

Weekly uptake rates will be communicated to the Trust, starting from the end of October 2025.

Health Inequalities

SFH acknowledges that vaccine uptake can be challenging amongst certain groups which potentially presents risks to these groups should they not choose to be vaccinated.
To proactively address this issue, the SFH staff flu plan will include the following steps aimed at improving uptake in this area:

- Flu planning group will include a Public Health Registrar to provide specialist advice in improving Health Inequalities.

- Representation at the flu planning group will also be invited from staff network groups

- Communications before and during the flu campaign will be tailored to groups identified as at risk of health inequalities and messages distributed in ways that will best deliver the information

- Information will be clear to these groups that access to the vaccine can be tailored to their needs based around their cultural preferences

- Support will be discussed with Spiritual and Pastoral care team to support colleagues who have reservation around vaccination for religious reasons

Summary

The staff flu vaccination programme forms an important part of the SFH approach to supporting the health, safety and wellbeing of colleagues during winter. Specifically, vaccination forms part of our prevention work aiming to reduce the impact of the flu virus on staff, patients and the wider community.

Acknowledging uptake rates have dropped over recent years this plan hopefully sets out an approach to engage colleagues and support them to access the vaccine in as many ways

possible. The plan also aims to tackle some of the cause of lower uptakes through wider engagement and managing information to dispel misinformation or doubts around the vaccine.

The group is asked to take assurance from the paper and to acknowledge the assurance checklist provided in Appendix 1.

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via Trust boards by November 2024

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all front-line healthcare workers	Yes – planned commitment to be recorded at Trust Management team meeting (date TBC)
A2	Trust has ordered and provided the cell-culture trivalent (TIVc) vaccine for healthcare workers	Yes – 5500 cell-culture trivalent (TIVc) and 150 adjuvanted trivalent (aTIV) vaccines ordered. Planned delivery w/c 15 September 2025
A3	Board receives an evaluation of the flu programme 2024/25, including data, successes, challenges and lessons learnt	Yes – summary of last year's flu programme presented to Board (Date TBC)
A4	Agree on a board champion for flu campaign	Yes – Chief Nurse
A5	All board members receive flu vaccination and publicise this	Yes – to take place at Trust Board meeting (Date TBC)
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Yes – long established group reconvened with trade union representation
A7	Flu team to meet regularly from September 2025	Yes – group will meet regularly from August 2025
B	**Communication plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Yes – Comms strategy in place to commence 1 October 2025
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	Yes – OH availability given to Comms for publication via social media and dedicated Intranet page
B3	Board and senior managers having their vaccinations to be publicised	Yes – To be arranged for next available board meeting
B4	Flu vaccination programme and access to vaccination on induction programmes	Yes – all front-line staff throughout flu season are offered flu vaccination at induction

B5	Programme to be publicised on screensavers, posters, and social media.	Yes – Comms strategy in place to commence late September 2025
B6	Weekly feedback on percentage uptake for directorates, teams, and professional groups	Yes – uptake percentages to be communicated from end October 2025
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate, and empowered.	Yes – established peer vaccinator model in place and will be mobilised again this year.
C2	Schedule for easy access drop-in clinics agreed.	Yes – drop-in clinics will be co-ordinated across the Trust in a number of accessible areas.
C3	Schedule for 24-hour mobile vaccinations to be agreed.	Yes – peer vaccinators often work a range of hours across the shift spectrum which will increase availability.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Yes – Incentives agreed and publicised as part of communication plan
D2	Success to be celebrated weekly	Yes - Weekly uptake will be celebrated through staff bulletin along with prize draw winner communications

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Research Q1 and Q2 2025 performance and progress report.	**Date:**	2nd October 2025
Prepared By:	Terri-Ann Sewell Research Operations Manager		
Approved By:	Jonathan Vanm Tam Non-executive Director		
Presented By:	Alison Steel, Head of Research and Innovation		

Purpose		
To provide Q1 and Q2 performance and progress, and a strategy update.	**Approval**	
	Assurance	
	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**

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	**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 this item has been presented before

None to date

Acronyms

EMRRDN – East Midlands Regional Research Delivery Network
R&I – Research and Innovation
DHSC – Department of Health and Social Care
RCF – Research Capability Funding
NMAHP's – Nursing, Midwifery and Allied Health Professionals
CRF – Clinical Research Facility
MRU – Mobile Research Unit
CRN- Clinical Research Network
NIHR – National Institute for Health Research
GCP – Good Clinical Practice
NTU – Nottingham Trent University
IAOCR – International Accrediting Organisation for Clinical Research
GSCA – Global Standard Clinical Trial Accreditation

Executive Summary

Performance - Data Cut 30/09/2025

- Recruitment into research studies at the end of Q2 2025 – 964**, 21**% of 4000 target. Lowest recruitment since 21-22
- Recruitment into commercial studies – 03 participants, a decrease of 14 participants in 23/24
- Studies open or in follow-up 85 in 18 specialities
- 21 new studies have been opened in Q1/Q2
- Actively recruited into 52 studies in Q1/Q2

Finance

- R&I Budget - **£904,178.51** allocated by EMRRDN, excl additional £33,500 won through successful bids.
- Income at end of Q2- **£50,869.90**
- DHSC RCF - £35,000 to maintain research capacity and capability

Patient Experience

- 125 PRES surveys completed Q1 and Q2
- 94% of participants felt research staff valued their participation in studies, and additional comments in the report.

Research Impact

- NMAPS -Visual map showing activity and outputs to support research engagement, led by Dr Kerry Evans and R&I

- Mobile Research unit- increasing community engagement and recruitment in hard-to-reach communities.

- Clinical Research facility- building complete, 1st patient visit booked. Launch 2nd Oct.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Research & Innovation

2026 - 2026 Q1/Q2 Performance and Strategy Update

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

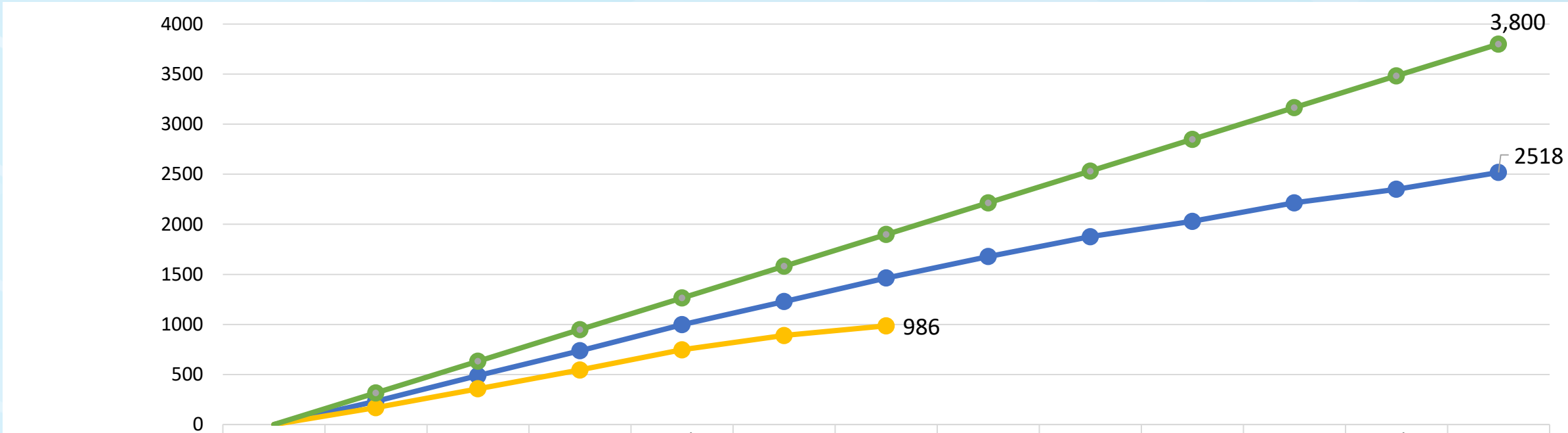
The Research and Innovation team is responsible for developing and supporting a varied research portfolio and ensuring better opportunities for patients and staff to participate in research activity, whilst informing the provision of high-quality, evidence-based health care.

The focus for R&I in 2024/25 is to continue growing a balanced research portfolio, including attracting increased activity from commercial sponsors. The research activity will be reviewed regularly, with bi-annual reporting to the Trust board and monthly reporting to Divisional teams and research investigators.

The R&I strategy 2022-2027, 'Research is for Everyone' sets out a clear vision to make research part of our daily business, realising the research potential in all areas of our hospitals for the benefit of patients, staff, and our community. This includes 4 key pillars: Place, Progress, People, and Partnership. This report provides an update on recruitment activity and progress against the key strategic objectives for year 2 and 3.

Performance

FY 2025 – 2026 Cumulative Monthly Recruitment



	FY Start	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
FY 24 - 25	0	233	488	737	998	1229	1464	1678	1876	2030	2215	2350	2518
FY 25 - 26	0	169	357	545	747	889	986						
FY 25 - 26 Target	0	316	632	948	1,264	1,581	1,898	2,215	2,532	2,849	3,166	3,483	3,800

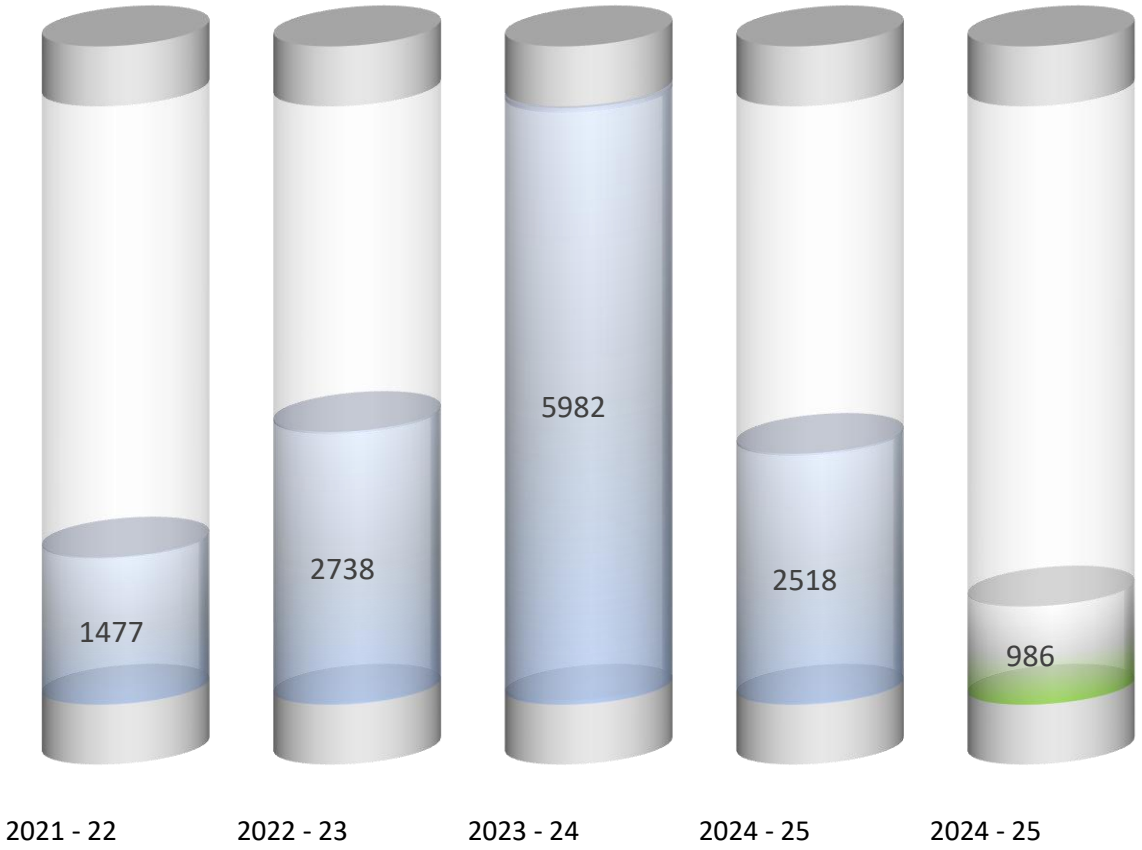
(Data cut: 19/09/2025)

Outstanding Care,
Compassionate People,
Healthier Communities

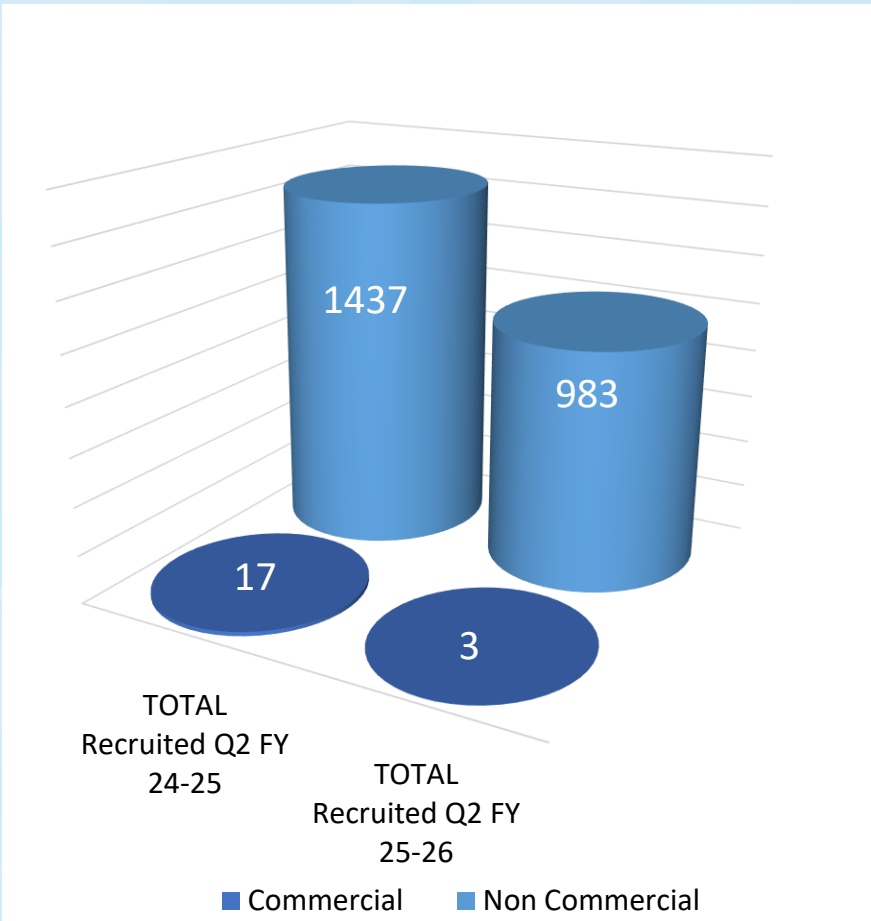
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Recruitment

Annual recruitment over five years



Recruitment 24-25 & 25-26 at Q2

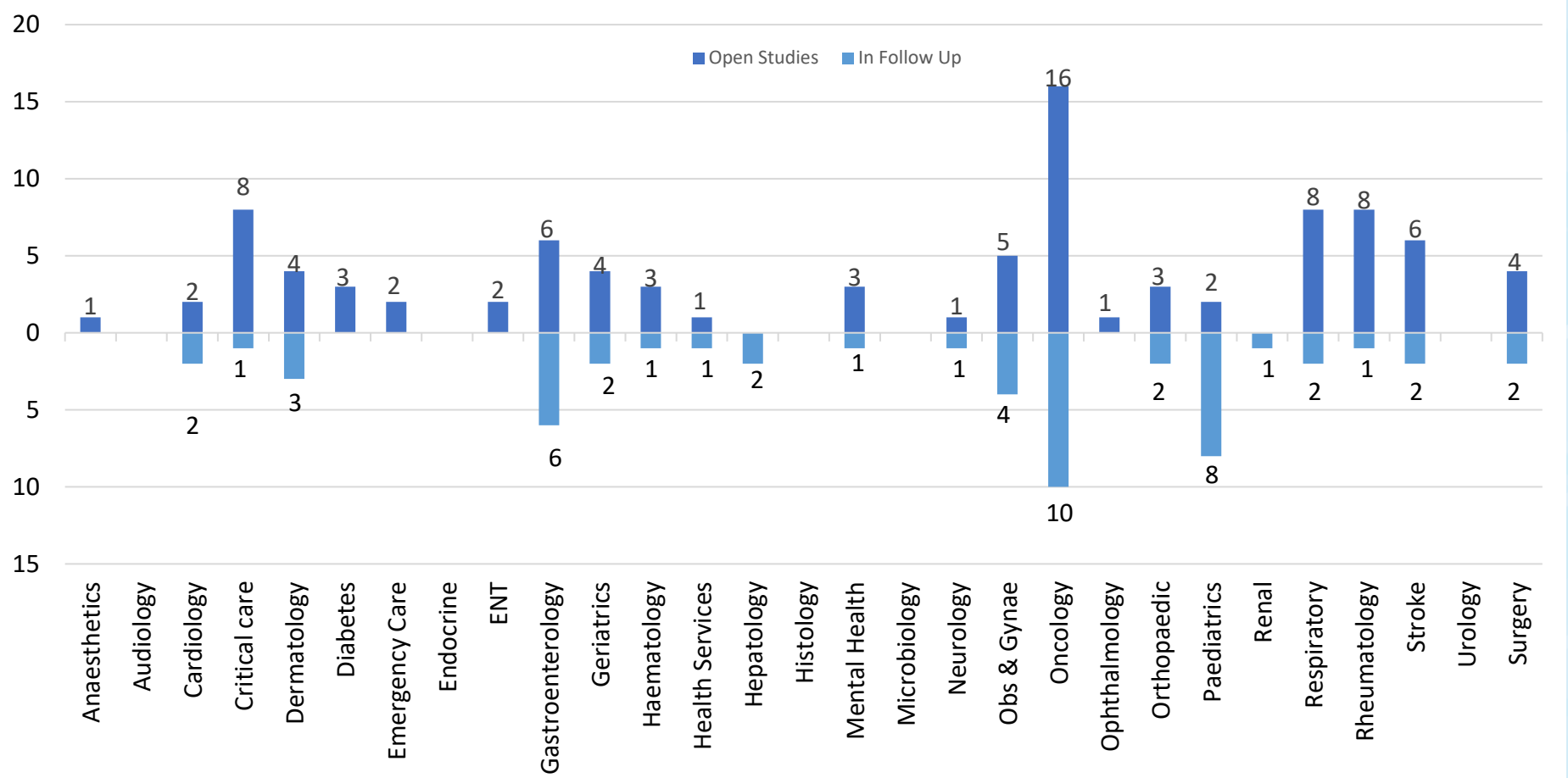


Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Performance

Total studies open & in follow-up 2025 - 2026, Q2 (Data cut: 19/09/2025)



	Open	In Follow Up
Anaesthetics	1	0
Audiology	0	0
Cardiology	2	2
Critical care	8	1
Dermatology	4	3
Diabetes	3	0
Emergency Care	2	0
Endocrine	0	0
ENT	2	0
Gastroenterology	6	6
Geriatrics	4	2
Haematology	3	1
Health Services	1	1
Hepatology	0	2
Histology	0	0
Mental Health	3	1
Microbiology	0	0
Neurology	1	1
Obs & Gynae	5	4
Oncology	16	10
Ophthalmology	1	0
Orthopaedic	3	2
Paediatrics	2	8
Renal	0	1
Respiratory	8	2
Rheumatology	8	1
Stroke	6	2
Urology	0	0
Surgery	4	2

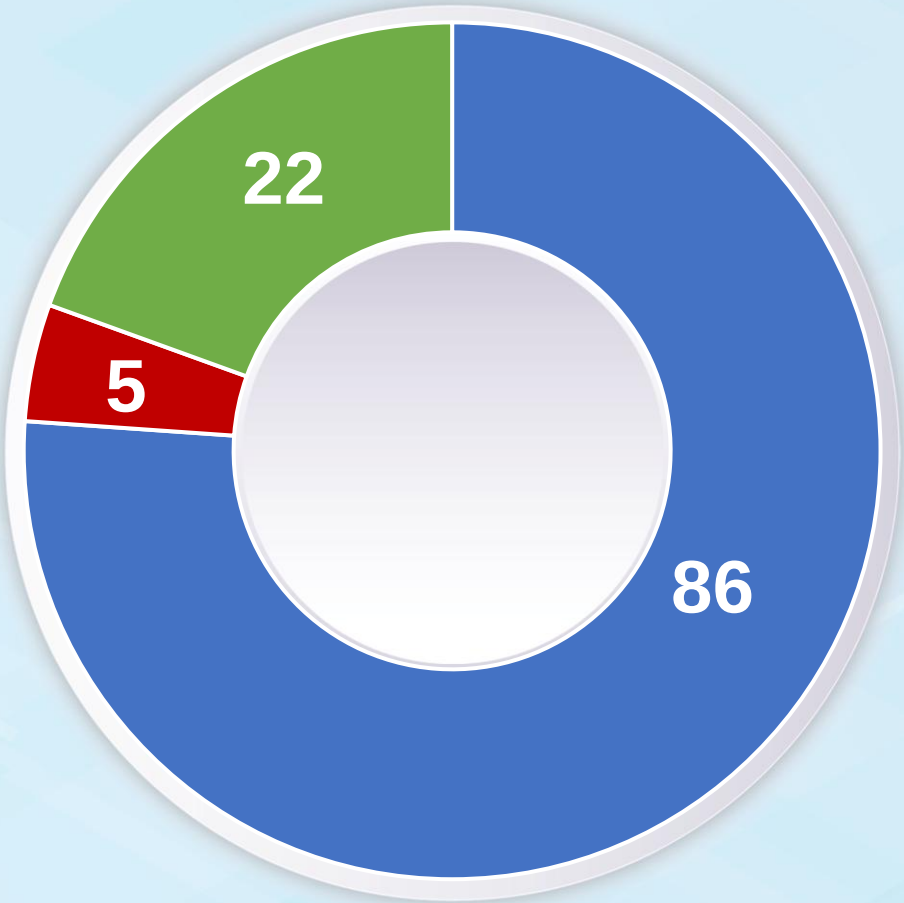
Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Portfolio Management

New Studies Opened 2025 – 2026: **22**

Studies Closed FY 2025 - 2026: **5**



Studies Actively Recruiting FY 2025-2026: **86**

(Data cut: 19/09/2025)

Finance

2024/25

RRDN East Midlands Income

Budget **£904,178.51**

RRDN Bids: **£33,500**

2025/26

Q2-3 Commercial Income £50,869.90

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

Department of Health Funding

£35,000

To maintain research capability and capacity

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Patient Research Experience

94%
Felt research staff have valued my taking part in this research study

I felt all the time that what I was doing was important.

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

Everything was explained fully and the team made sure I understood. Both members were polite and friendly.

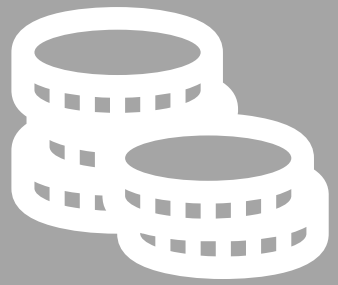
The dedication of the nurses/staff that I meet every 6 months.

Everything was explained fully to me. The staff were polite, courteous and put me at ease. This research study was very easy to do.

FY 2025/2026
Responses: 125

Preventing ill health 25

Productivity & Value for Money 16



Work collaboratively with the community 11

Reduce overall length of stay 8

Delivering digital care 6

Staff availability / Reducing workload pressures 5

Improve Maternity Care 5

Health Inequalities 16

Increase in Healthy Life Years 12

Reduce bed occupancy 8

Reducing falls 3

Early Cancer diagnosis 3

Hypertension / Cardiovascular 2

1 COPD/ COVID/ FLU/ RSV Vaccine

1 Frailty

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Our Research Impact

6 Publication and academic poster workshops attended by **21** staff

32 Individual NMAHP discussions to support new and innovative SFH-led research

6 Clinical academic workshops with clinical teams

32 SFH-wide Research Champions

4 NMAHP peer-reviewed publications

2 National / international conference presentations

2 Pump priming competition launch awarding projects

2 Nurses awarded NIHR research masters studentships

1 AHP awarded NHS/HEE research internship

2 SFH Consultant NMAHP-led research - developed, in progress

	Progress	Place	People	Partnerships
Objectives	**1.1** Collaboration with EMCRN & commercial sponsors to increase commercial research opportunities **1.2** Streamline the set-up process for faster delivery **1.3** Engage with ICS-wide research partners to develop a Nottingham-wide commercial study set-up network.	**2.1** Open a new Clinical Research Facility at Kings Mill Hospital in for early phase clinical trials of new drugs, devices, and diagnostics **2.3** Secure SFH mobile research unit to deliver research across primary care settings and undertake "Research Ready" engagement with our communities	**3.1** Further develop the role of the Research Academy and research opportunities for SFH staff **3.2** Investment into our management workforce to ensure a sustainable future for research and future developments **3.3** Research to be a fundamental element of NED role	**4.1** Increase our academic and industry partnerships to maximise mutual benefits from collaboration **4.2** Collaboration with Chesterfield Royal NHS Trust in securing and utilising the mobile research unit **4.3** Pursuing NTU collaboration as part of EMERGE bid
Risks	**1.1** Reduction in access to novel interventions and medicines. Loss of income, reputation, and future growth as a research system partner **1.2** Loss of repeat business, reduction in portfolio size. Failure to meet CRN targets **1.3** Inability to consistently attract industry to the EM region	**2.1** Significant impact on achieving objectives 1.1 and 4.1. Negative impact recruitment and retention and ability to fulfil our partnership with NUH for NIHR CRF bid 2026 **2.3** As 2.2, but also lack of response to the changing research landscape and popularity for de-centralised trials will have a negative impact on commercial activity	**3.1** Unable to offer the development and training opportunities to SFH staff reduce research engagement. Negative impact on staff satisfaction **3.2** Inadequate career pathways for research staff, impact on recruitment and retention. Loss of expertise to develop R&I at SFH **3.3** Missed opportunity to engage in high level leadership and promotion of SFH's growing positive research culture	**4.1** Fail to secure and sustain business from industry and showcase SFH research capabilities, linked to 1.1. Reduced access to research expertise and training for our staff. Inability to be an equitable research partner across the system **4.2** As 2.2 and 2.3 **4.3** Missed opportunity to co-create in the Med Tech space
Progress	IAOCR Bronze level accreditation achieved-year 3 Bronze level achieved for 25/26. MRU successfully recruiting patients into research studies in hard-to-reach areas. Increased engagement with partners and community settings.	Building work complete and the CRF 1st patient September 24th 2025. Launch 2nd October and open day to be planned for SFH staff. MRU successfully recruiting patients into research studies in hard-to-reach areas. Increased engagement with partners and community settings.	**3.1** Kerry Evans is leading the academy process- Clinical and academic posts now available. Research Champions liked in with ward accreditation. **3.2** Band 6 Study set up manager to be appointed to assist the Band 4 and to streamline study set up times and increase portfolio. NED commenced in October 2024. F2 foundation doctor to work in the CRF- post currently being created.	Access to select platforms to showcase our capabilities Membership of the Global Advisory Board for GSCA IAOCR Joint Primary care commercial link nurse developing new relationships and interest from commercial sponsors . Collaborations started with Health Innovation East Midlands.

Meeting of the Board of Directors in Public - Cover Sheet

Subject:	NHS Impact	**Date:**	2nd Oct 2025
Prepared By:	Jim Millns, Associate Director of Transformation		
Approved By:	Simon Roe, Chief Medical Officer		
Presented By:	Simon Roe, Chief Medical Officer		

Purpose

The purpose of this report is to provide the Board of Directors with an update on the completion of the **NHS Impact Self-Assessment Exercise** and provide an overview on the actions being taken to redefine and consolidate the role and purpose of Quality Improvement within Sherwood Forest Hospitals.	**Approval**	
	Assurance	
	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		

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	**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 this item has been presented before

CMO Cabinet (via email).

Acronyms

NHS = National Health Service
QI = Quality Improvement
MARS = Mutually Agreeable Resignation Scheme

Executive Summary

1. Introduction

1.1 As Board Members will recall, the NHS Impact self-assessment exercise is designed to help NHS organisations understand where they are in terms of adopting the NHS Impact framework. This in turn helps to inform organisations what they need to focus on.

1.2 The NHS Impact framework is a structured and methodical approach to improvement, which describes the conditions and practices that need to be in place for improvement activity to be impactful and sustainable.

1.3 The framework has five components: *Leadership for Improvement, Building Improvement Capability, Engaging Patients and Communities, Embedding Improvement in Daily Work and Using Data* and *Evidence for Improvement*.

1.4 NHS Impact also emphasises the importance of using a shared language, connecting local improvement work to ICB/National priorities, tackling health inequalities (as a core part of improvement) and creating a learning culture where colleagues are encouraged to be curious and open.

1.5 NHS Impact, and the associated self-assessment, are therefore important, as they aim to build a long-term, organisation-wide culture of continuous improvement as opposed to an organisational culture that is built on short-term project work and top-down initiatives.

1.6 Given the significance (and importance) therefore of getting this right, and the need to encompass the views of multiple stakeholders; we have decided to take a slightly more methodical and structured approach. **This is one of two reasons we have not yet completed the self-assessment exercise for 2025/26**.

1.7 The second reason however, which in some respects is more significant, is the fact that the Improvement Faculty and the wider Quality Improvement agenda across the Trust is currently subject to change and evolution. Although the attached report provides further details of these changes, in summary they involve a) a change to the remit of the Improvement Faculty (*see slide 5*) b) the Introduction of Clinical Transformation Leadership roles (*see slide 6*) c) a proposed independent review of the Improvement Faculty (*see slide 6*) and d) the development and launch of the Continuous Quality Improvement Strategy (*see slide 7*).

1.8 Undertaking an assessment whilst this change is ongoing would be counterproductive. It is important that the changes are as a minimum understood, if not fully implemented, before an assessment is undertaken. Given the main driver of the self-assessment is to highlight the areas where we need to focus (i.e. the areas identified as being weakest), it is important that evolution and perception are aligned; given the need to target our resource at those areas where it is needed the most.

2. <u>Recommendations</u>

2.1 Whilst the original purpose of this report was to provide the Trust Board of Directors with an overview of the outcomes of the latest NHS Impact self-assessment exercise, it is clear that the Improvement Faculty and the wider Quality Improvement agenda is in a transitionary phase. The purpose of the self-assessment exercise is to highlight those areas where we need to focus our efforts. Whilst we are in transition however, self-assessment is unlikely to reflect any of the planned or enacted changes, meaning the outcomes may be slightly 'skewed'. It is possible therefore that the outcomes might be different if we repeated the exercise in 3-4 months, once the changes are understood and have taken effect.

2.2 The purpose of the report has therefore changed slightly, so that it now provides an update on the continual evolution of the Improvement Faculty and the way in which the Trust needs to approach quality improvement. The independent review of the Improvement Faculty will be particularly insightful, given it will allow us an opportunity to '*future proof*' the Improvement Function within the organisation, plus provide clarity on its remit, which has at times been unclear.

2.3 The Trust Board of Directors are therefore asked to:

a. Note the contents of the attached report.
b. Agree to receive an update on the outcomes of the independent review of the Improvement Faculty that will shortly be commissioned (it is anticipated it will be complete by January 2026).

c. Agree to receive the outcomes of the NHS Impact self-assessment which will be completed in February/March 2026; when the changes as noted above are better understood or (where appropriate) have had opportunity to take effect.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

NHS Impact – Report to Trust Board of Directors

Meeting of the Board of Directors (Public)
2nd October 2025

Contents

1. Introduction (1)

As Board Members will recall, the NHS Impact self-assessment exercise is designed to help NHS organisations understand where they are in terms of adopting the NHS Impact framework. This in turn helps to inform organisations what they need to focus on.

The NHS Impact framework is a structured and methodical approach to improvement, which describes the conditions and practices that need to be in place for improvement activity to be impactful and sustainable.

The NHS Impact framework has five components:

a. **Leadership for Improvement** – where leaders at every level (board to ward) set a clear vision for improvement, prioritise it, and create time and support for staff to engage.
b. **Building Improvement Capability** – where staff are equipped with the knowledge and skills to use improvement science and methods (e.g., QI tools, data use, co-design); growing a culture where continuous learning is normal.
c. **Engaging Patients and Communities** – where patients, families, and communities are active partners in redesigning services. Coproduction should be central, not optional.
d. **Embedding Improvement in Daily Work** – where improvement is part of '*how we do things*', and where frontline teams are empowered to test, adapt, and sustain changes.
e. **Using Data and Evidence for Improvement** – where data is timely, meaningful, and transparent, and where teams use measures to learn and adapt, not just to upward report.

1. Introduction (2)

NHS Impact also emphasises the importance of using a shared language, connecting local improvement work to ICB/National priorities, tackling health inequalities (as a core part of improvement) and creating a learning culture where colleagues are encouraged to be curious and open.

NHS Impact, and the associated self-assessment, are therefore important, as they aim to build a long-term, organisation-wide culture of continuous improvement; as opposed to an organisational culture that is built on short-term project work and top-down initiatives.

Given the significance (and importance) therefore of getting this right, and the need to encompass the views of multiple stakeholders; we have decided to take a slightly more methodical and structured approach. This is one of two reasons we have not yet completed the self-assessment exercise for 2025/26.

The second reason however, which in some respects is more significant, is the fact that the Improvement Faculty and the wider Quality Improvement agenda across the Trust is currently subject to change and evolution (*see section 2*). Undertaking an assessment whilst this change is ongoing would be counterproductive. It is important that the changes are as a minimum understood, if not fully implemented, before an assessment is undertaken. Given the main driver of the self-assessment is to highlight the areas where we need to focus (i.e. the areas identified as being weakest), it is important that evolution and perception are aligned; given the need to target our resource at those areas where it is needed the most.

2. Changes to the Improvement Faculty and Quality Improvement at Sherwood Forest Hospitals (1)

As noted above, one of the key reasons why we have not yet completed the NHS Impact self-assessment, is due to changes that a) have already been enacted and b) will potentially be enacted in future. To ensure the assessment accurately highlights the areas where we need to focus, these changes (both actual and potential) need time to be understood and to embed. These are summarised below.

a. Changes to the Remit of the Improvement Faculty

Financial improvement, including the Programme Management Office function (PMO), previously delivered by the Improvement Faculty has now moved to the Chief Financial Officers directorate. The reason for this change is to ensure that the project and programme resource associated with the delivery of financial improvement is much more aligned (and collocated) with the financial management function. Three staff have therefore also moved to finance.

Despite the reduction in resource (3 members of team have moved and a further 2 have taken MARS), this change in remit provides a significant opportunity for the Improvement Faculty to focus on capability, engagement, culture and the delivery of large-scale transformative change, aimed at addressing long-standing systemic problems. This will help to secure the Trusts longer term sustainability (qualitative and quantitative).

In addition, this change will also help delineate between specific roles and responsibilities, therefore avoiding duplication.

2. Changes to the Improvement Faculty and Quality Improvement at Sherwood Forest Hospitals (2)

b. Introduction of Clinical Transformation Leadership Roles

The purpose of these roles is to promote clinical leadership and clinical engagement and to help 'unblock' tricky issues relating to clinical practice and culture. The roles have been in place for approximately 8 weeks, and whilst the benefits have already started to be realised, it will take time for the roles to become fully established.

c. Independent Review of Improvement Faculty

Although the introduction of the Clinical Transformation Leadership Roles has, in part, mitigated the loss of Improvement Faculty resource; skill mix will clearly be an integral element of the longer-term effectiveness of the Faculty and the role it needs to fulfil in future.

It is for this reason therefore that an independent review of the Improvement Faculty will shortly be commissioned. As noted above, the main purpose of this review will be to ensure that the Faculty is adequately resourced and skilled to meet present and future organisational demands. Put differently, the question for which we are seeking an impartial response is '*based on the size of the Trust, the configuration of our local population and the priorities as defined within the Trusts strategy, what should an Improvement Team look like at Sherwood Forest*'.

This will ensure there is clarity in terms of what the role of the Improvement Faculty is and therefore the expectations in terms of what they need to deliver. Up until now, the answers to both these questions have been opaque at best, which has led to unhelpful conjecture about what the Improvement Faculty's function actually is. It is anticipated that the independent review will be complete by the end of the year.

2. Changes to the Improvement Faculty and Quality Improvement at Sherwood Forest Hospitals (3)

d. Development and Launch of the Continuous Quality Improvement Strategy (CQIS)

The CQIS will be instrumental in defining the organisations ambition and aspiration in terms of how Quality Improvement will be adopted and embedded by way of upholding our organisational commitment of becoming a Trust that '*continuously learns and improves*'. Whilst this is of course inextricably linked to the changing remit of the Improvement Faculty, this is as much about the longer-term health of the organisation.

The CQIS will articulate and therefore underpin the required cultural shift needed to ensure that Quality Improvement becomes a key component element of everybody's role, which importantly empowers every member of the wider workforce to ask the question 'how can I improve what I do', with 'permission' to make the requisite changes, utilising improvement tools and techniques which will become embedded into everyday practice.

We are currently in the engagement and consultation stage, speaking with key stakeholders (including clinical and operational colleagues). Our plan is to have a final draft ready for the end of October, with a view to launching the Strategy during *Improvement Week* (week commencing 3rd November 2025).

3. Summary and Recommendations

Whilst the original purpose of this report was to provide the Trust Board of Directors with an overview of the outcomes of the latest NHS Impact self-assessment exercise, it is clear that the Improvement Faculty and the wider Quality Improvement agenda is in a transitionary phase. The purpose of the self-assessment exercise is to highlight those areas where we need to focus our efforts. Whilst we are in transition however, self-assessment is unlikely to reflect any of the planned or enacted changes, meaning the outcomes may be slightly 'skewed'. It is possible therefore that the outcomes might be different if we repeated the exercise in 3-4 months, once the changes are understood and have taken effect.

The purpose of the report has therefore changed slightly, so that it now provides an update on the continual evolution of the Improvement Faculty and the way in which the Trust needs to approach quality improvement. The independent review of the Improvement Faculty will be particularly insightful, given it will allow us an opportunity to '*future proof*' the Improvement Function within the organisation, plus provide clarity on its remit, which has at times been unclear.

The Trust Board of Directors are therefore asked to:

a. Note the contents of this report.
b. Agree to receive an update on the outcomes of the independent review of the Improvement Faculty that will shortly be commissioned (it is anticipated it will be complete by January 2026).
c. Agree to receive the outcomes of the NHS Impact self-assessment which will be completed in February/March 2026; when the changes as noted above are better understood or (where appropriate) have had opportunity to take effect.

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 August 2025	**Date:**	2nd October 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 were considered by the appropriate Trust Board sub-committee.
The whole report was reviewed by Trust Management Team.

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 August 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 will be reviewed by our Analytical and Intelligence team to agree an audit process that can be adopted Trust-wide.

We have had a challenging July and August across several of our performance domains. In July we saw high patient demand on our urgent and emergency care services which was compounded by the period of Industrial Action at the end of the month. We experienced a seasonal ease in urgent and emergency care demand in August; however, this was not to the extent that we saw in 2024. We have seen discharge delays increase significantly over the summer period triggering as special cause variation and reaching levels not seen since early 2024. The challenge discharge patients in a timely manner, drove increased patient length of stay and flow issues into and through our hospitals. The delays in admitting patients due to a lack of beds, resulted in our Emergency Department frequently being overcrowded leading to increase waiting times which can increase the risk of delay-related harm. Operational Pressures Escalation Level (OPEL) four actions together with the deployment of our Full Capacity Protocol were implemented throughout this unpreceded period of challenging flow over the summer. Operating in escalation places pressure on our people and the financial position of the Trust and can compromise the delivery of some of our quality of care metrics.

Areas of focus for improvement include: reducing MRSA and c difficile levels, improving VTE risk assessment compliance, reducing our levels of sickness, reducing agency usage, improving four and 12-hour emergency access, reducing the number of medically safe patients, improving 18-week referral to treatment performance, recovering our diagnostic DM01 position, strengthening performance against our cancer standards, and reducing the financial risk within the organisation through the delivery of financial efficiency plans.

We have noted strong performance across several areas including: SHMI which remains as expected, complaints, staff turnover, mandatory and statutory training, bank usage, patient initiated follow up, elective long waits and cancer 28-day faster diagnosis.

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 August 2025

Outstanding Care,
Compassionate People,
Healthier Communities

Integrated Scorecard

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

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

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

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.

Integrated Report

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

Category	At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-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	1.9	2.4	3.0	2.4	2.6	2.1	1.7	2.6	1.9	2.4	2.2		2.2				
		Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
		MRSA reported in month	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✗ 1	✗ 2				
		Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	7	4	6	4	5	5	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 55	✗ 31				
		Number of gram-negative bloodstream infections reported in month	n/a	8	5	8	0	5	1	5	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	50	✓ 22				
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.2	0.1	0.0	0.1	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1				
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 6	✗ 1				
		Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	1	0	2	2	1	0	5	13	10	2	11	17	41				
		Percentage of inpatient Service Users undergoing risk assessment for VTE	n/a	≥95%	✗ 94.2%	✗ 94.5%	✗ 84.6%	✗ 84.1%	✗ 85.1%	✗ 89.6%	✗ 90.5%	✗ 89.7%	✗ 89.4%	✗ 88.0%	✗ 85.3%		✗ 88.3%				
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 0.8	✓ 0.8	✓ 0.4	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 0.9	✓ 1.4				
		Compliments received in month	No Standard	No Standard	204	160	147	140	152	184	155	115	141	157	109	1831	677				
	Effective	SHMI	As Expected	As Expected	✓ 106	✓ 106	✓ 106	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 107				
		Still birth rate	≤4.4	≤4.4	✓ 3.4	✗ 10.3	✓ 0.0	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.1	✓ 4.3	✗ 5.5				
		Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 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	-	-	✓ 7.1	-	-	-	-	-	✓ 7.1	-				
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✗ 9.2%				
		Time to hire	n/a	≤53.1 days				✓ 49.0	✓ 34.0	✓ 27.0	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0		✓ 26.4				
		Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.7%	✓ 0.5%				
		Appraisals	≥90%	≥90%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 89.99%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 89.0%	✗ 88.8%				
		Mandatory & statutory training	≥90%	≥90%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 91.5%	✓ 92.9%				
		Medical job plan compliance	n/a	≥95%				✗ 57.0%	✗ 86.1%	✗ 76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%		✗ 73.0%				
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 5.0%	✗ 4.9%				
		Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	-	-	-	-	✗ 58.0%	-				
		Employee relations management	<17	<21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✗ 18	✗ 23	✗ 18	✗ 18	✗ 21	✗ 20				
	New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✓ 6.8%	✓ 7.1%	✗ 8.9%	✓ 6.5%				
		Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 4.0%	✗ 2.8%				
		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%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
		Agency (over price cap)	≤40.0%	≤40.0%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 52.9%	✓ 38.1%				
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 91.4%	✗ 88.8%				
		Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 0.7%	✗ 0.7%				
		ED 4-hour performance	≥76%	≥Plan	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 71.0%	✗ 74.9%				
		ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 3.4%	✓ 2.9%				
		Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	16	17	31	26	19	18	21	19	22	24	23	104				
		Adult G&A bed occupancy	≤92%	≤92%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 94.5%	✗ 95.5%				
		Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	3.1	3.2	2.9	2.7	3.1	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.0	✓ 3.3		✓ 3.3				
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 64	✗ 67				
	Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 11.0%	✓ 6.0%	✓ 10.8%				
		Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	62.9%	63.2%	63.8%	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%		✗ 63.2%				
		Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	2.2%	2.1%	1.7%	1.8%	1.6%	1.3%	✗ 1.3%	✗ 1.2%	✗ 1.1%	✗ 1.1%	✓ 1.0%		✗ 1.1%				
	Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✓ 93.1%	✗ 87.9%				
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	-	✓ 78.3%	✓ 80.1%				
		Cancer 31-day treatment performance	≥Plan	≥96%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	-	✓ 91.9%	✗ 90.6%				
		Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	-	✗ 64.4%	✓ 65.3%				
Best Value Care	Financial Performance	Financial surplus / deficit	n/a	≥£0.00m							✗ -£0.90	✗ -£0.70	✗ -£0.20	✓ £0.10	✓ £0.02		✗ -£1.68				
		Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£0.17	✗ -£0.79	✗ -£0.10	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✓ £0.01	✗ -£0.98				
	Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £4.70	✗ -£1.97	✗ -£0.20	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✓ £0.08	✗ -£4.14				
		Risk adjusted efficiency forecast to plan (%)	n/a	100%							✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%		✗ 68.0%				
	Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£0.78	£0.78	£13.70	£4.19				
		Reported bank expenditure	No Standard	No Standard	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£2.09	£2.12	£30.55	£9.69				
	Rate of Productivity	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✓ 6.9%	✓ 5.4%	✓ 4.6%	✓ 3.3%	✓ 4.3%	✓ 3.1%	-	-	-	-	-		-				
	Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%							✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 0.0%		✗ 47.6%				
		BPPC - Value of bills paid within target	n/a	≥95%							✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%		✗ 75.9%				
		Operating expenditure days	n/a	≥5							✓ 16	✓ 16	✓ 13	✓ 10	✓ 10		✓ 10				
	Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£1.41	£1.01	£1.92	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✓ £33.58	✗ £3.74				
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)			547	557	544	515	543	582	552	562	577	582	530	547	561				
		Non-elective admissions			146	146	141	142	150	146	139	139	140	147	143	145	142				
	Electives	Average daily elective referrals			374	350	304	346	362	330	326	325	352	365	307	341	342				
		Outpatients - first appointment			349	347	294	327	339	323	318	308	335	355	273	347	317				
		Outpatients - follow up			889	851	748	875	907	855	849	802	853	915	717	852	827				
		Outpatients - procedures			278	258	236	287	278	254	257	254	267	293	240	265	262				
		Day case			126	126	110	127	126	116	114	116	123	126	117	122	119				
		Elective inpatient			16	15	12	12	13	13	13	14	15	15	11	14	14				
	Diagnostics	Diagnostics			506	514	462	496	518	490	476	464	477	494	461	479	474				

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Quality of Care

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-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	1.9	2.4	3.0	2.4	2.6	2.1	1.7	2.6	1.9	2.4	2.2		2.2				
	Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
	MRSA reported in month	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✗ 1	✗ 2				
	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	7	4	6	4	5	5	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 55	✗ 31				
	Number of gram-negative bloodstream infections reported in month	n/a	8	5	8	0	5	1	5	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	50	✓ 22				
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.2	0.1	0.0	0.1	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1				
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 6	✗ 1				
	Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	1	0	2	2	1	0	5	13	10	2	11	17	41				
	Percentage of inpatient Service Users undergoing risk assessment for VTE	n/a	≥95%	✗ 94.2%	✗ 94.5%	✗ 84.6%	✗ 84.1%	✗ 85.1%	✗ 89.6%	✗ 90.5%	✗ 89.7%	✗ 89.4%	✗ 88.0%	✗ 85.3%		✗ 88.3%				
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 0.8	✓ 0.8	✓ 0.4	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 0.9	✓ 1.4				
	Compliments received in month	No Standard	No Standard	204	160	147	140	152	184	155	115	141	157	109	1831	677				
Effective	SHMI	As Expected	As Expected	✓ 106	✓ 106	✓ 106	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 107				
	Still birth rate	≤4.4	≤4.4	✓ 3.4	✗ 10.3	✓ 0.0	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.1	✓ 4.3	✗ 5.5				
	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Domain Summary: Quality of Care

Overview

Lead: Executive Chief Nurse/Chief Medical Officer

During Jul-25 and Aug-25, our hospitals have continued to experience busy periods with a continued high volume of people accessing urgent care; the Trust has often been in escalation and using surge capacity. There were resident doctor strikes from 25 to 30 Jul-25. Our focus has been to ensure the safety and care of our emergency and inpatient pathways. The operational and managerial impact of planning and dealing with periods of Industrial Action cannot be overstated. Safety metrics and incidents have been carefully reviewed during the disruption. No additional obvious patient harm has been identified, though this would not consider potential harm from late diagnosis or decision making due to lost outpatient appointments.

There are five off-track metrics during Jul-25 and Aug-25:

- **MRSA reported in month**: two Hospital Onset Hospital-Acquired (HOHA) MRSA bacteraemia. When benchmarking against our peer organisations, we are one of two Trusts to have the highest amount of bacteraemia.
- **CDiff reported in month:** 13 Hospital Onset Hospital Acquired (HOHA) and three Community Onset Hospital Acquired (COHA) infections for Cdifficile. We have continued to observe an increase in our rates compared to the same period last year. When benchmarking against peer organisations, we remain the fifth highest organisation out 11. A separate action plan for Cdifficile has been developed, focused on organisation, diagnostic and sampling management, antimicrobial stewardship, Infection Prevention and Control (IPC) service and management, environment, surveillance, and health care economy and education.
- **HAPU (Cat 3 / 4):** one avoidable category three pressure ulcer.
- **Percentage of inpatient service users undergoing risk assessment for VTE:** 88.3% year to date. Divisions have been tasked with developing recovery plans to address key areas of concern. Initial findings have highlighted that review assessments for patients with longer hospital stays are often not completed as required. While Nervecentre generates alerts for these assessments, they are presented alongside multiple other notifications, making it difficult for resident doctors to easily identify and act on them. Discussions have taken place with Nervecentre, and a potential workaround has been proposed to improve visibility and compliance. In addition, the Medication Safety Group is currently reviewing the enoxaparin dosing protocol. Their aim is to simplify the process and ensure that a dose of enoxaparin can be administered within 14 hours of admission, in line with best practice and patient safety standards.
- **Still birth rate:** four intrapartum stillbirths (ISB). 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. Due to increased reporting of ISB, cases will be reviewed collectively for themes and the Governance team are undertaking review with guidance from MNSI, as their investigations will run alongside the Trust's.

Zero Never Events were reported during this reporting period and zero Patient Safety Incident Investigation (PSII) were commissioned by the Patient Safety Incident Response Group (PSIRG).

Summary Hospital-level Mortality Indicator (SHMI) remains as expected.

The following slides contain more detailed performance information across the Quality of Care domain.

Indicator in Focus: Infection Prevention and Control

NHS Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

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

- Cdifficile: 65 cases
- Ecoli: 80 cases
- Klebsiella: 15 cases
- Pseudomonas: 9 cases
- MRSA: 0 cases.

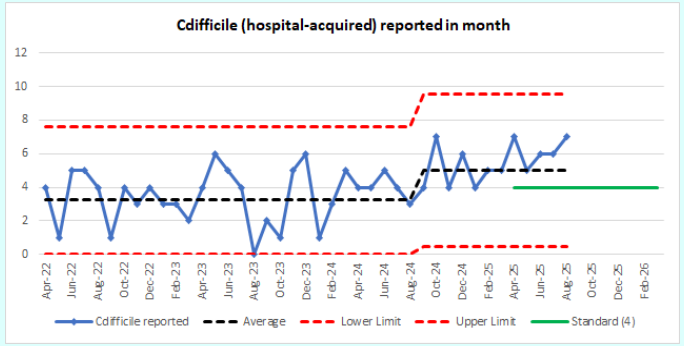
During Jul-25 and Aug-25, for Cdifficile we have had 13 HOHA and three COHA infections. We have continued to observe an increase in our rates compared to the same period last year. When benchmarking against peer organisations, we remain the 5th highest organisation out 11.

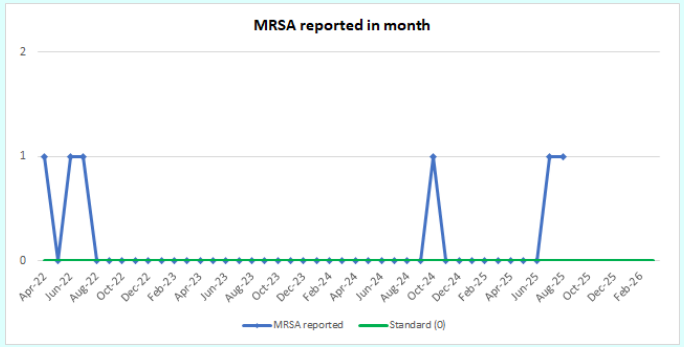
For MRSA bacteraemia we have had two HOHA in Jul and Aug-25. When considering benchmarking against our peer organisations, we are one of two Trusts to have the highest amount of bacteraemia.

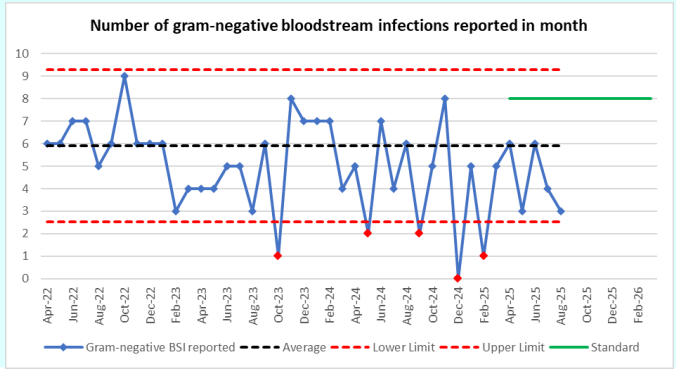
For gram-negative bacteraemia we are currently in a good position, and when benchmarking against our peers we remain one of the three Trusts with the lowest numbers.

Root causes	Actions and timescale	Impact
Cdifficile	A separate action plan for Cdifficile has been developed, focused on organisation, diagnostic and sampling management, antimicrobial stewardship, IPC service and management, environment, surveillance, and health care economy and education.	To promote knowledge and improve practice and patient environment.
MRSA – Cross transmission (outbreak)	Increased environmental Personal Protective Equipment (PPE) audits.	To improve patient environment.
	Update training on appropriate PPE usage.	To promote knowledge and improve practice.
	Training on appropriate hand decontamination methods.	To promote knowledge and improve practice.
	Additional joint walk-arounds to monitor Medirest cleaning with an action plan requested from Medirest.	To improve patient environment.

Data







Indicator in Focus: Hospital Acquired Pressure Ulcers (HAPU)

NHS Sherwood Forest Hospitals NHS Foundation Trust

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. In Aug-25, SFH reported one avoidable category three pressure ulcer on an end-of-life patient on Short Stay Unit (SSU) who was extremely cachectic. This incident investigation is still ongoing; initial analysis identifies the following root causes and plans are in place to action lapses in care.

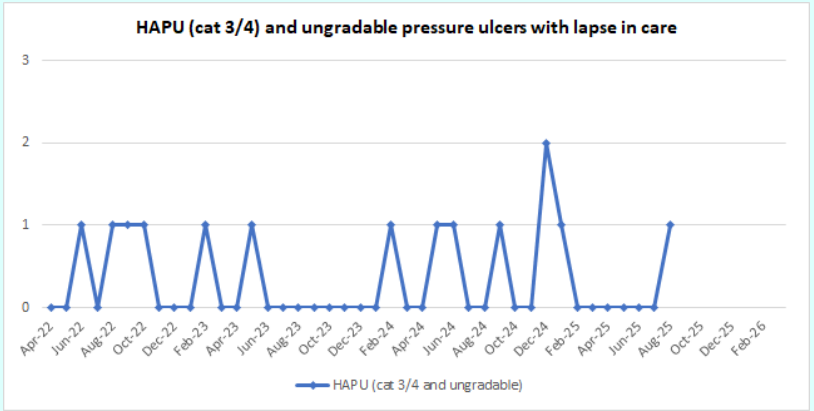
We remain on track for hospital acquired (category two) pressure ulcers per 1,000 occupied bed days.

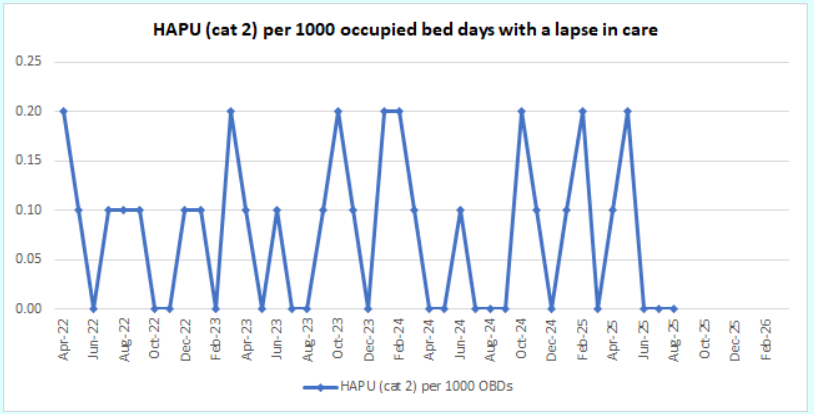
SFH pressure ulcer documentation moved from paper records to Nervecentre in Aug-25.

Initial planned timescale for actions below to be completed by 31 Oct-25. Monitoring and auditing will be extended until assurance of standards is evident.

Root causes	Actions and timescale	Impact
Lapses in skin monitoring and patient repositioning	Increase in monitoring, spot checks, auditing by ward senior team and Tissue Viability Nurses (TVNs).	• Reduce likelihood for similar incidents. • Improve staff knowledge and standards of record keeping.
	Ward based training from senior team and TVNs to provide further support with Nervecentre records.	
	Formal Tissue Viability (TV) education to be attended by all staff involved.	
	Incident will be incorporated into TV training updates to share learning.	
	Senior Urgent and Emergency Care team meeting with all staff involved.	
Lapses in concordance management with family and failure to escalate family declining repositioning to senior or specialist teams	Formal training sessions to be provided by End of Life (EOL) team in relation to difficult discussions with families to support staff confidence.	

Data





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 during Jul-25 and Aug-25, there were no PSII's commissioned by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the Integrated Care Board (ICB) were present. Three Maternity and Newborn Safety Investigations (MNSIs) were commissioned, one in Jul-25, one in Aug-25, and one incident that occurred in Aug-25 that was reported on 1 Sep-25, all reported as intrapartum stillbirths (ISB).
One case, an Intrapartum Intrauterine Fetal Death (IUFD) reported to MNSI in Aug-25, was rejected due to consent not being given by the family.

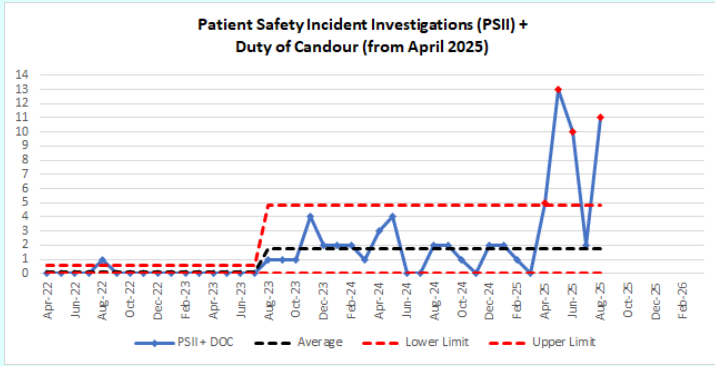
PSII with potential coronial interest	MSNI investigation	Never Events
None commissioned.	Three commissioned	None reported in Jul-25 and Aug-25

During Jul-25, one PSII was signed off. The key learning points were identified as follows:

1) Utilise National Safety Standards for Invasive Procedures (NatSSIPS 2) techniques to enable the team to use 'stop' moments to ensure communication, such as when a team member notes an unusual occurrence.
2) Review the provision of magnifying lamps / electrical sockets in the clean room of the sterile services department.
3) Update the clinical document titled: Swab, Sharps, Instruments and Sundries Count Procedure for the Operating Department to include an additional check of both reusable and non-reusable drill bits each time used in one procedure.

In Aug-25 there were no PSII's signed off at PSIRG. However, a progress tracker providing updates on open investigations is discussed on a regular basis. Duty of Candour (DoC) is undertaken for all incidents that meet the threshold for moderate harm and above. Since the implementation of the Patient Safety Incident Response Framework (PSIRF), divisions are required to initiate Duty of Candour as soon as the harm threshold is met. This change has helped accelerate the process of offering timely apologies to patients, families, and carers affected by such incidents. From Apr-25 onwards, the data reflects all Duty of Candour activity undertaken across relevant incidents. Before this date, the recorded data specifically relates to the Duty of Candour completed for Patient Safety Incident Investigations (PSIIs).

Data



Root causes	Actions and timescale	Impact
IUFD attended triage 40+3/40 in labour.	It was agreed by the division that no immediate actions were required; await the MNSI. Due to increased reporting of ISB cases to be reviewed collectively for themes.	MNSI ongoing.
Confirmed IUFD.	It was agreed by the division that no immediate actions were required; await confirmation as to whether MNSI have taken the investigation. Due to increased reporting of ISB cases to be reviewed collectively for themes.	Reported to MNSI.
Intrapartum stillbirth (ISB).	Governance team undertaking review with guidance from MNSI, as their investigations will run alongside the Trust's with cases to be reviewed collectively for themes.	Reported to MNSI.
Intrapartum IUFD.	Due to increased reporting of ISB, cases to be reviewed collectively for themes	Rejected by MNSI as no consent given by family.

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

Sherwood Forest Hospitals NHS Foundation Trust

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 by-passing the automatic prompt.

All divisions have been tasked with developing recovery plans.

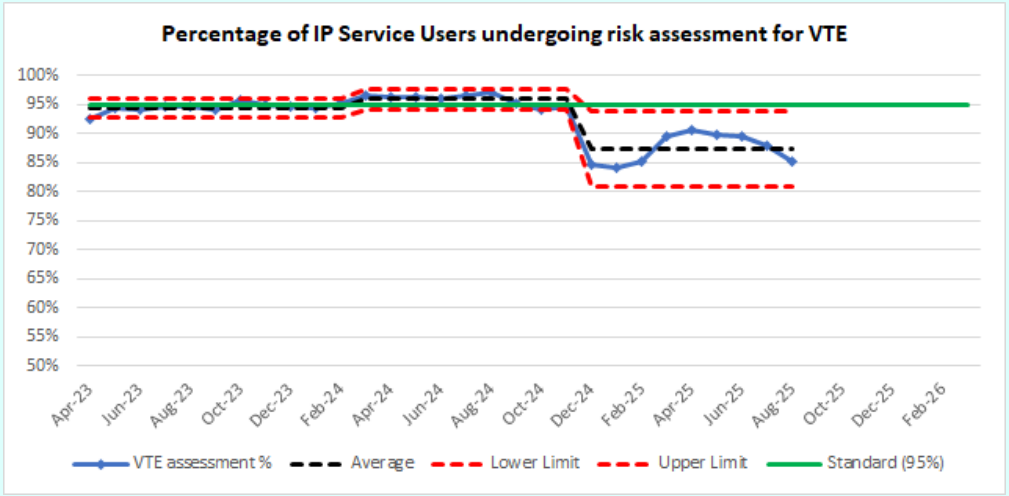
Initial work has highlighted that the review assessments for longer stay patients do not get completed. Although Nervecentre has alerts, this is combined with several other alerts, which do not make them obvious to the resident doctors who need to complete the assessments again. Discussions with Nervecentre have been conducted and a workaround has been suggested.

Additionally, the Medication Safety Group are looking at the enoxaparin dose sentence to see if we can make it easier to give a dose of enoxaparin within 14 hours of admission.

During Jul-25 and Aug-25, there have been 34 patients who have been identified as requiring a VTE case review following positive diagnostic results. Of these 34 case reviews nine remain outstanding; the 25 reviews completed were deemed not preventable by the reviewing clinicians.

Root causes	Actions and timescale	Impact
Emergency Assessment Unit (EAU) identified as issue due to volume of patients going through the department.	Urgent & Emergency Care (UEC) to focus on EAU performance and undertake a safety sprint during Sep-25 to improve performance with VTE assessment.	Improve compliance.
Clinicians by-passing the automatic prompt.	Divisions to develop recovery action plans with a likely focus on clinical guidance and education (including at medical induction). Divisions to provide an update at Sep-25 Divisional Performance Reviews (DPRs).	Support performance recovery.
	Review potential system configuration changes to prevent clinicians by-passing completing the VTE risk assessment on admission, ensuring it is a mandatory part of the patient admission process.	

Data



Indicator in Focus: Still Birth Rate

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

During Jul-25 and Aug-25, we have reported four intrapartum stillbirths. 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.

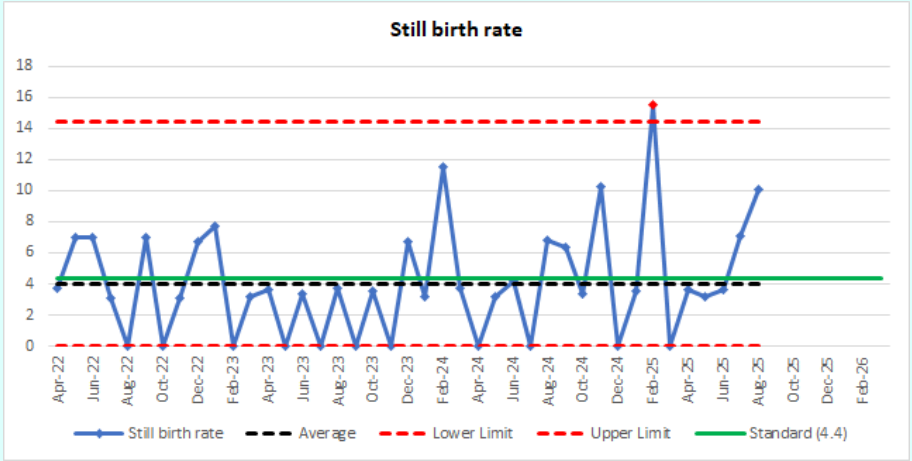
July 2025

- Low risk pregnancy, attend in labour at 40 weeks and three days gestation. Unable to auscultate fetal heart and Intrauterine fetal death (IUFD) confirmed. Due to signs of labour, reported as Intrapartum stillbirth (ISB).
- Unbooked pregnancy, delivered baby at home with no signs of life. Due to clinical presentation and estimated gestation discussed with MNSI and reported as an ISB. MNSI have since rejected the case for review.

August 2025

- Maternity team care, attended in early labour and remained on the maternity ward. ISB confirmed during latent phase of labour, mum developed sepsis. Case referred to MNSI.
- Low risk pregnancy, attended triage with signs of labour and Antepartum Haemorrhage (APH). No fetal heart detected and ISB confirmed, transferred to theatre for an emergency lower segment caesarean section (LSCS) due to bleeding. Reported to MNSI.

Data



Root causes	Early/ urgent learning identified
Due to increased reporting of ISB, cases to be reviewed collectively for themes	Governance team undertaking review with guidance from MNSI, as their investigations will run alongside the Trust's.
	Alert reviewed from the trial of national system, Maternity Outcomes Signaling System (MOSS), awaiting clarity around governance process however Trust, System and Regional teams already informed of the thematic review.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

People and Culture

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Domain Summary: People and Culture

Overview	Lead: Chief People Officer

The 2025/26 year-to-date (YTD) position is strong in seven out of 12 people and culture indicators which are meeting or exceeding the standard. In Aug-25, we achieved eight out of 12 indicators, showing progress.

Turnover has remained strong, staying below the standard, with YTD reporting at 0.5%.

The appraisal compliance level has fluctuated and is reported at 88.8% YTD, prompting significant efforts to promote the benefits and ensure the quality of appraisals. Divisions and services, along with Executives at Divisional Performance Reviews, have reviewed and challenged the position.

Our Mandatory and Statutory Training (MaST) compliance level has consistently surpassed targets throughout 2025.

Sickness absence levels for YTD are reported at 4.9%, higher than our standard of 4.2%, but still within the upper and lower statistical process control limits. Significant work is underway within the Trust with details in the 'indicator in focus' page. The wider NHS sickness absence for quarter one was 5.3%, with Acute Trusts sitting sightly higher at 5.4%. 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. Additionally, internal analysis on 2025/26 quarter one data shows we ranked 7th out of 23 across Midlands Acute Trusts.

Employee relations cases over the reporting period have remained high though sits below the standard. We are seeing elevated levels associated with grievances; these are being managed in line with processes.

Quarter two to date has also seen a continued improvement in our bank usage level, aligned with ongoing efforts to meet NHS planning expectations of a 15% reduction in bank usage. We have seen current fluctuations aligned with the period of Industrial Action and the acuity of the hospital, including being on a high Operational Pressures Escalation Level (OPEL) and at times implementing our Full Capacity Protocol (FCP). However, the bank usage is showing a reducing level. Our plans are to cease all Administrative and Clerical (A&C) bank usage, with any planned exceptions to be agreed with Executive Leads and are bringing in stronger visibility and governance around clinical bank usage.

Agency usage is showing a level above the standard. As with bank, we have seen spikes that are associated with high OPEL levels and FCP, however work is being undertaken to address increases. There has been zero use of 'off framework' agency and over price cap agency is achieving standard. Our plans are to cease all new agency bookings, with any exceptions to be signed off by the Executive Lead and develop exit strategies with clear timescales for all agency workers to be developed and presented to Transformation Groups for agency staff and escalated to Trust Management Team (TMT).

We have received the Trust NHS Oversight Framework (NOF) ratings. Across the people domains the provider score is 1.98, which sits us in with segment one. Within this sickness absence is score at 2.47 (segment two) and staff engagement is scored at 1.5 (segment one).

We have implemented a successful Mutually Agreed Redundancy Scheme (MARS) programme; the next few months will see staff exit SFH in line with our planned reductions.

The following pages provide more detailed performance information across the people and culture domain.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: People and Culture

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-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			✗ 7.1			-			✓ 7.1	-				
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✗ 9.2%				
	Time to hire	n/a	≤53.1 days				49.0	34.0	27.0	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0		✓ 26.4				
	Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.7%	✓ 0.5%				
	Appraisals	≥90%	≥90%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 89.0%	✗ 88.8%				
	Mandatory & statutory training	≥90%	≥90%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 91.5%	✓ 92.9%				
	Medical job plan compliance	n/a	≥95%				57.0%	86.1%	76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%		✗ 73.0%				
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 5.0%	✗ 4.9%				
	Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	-	-	-	-	✗ 58.0%					
	Employee relations management	<17	<21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✗ 21	✓ 20				
New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✓ 6.8%	✓ 7.1%	✗ 8.9%	✓ 6.5%				
	Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 4.0%	✗ 2.8%				
	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%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 52.9%	✓ 38.1%				

Indicator in Focus: Vacancy Rate

Sherwood Forest Hospitals NHS Foundation Trust

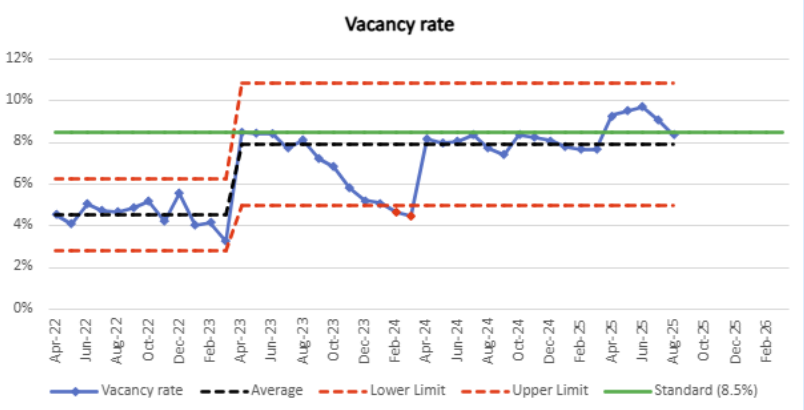
Overview and national position

The year-to-date vacancy position is reported at 9.2%, which is above the standard (8.5%). There has been an observed decrease over the last few months that is aligned to the growth in substantive whole time equivalents (WTEs). In 2025/26 quarter two, performance is between the mean and upper control limit.

Nationally there is an increase in vacancies and this trend is seen across the Nottingham and Nottinghamshire Integrated Care System (ICS).

Since Apr-25 we strengthened the Vacancy Control Panel (VCP) process. This reduced the average roles advertised from 14.6 to 12.3 WTE, and from Aug-25 we enhanced these controls that further reduce the average roles advertised from 12.3 to 7.0 WTE. In Sep-25 we have implemented further control and will monitor the impact.

Data



Root causes	Actions and timescale	Impact
Our vacancy level is calculated from a variance between establishments and number of people in-post. It is being artificially inflated due to stronger financial controls and grip and control associated with our internal vacancy control processes.	• Aligned to financial control, we monitor vacancies on a fortnightly basis via our VCPs. Within our VCP processes, we strongly scrutinise all posts and only advertise level two and three category posts through a break-glass process. • The Trust has implemented an Administrative and Clerical recruitment freeze.	We actively manage vacancies on a fortnightly basis via the VCP process and have strong governance processes around this.

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 Aug-25, achieving 87.4% and 88% respectively. The year-to-date position is at 88.8%. Performance during 2025/26 continues to fall between the upper and lower statistical control limits demonstrating movement within usual variation.

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 88.6% cases.

Root causes

Patient demand and hospital acuity has impacted on compliance.

Annual leave and absence levels.

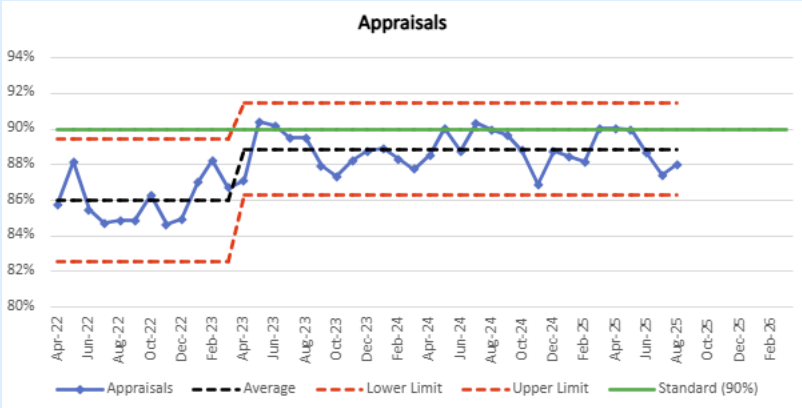
Actions and timescale

- Service lines with low appraisal rates are supported to develop trajectories for improvement.
- In addition, service lines are sighted on non-compliance rates and assurance is sought via monthly service line performance meetings. This is 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.

Data



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

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

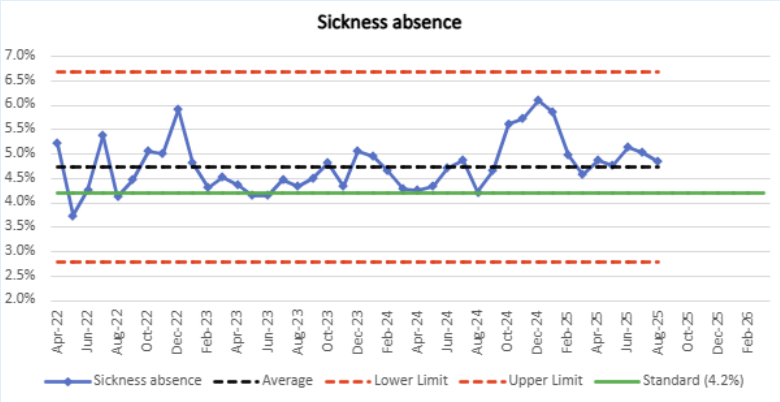
The YTD sickness position is reported at 4.9%, this sits above our standard (4.2%), but within the upper and lower SPC levels. We are noting a reduction to sickness absence levels, currently reported at 4.8% in month 5. Across short-term elements, we are noting high levels of staff reporting absences related to cold, cough, influenza, and chest & respiratory problems. Long-term elements are related to stress and anxiety reasons. We are reporting a reduction across long term absence.

We report and discuss monthly the sickness absence position at a divisional and service line level. 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 treatments; sickness relating to processes directly and indirectly; personal issues such as family illness, bereavement and financial worries; and safeguarding.

The wider NHS sickness absence for quarter one was 5.3%, with Acute Trusts sitting slightly higher at 5.4%. It is recognised by NHSE 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. Internal analysis on quarter one data shows we ranked 7th out of 23 Midlands Acute Trusts.

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).

Data



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.
- Additional coaching and training being provided across Jul-25 to Sep-25, including attendance at team development days and meetings.
- Sickness absence key performance indicators are monitored through People and Performance meetings, Service Line meetings and via DPRs.
- 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

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

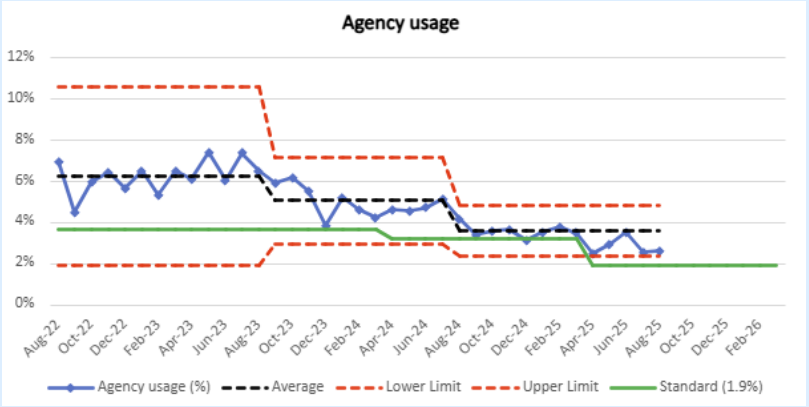
Overview and national position

The year-to-date agency position is reported at 2.8%, with the Aug-25 position at 2.6%. This sits above the standard (1.9%). Our current agency position for Aug-25 shows a zero usage of off framework agencies and a strong performance within 'on framework, over price cap' position.

We have modelled this, with plans over the 2025/26 period to sit around the NHS planning guidance. Our targets have been amended to reflect this. Within month five, we are showing a 31.4% reduction to bank usage and 12.1% 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.

Data



Root causes	Actions and timescale	Impact
As the data informs us, 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 speciality 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.	

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Timely Care

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

During the last two months, we have seen deterioration in several Urgent and Emergency Care metrics; metrics that we saw improve during the same period last year. Our headline A&E 4-hour performance metric was very low at 68.8% in Aug-25, well below our operational plan, and much lower than the 82% we saw last year. This performance challenge is also apparent in our Emergency Department (ED) 12-hour length of stay performance and in our 30-minute ambulance handover performance. While demand has been high throughout 2025/26, it did seasonally reduce in Aug-25. The challenge in Aug-25 related to issues in our ability to discharge patients with an associated rise in length of stay during this period across mainly our medical specialties. This was, in part, driven by rising levels of medically safe for transfer (MSFT) patients across our bed base. MSFT patient levels had been very low since spring 2024; the rise observed since Jul-25 has been sharp, difficult to mitigate, and largely relates to increased numbers of pathway one discharge patients waiting to leave hospital (patients being discharged with a package of care). The increase in length of stay has resulted in flow challenges cascading through the hospital to A&E. The poor outflow from A&E created overcrowding leading to increased waiting times that can increase the risk of delay-related harm and reduced patient experience.

In terms of planned care, we have continued to reduce the number of long wait patients. Our 52-week wait backlog was at 0.97% of the total patient tracking list (PTL) 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 61.3% in Aug-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 plan has resulted in us being put into tiering, 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 as we look to improve performance to meet our plan by Dec-25.

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, closing in Jul-25 at 89%. 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 increased in recent weeks, though recovery plans are 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%

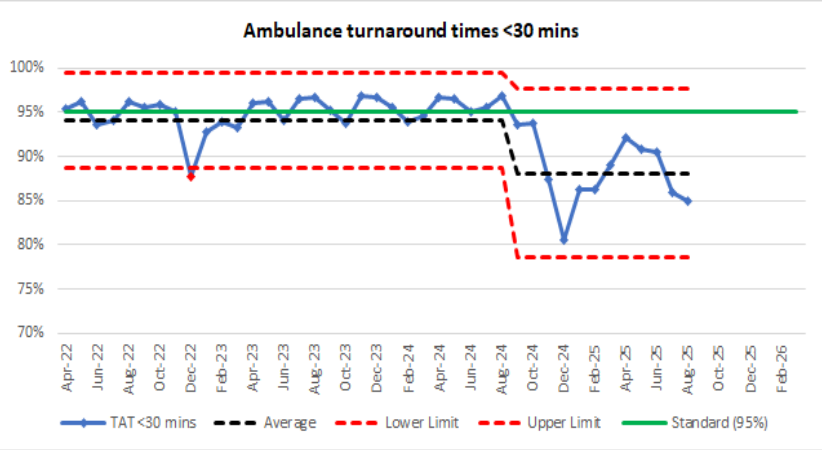
Green tick = target met/exceeded; Red cross = target not met

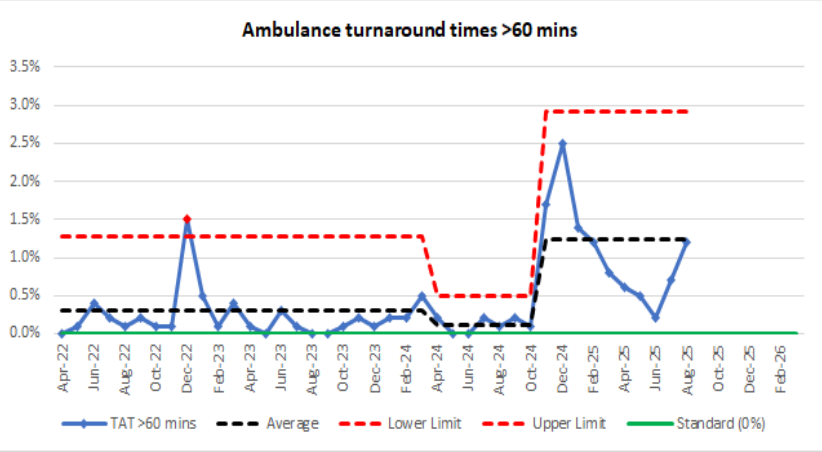
At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	2024/25 Final	2025/26 YTD	Latest Benchmark Position (Jul 25)	STAR Data Quality Assurance S	T	A	R
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 91.4%	✗ 88.8%	✓ 70 / 176				
	Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 0.7%	✗ 0.7%	✓ 62 / 176				
	ED 4-hour performance	≥76%	≥Plan	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 71.0%	✓ 74.9%	✗ 96 / 141				
	ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 3.4%	✓ 2.9%	✓ 43 / 174				
	Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	16	17	31	26	19	18	21	19	22	24	23	104					
	Adult G&A bed occupancy	≤92%	≤92%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 94.5%	✗ 95.5%	✗ 120 /179				
	Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	3.1	3.2	2.9	2.7	3.1	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.0	✓ 3.3	3.1	✓ 3.3					
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 64	✗ 67					
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 11.0%	✓ 6.0%	✓ 10.8%	✓ 4 / 134				
	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	62.9%	63.2%	63.8%	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%	64.6%	✗ 63.2%					
	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	2.2%	2.1%	1.7%	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	1.3%	✓ 1.1%					
Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✓ 93.1%	✗ 87.9%	✓ 42 / 134				
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	-	✓ 78.3%	✓ 80.1%	✓ 21 / 132				
	Cancer 31-day treatment performance	≥Plan	≥96%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	-	✓ 91.9%	✗ 90.6%	✗ 113 / 132				
	Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	-	✗ 64.4%	✓ 65.3%	✗ 91 / 132				

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

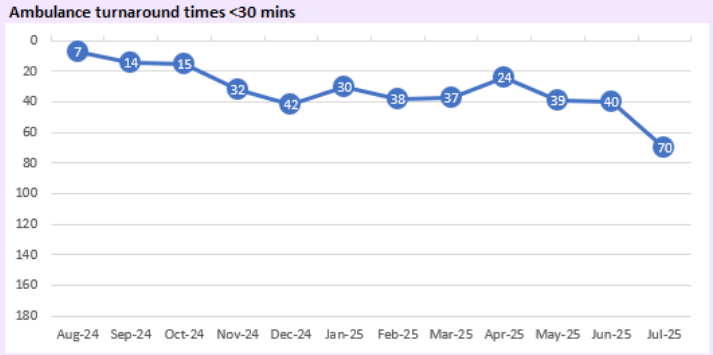
Sherwood Forest Hospitals NHS Foundation Trust

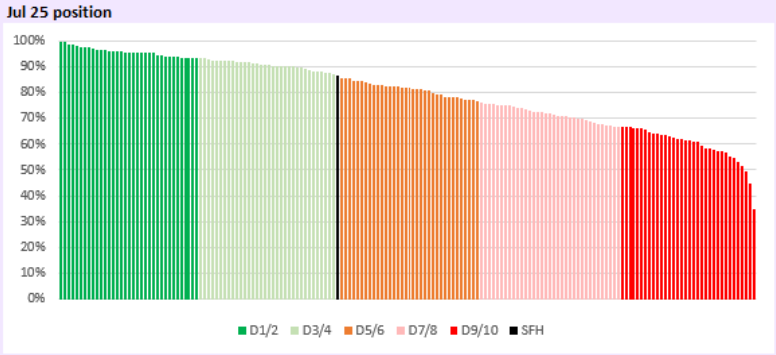
Local data (to Aug-25)

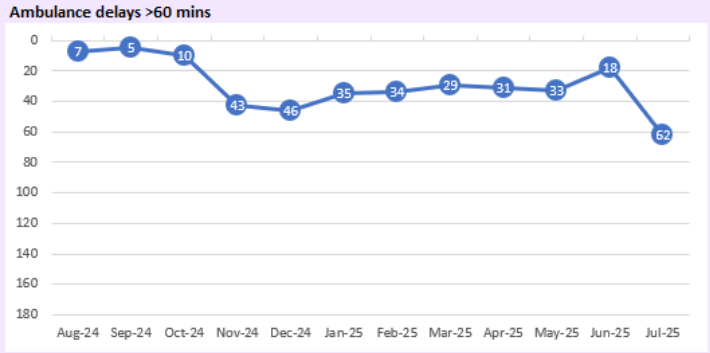


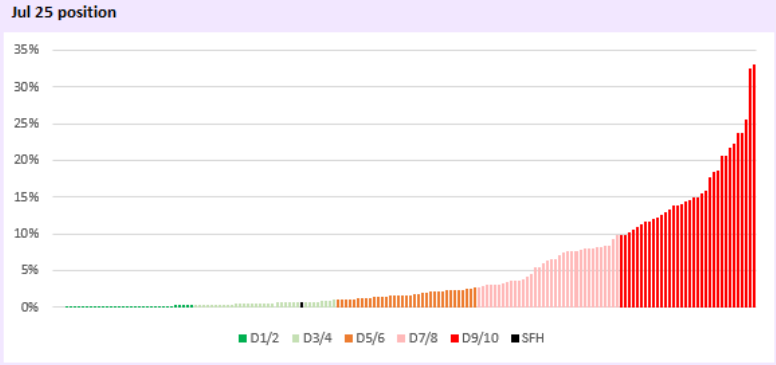


Benchmark position (to Jul-25)





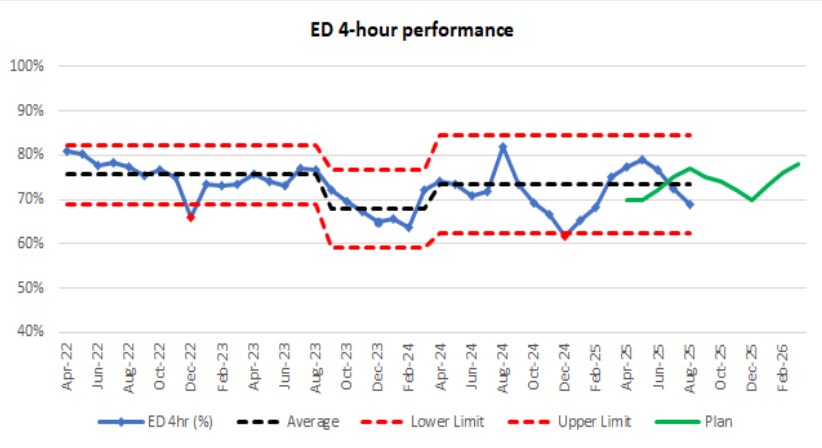


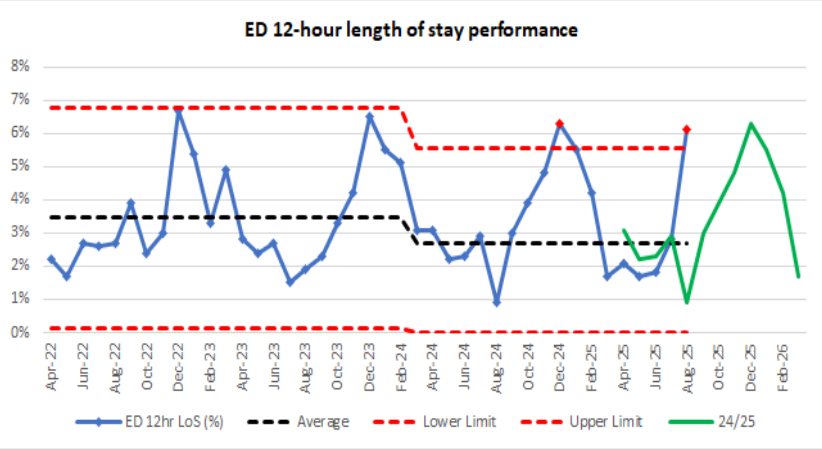


Indicators in Focus: Urgent Care – A&E (2/4)

Sherwood Forest Hospitals NHS Foundation Trust

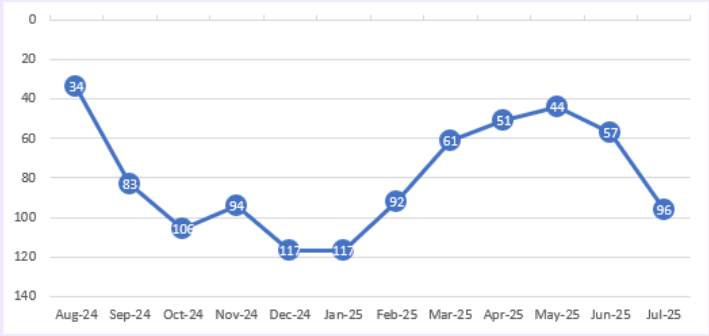
Local data (to Aug-25)



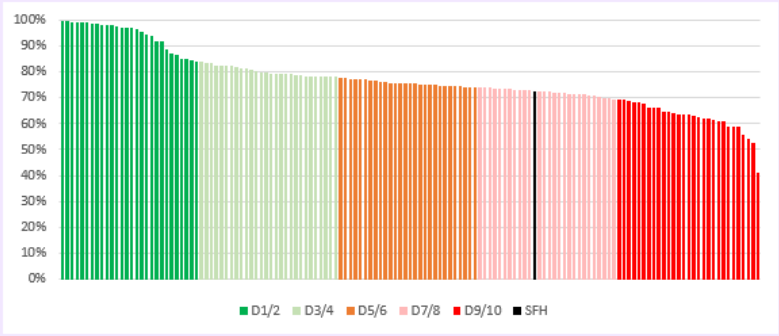


Benchmark position (to Jul-25)

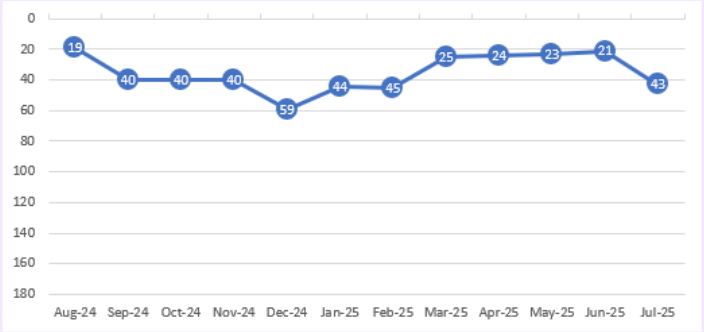
ED 4-hour performance



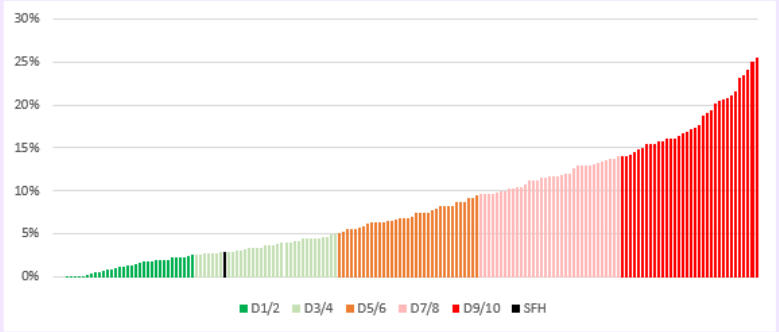
Jul 25 position



ED 12-hour length of stay performance



Jul 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 85% in Aug-25, having peaked at 92.1% in Apr-25. This is reflected in our benchmarking position, which has dropped to the bottom of the fourth decile; in 2024 we were in the top 10%.

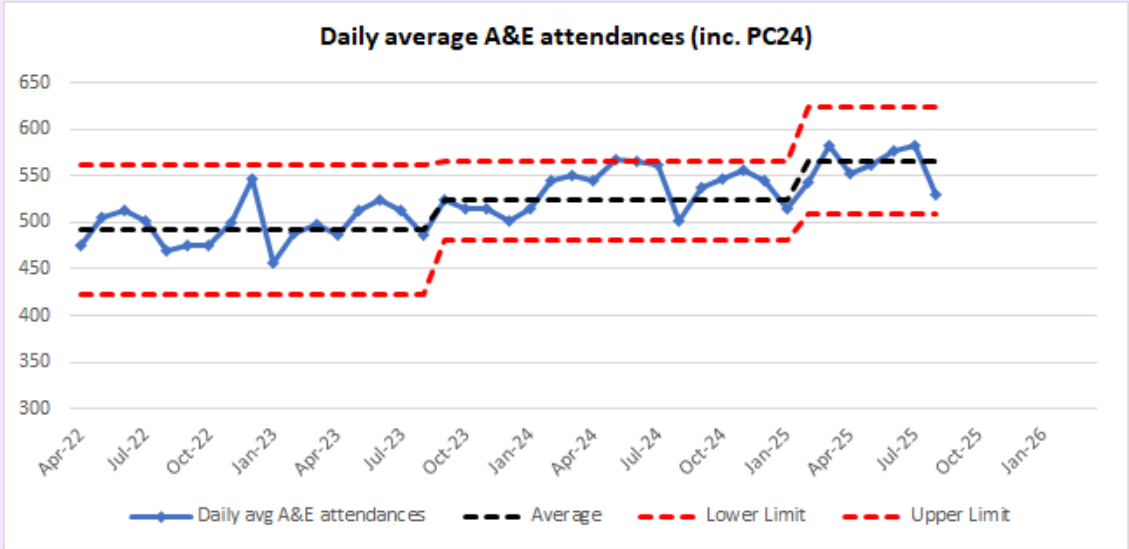
Ambulance 60-minute handover performance also deteriorated in the last two months, with 1.2% of arrivals being handed over in more than 1-hour in Aug-25; this is our poorest performance since Feb-25. This is reflected in our benchmarking position trend where we have dropped into the fourth decile of Trusts nationally in Jul-25.

A&E 4-hour performance deteriorated significantly during Jul-25 and Aug-25, falling below our operational plan (by circa 8%) and below the performance we achieved during the same period last year. Daily average A&E attendances seasonally reduced in Aug-25; however, continue to trend higher than in 2024/25. Length of stay during this period has increased particularly in medical specialties. Medically safe numbers have grown significantly during the last two months and is impacting length of stay and inpatient flow. The hospital flow challenges are causing outflow issues in A&E department, causing overcrowding which is driving the poor 4-hour and ambulance handover performance. Our benchmarking position has deteriorated during this period, and we are 96th nationally out of 141 Trusts in Jul-25.

A&E 12-hour performance triggered special cause variation after a significant deterioration during Aug-25 to levels akin to those seen during winter, rising to the second-highest level observed since Dec-23 and significantly above our operational plan. Until Aug-25, we had been better than plan on this metric. We have dropped out of the top 20% in our Jul-25 benchmarking position.

Following a positive beginning of 2025/26 in terms of A&E performance, the last two months have been very challenging and largely unexpected given performance trends from this period last year and improvements in length of stay at the start of the financial year. 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

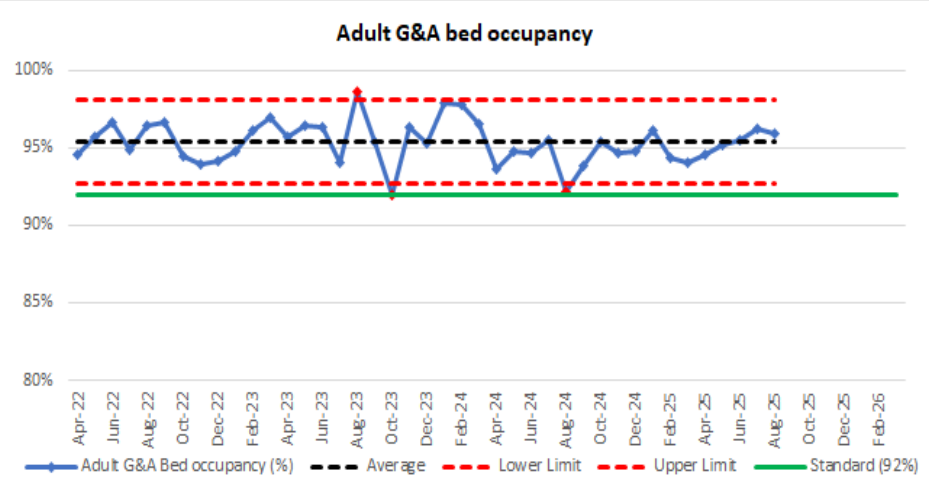
Surges in Accident and Emergency (A&E) attendance demand.	• Admission and attendance avoidance with system partners include:
	  - Focus on frailty attendances: Call before you convey; use of urgent care response teams.
	  - Development of alternatives to ED workstream in line with the Emergency Care Improvement Plan.
	  - Development of Acute Frailty Service commencing early Oct-25.
		• 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.

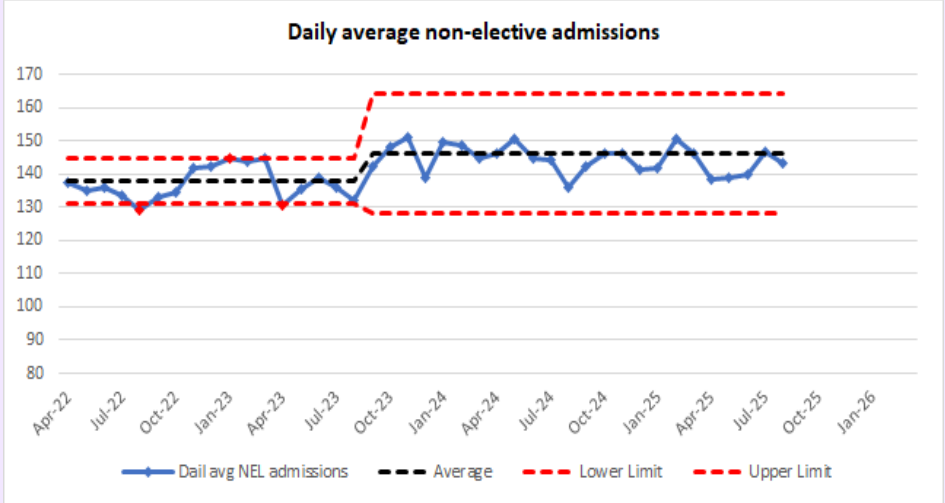
	• Optimise approach to Same Day Emergency Care (SDEC) for patients who would otherwise be admitted to hospital.	• Increase in patients through Frailty and Surgical SDEC. • Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our Emergency Department (ED). • Decrease 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 – workshop concluded in Sep-25.	
	• Develop recommendations following Recommended Summary Plan for Emergency Care and Treatment (RESPECT) audit.	
	• Work with systems partners to better understand the increase in the number of Mental Health presentations in ED.	• Reduce ED overcrowding and improve staff to patient ratio through reduction in 1:1s required.
Insufficient staffing to manage A&E demand.	• Consultant cover five days per week at Newark Urgent Treatment Centre from Sep-25.	• Decrease in mean time in department for non-admitted patient to <180 minutes.
	• Recruit five new ED Consultants following review of all vacancies with a move to Consultant on site cover until 2am, expected start date Dec-26/Jan-26.	
	• Implement ED Nervecentre task list to improve visibility of tasks and escalations to progress patients care and journey.	
	• Pre-allocate Consultant to dedicated areas and provision of clear expectations and oversight for each area including two-hourly huddles and oversight 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%.
	• New Clinical Decisions Unit opened Apr-25 and Majors rebuild planning commenced.	
	• Patient flow actions detailed on the following slides.	

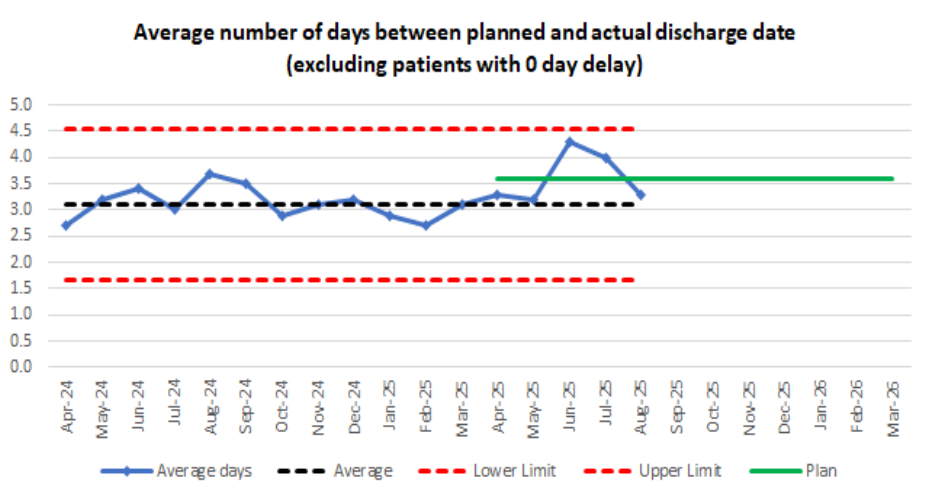
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

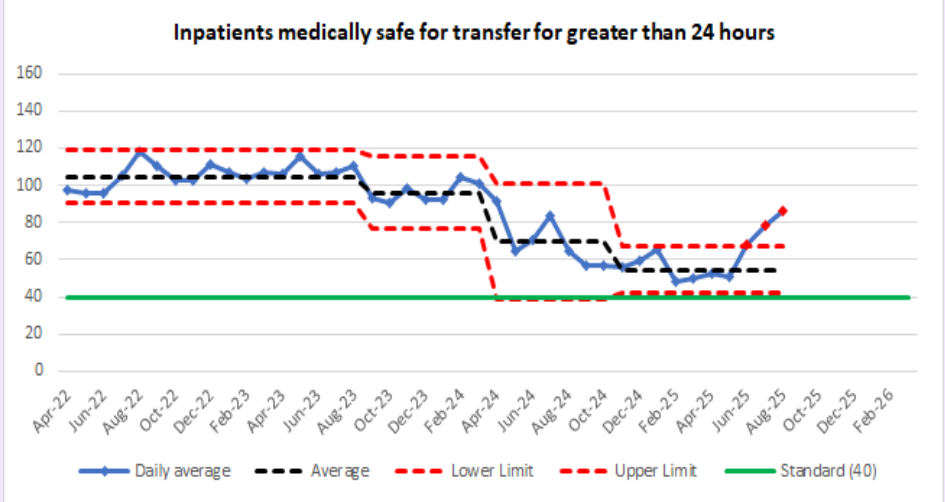
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

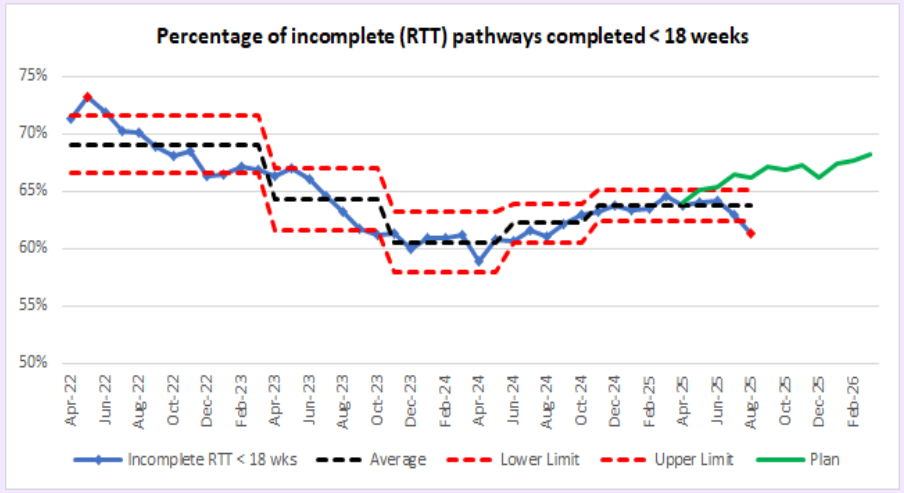
- General and Acute (G&A) bed occupancy is trending within statistical process control limits; with no unexpected variation. We did not experience reduced occupancy in Aug-25 like we saw in Aug-24.
- The number of patients Medically Safe For Transfer (MSFT) for greater than 24 hours have increased since Jun-25 and have sustained at elevated levels not seen since Mar-24, showing special cause variation. This is being largely driven by significant delays in the availability of pathway one packages of care for patients awaiting discharge.
- Length of stay increased in Aug-25, particularly in medical specialties. Some of this increase will be attributable to the increase in MSFT patients. This has impeded patient flow through the hospital and affected 4-hour emergency access, 12-hour and ambulance handover performance significantly.

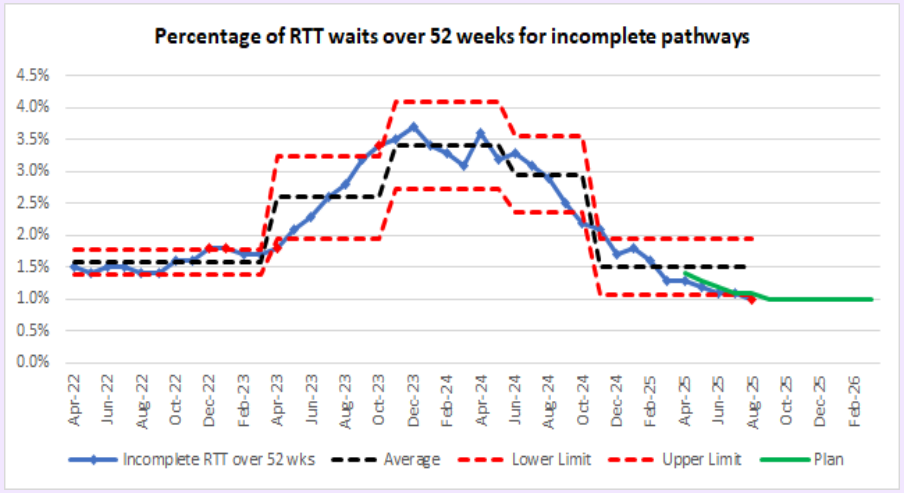
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• The 'Getting the Basics Right ' programme championed by the Chief Operating Officer and Chief Medical Officer. Focus on board rounds and ward processes to reduce delays and improve patient length of stay.	• Reduced delays and improved patient length of stay across all discharge pathways.
	• Increased frequency of long length of stay (LOS) meetings for both pre and post medically safe patients.	• LOS meetings identify discharge delays and enable conversations with partner agencies to resolve them swiftly.
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.	• Improve 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)

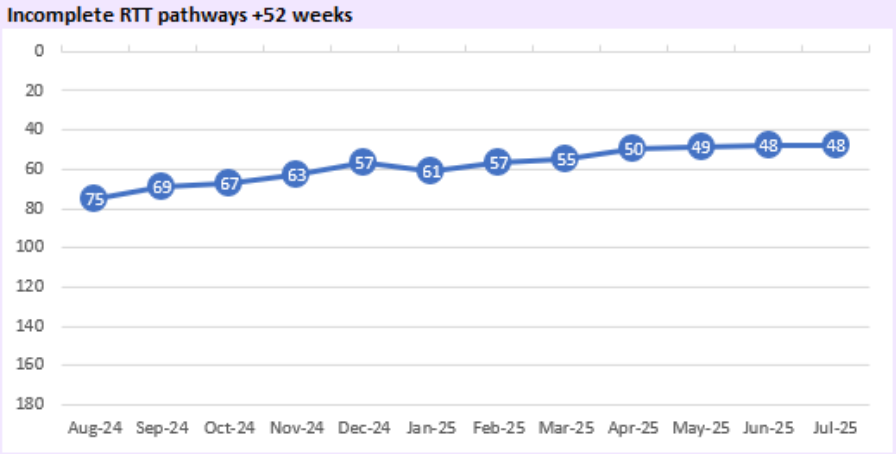
Sherwood Forest Hospitals NHS Foundation Trust

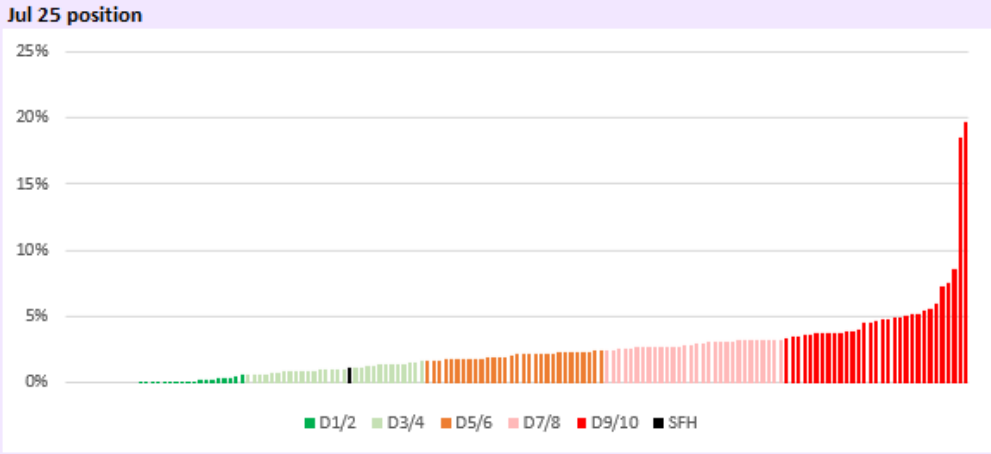
Data





Benchmarking Position and Standings





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

NHS Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

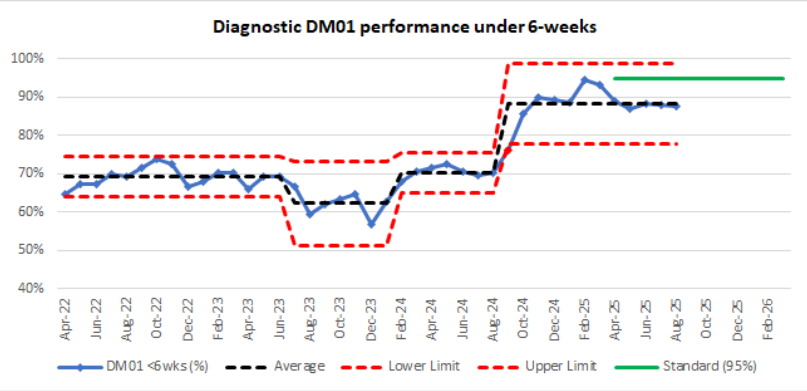
- Referral to Treatment (RTT) 18-week performance at SFH has decreased slowly through 2025/26 and is currently circa 5% below our operational plan, which is set to deliver a 5% improvement on our Nov-24 position. This is in part being driven by a deteriorating position in the proportion of patients awaiting a first outpatient appointment within 18-weeks. We are presently fourth best in the Midlands region.
- 52-week wait pathways continue to reduce and we have improved to sit inside our operational plan target for the end of 2025/26 (to achieve 1% of the total incomplete PTL [Patient Tracking List]).
  Our 52-week wait benchmarking position continues to improve relative to the rest of the country (we are getting better whereas the national position has deteriorated).

Root causes	Actions and timescale	Impact
Insufficient surgical capacity within key specialities to meet demand.	• Cross-provider PTL and support for patients in place.	• Equalise waits across the system. • Treat longest waiting patients first regardless of provider.
	• Insourcing to increase ENT capacity in place, and from the end of 2025/26 quarter one, extended to weekends.	• Two to three lists per week increasing ENT capacity to further reduce in long waits in a sustainable way. • Increase the volume of FESS that can be booked each week by up to two patients per week. • Achieved zero ENT 65-week breaches Aug-25 and are tracking ahead of 52-week wait trajectory.
	• Additional equipment to increase Functional Endoscopic Sinus Surgery (FESS) delivered Mar-25 enabling more patients to be booked.	
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: – Insourcing up to eight lists per week and covering additional gaps with increased hours for part-time clinicians since Mar-25. – Consultant acting up from Aug-25.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations.
Insufficient capacity to reduce first appointment backlogs within our baseline capacity.	• Outsourcing ENT first appointments commenced in Aug-25.	• Reduce waits for first outpatient appointments – 264 patients successfully transferred. • Increase skin cancer first appointment capacity (preventing increased capacity for long waiters). • Improve Trust performance against first activity trajectory.
	• Dermatology locum appointments commenced in Jul-25 to release consultant capacity for clinics (cancer). Clinic capacity review to increase first appointments from Sep-25.	
	• Outsourcing Ophthalmology first appointments commenced end of 2025/26 quarter two.	
	• Urology substantive consultant appointment commenced end of 2025/26 quarter two.	
	• Additional clinics for Paediatric Allergy appointments to commence at the beginning of quarter three.	
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 and will go live with DrDoctor Pilot at the beginning of quarter three.	• PTL will be ‘clean’ and represent only those patients genuinely waiting treatment. • Reduction in overall incomplete PTL position through validation.
	• Leadership team agreed to recruit to vacancies in Jul-25 following several colleagues leaving in 2025/26 quarter one. Recruitment and workforce change underway to increase validation capacity.	

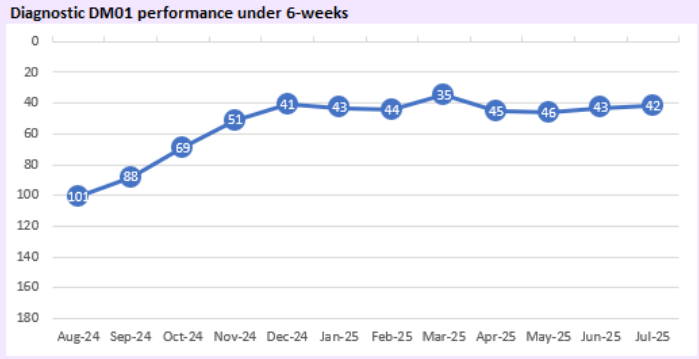
Indicators in Focus: Diagnostics (1/2)

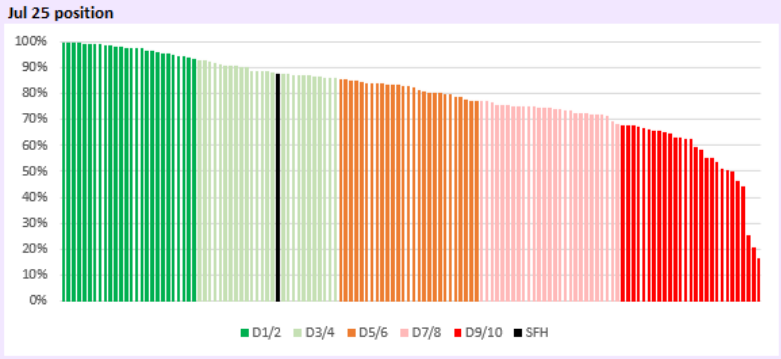
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Aug-25)



Benchmark position (to Jul-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, and trends in the service generally result in a similar overall position trend.

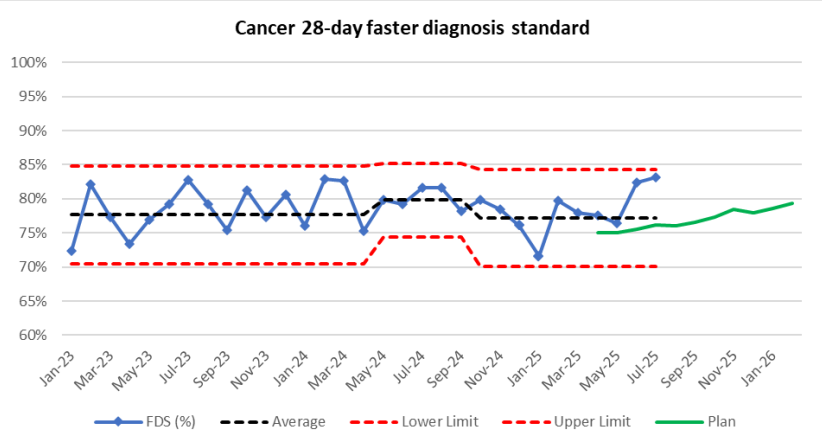
Indicators in Focus: Diagnostics (2/2)

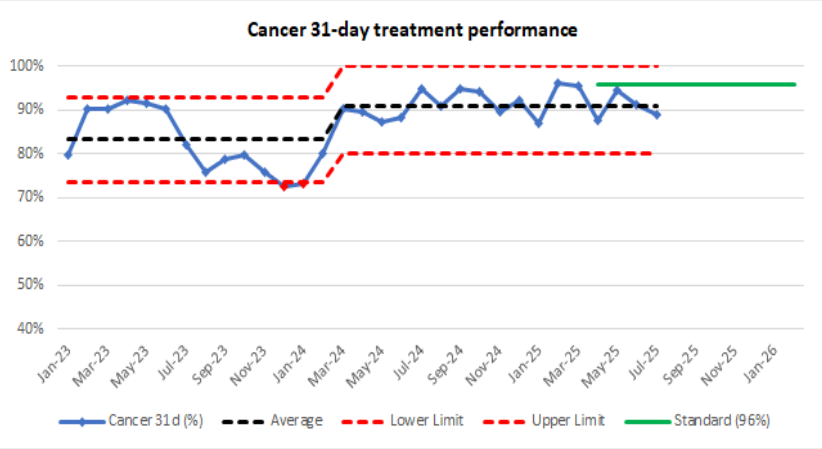
Root causes	Actions and timescale	Impact
Insufficient Echocardiography baseline capacity to reduce the number of patients waiting and reduced administration and clerical (A&C) capacity to manage booking capacity.	• Insourcing recommenced to increase capacity and deliver above planned activity levels from Jun-25.	• 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 book into a minimum of six weeks in advance is in development.	• Advanced booking of appointments to enable greater patient choice.
	• Cross cover provided where possible and targeted capacity towards long waits and urgent patients.	• Improved DM01 performance.
Sustained growth in CT Cardiac, insufficient available capacity of specialist workforce and equipment failure.	• Arrival and testing of the new CT scanner completed, and regular CT Cardiac radiologist-led capacity established from Jun-25.	• Increased capacity and reduction in long waiters. • Improved DM01 performance.
	• Review of clinical pathways to expand the volume of patients eligible for radiologist-led capacity.	• Release Consultant Cardiologist capacity. • Reduction in long waiters. • Improved DM01 performance.
Insufficient baseline capacity to reduce backlogs in Sleep (impacted by an increase in out of area referrals throughout 2024 which has now stablised in 2025).	• Funding to secure additional devices to right-size capacity from Apr-25 as part of the Community Diagnostic Centre (CDC) underway.	• Improved DM01 performance.
	• Successful recruitment to technician and physiologist capacity to increase Sleep Studies following a successful bid to purchase an additional 11 devices. Go live in quarter three with an additional 16 sleep studies per week.	• Reduction in long waiters and prevent of 13-week breaches.

Indicators in Focus: Cancer (1/3)

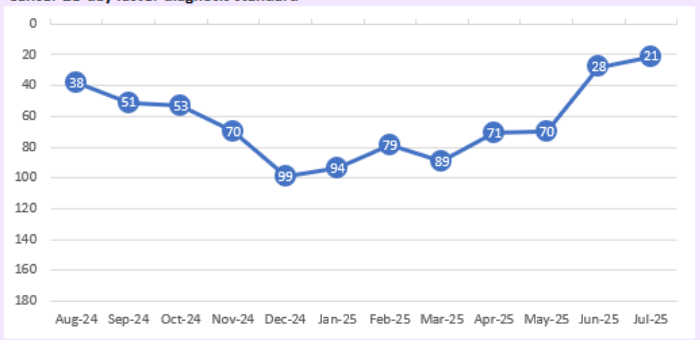
Sherwood Forest Hospitals NHS Foundation Trust

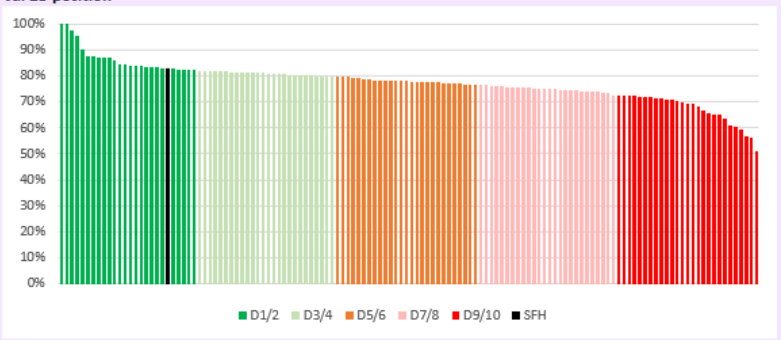
Local data (to Jul-25)

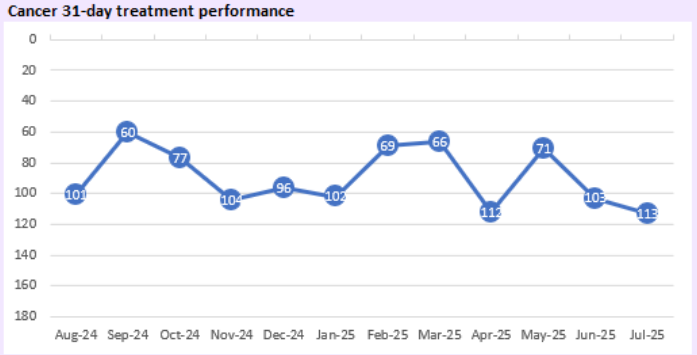


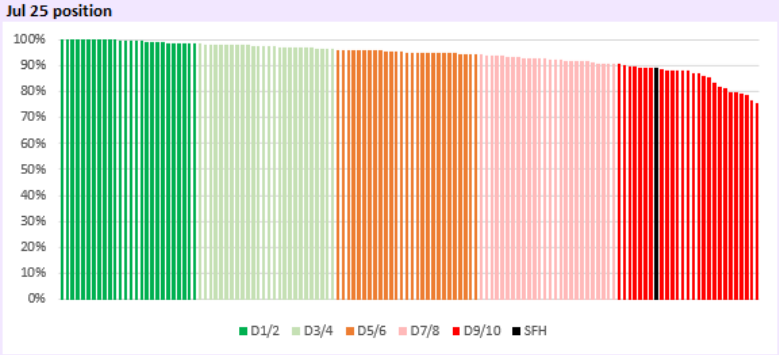


Benchmark position (to Jul-25)





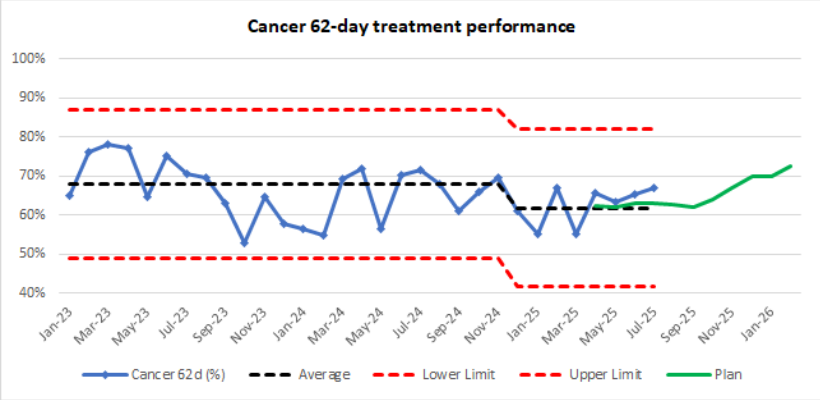




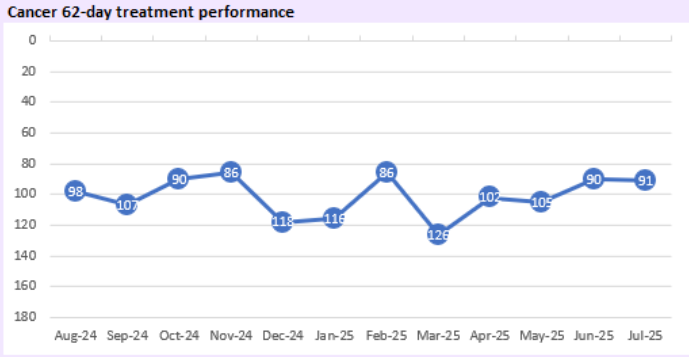
Indicators in Focus: Cancer (2/3)

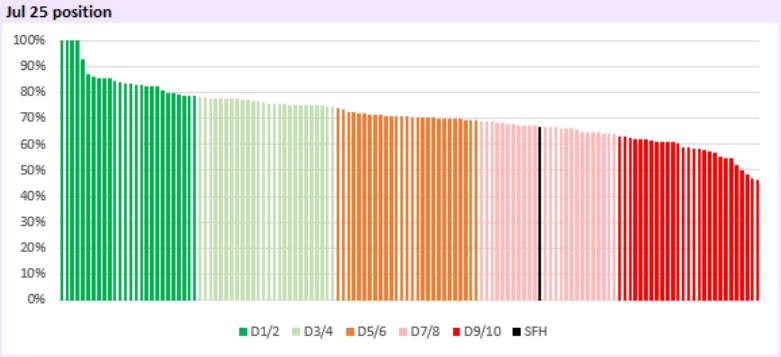
Sherwood Forest Hospitals NHS Foundation Trust

Local data



Benchmark position





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 improvement to 80% by the end of 2025/26 as part of the national ambition. Our benchmark position is now in the top quartile nationally.
- Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024, closing in Jul-25 at 89%. This is below the 96% national standard which is our operational plan. Our variable position is reflected in our benchmark position which typically is in the lower quartiles nationally. To benchmark in the upper quartile, we need to exceed the 96% national standard.
- Cancer 62-day treatment performance has been unusually stable over the past four months. We have performed better than our plan throughout 2025/26, closing at 66.5% in Jul-25. 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. Like 31-day treatment performance, we benchmark in the lower quartile nationally.

Indicators in Focus: Cancer (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact
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.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
	• East Midlands Cancer Alliance (EMCA) funding to implement seven-day working across Histopathology is underway and due to commence 2025/26 quarter three.	
	• Ongoing pay per point scheme to support additional cancer reporting.	• More than 4,800 additional points reported.
Insufficient clinical triage and decision-making workforce capacity in Upper Gastrointestinal (UGI).	• EMCA funding confirmed at the end of 2025/26 quarter one to increase clinically-led triage capacity to streamline the front end of the pathway to support with patient engagement and the timely management of clinical decisions. Recruitment underway to be in post from quarter three.	• Improvement in first seen within seven days, reducing the time on the overall pathway.
Insufficient capacity to meet demand in Lower Gastrointestinal (LGI) and patient compliance issues.	• Implementation of 'welcome' calls prior to consultant led clinic for first seen patients to increase engagement and compliance and reduce those that do not attend.	• Improved FDS performance. • Reduced 62-day backlog. • First seen within 7-days sustained >50%.
Insufficient capacity to meet radiology reporting turnaround targets.	• Recruitment to four WTE Consultant Radiologists to commence for 2026/27 deployment.	• Improve radiology reporting turnaround.
Increase in complex patients requiring multiple investigations in Lung.	• Review of patients over 62 days to understand the increase in complexity driving up the number of patients on the backlog, despite the tumour site performing well against the optimal timed pathway. Report from EMCA completed and made available at the end of quarter two.	• Identification of actions to impact backlog reduction and improve 62-day performance.
Insufficient capacity to meet demand for oncological breast treatment and an increase in patient complexity requiring multiple investigations.	• Business case development underway to implement an alternative clinical approach to establishing tumour location. Trial commenced Jul-25.	• Reduction in re-excision to improve productivity and patient experience.
	• Joint Oncology PTL in place with NUH (as the service provider) to escalate patient pathways and identify capacity. Moving to single PTL at NUH (Oncology service provider).	• Improvement in 62-day backlog.
	• Implementation of triage multidisciplinary team (MDT) to increase decision timeliness to manage demand from quarter two. MDT standard operating procedure (SOP) approved.	• Improvement in 62-day performance.
Increase in Urology demand driving insufficient capacity and complex patients requiring multiple investigations.	• Successful capital bid for Local Anaesthetic Transperineal Prostate (LATP) machine at Newark. The pathway will be further streamlined to reduce waits for patients where pre-op is not required and through flexing clinical capacity where demand for specific tests is required.	• Reduction in LATP waits.
	• Recruitment of substantive consultant commenced end of quarter two as planned.	• Improvement in cancer waiting times standards.
	• Establishment of working group to identify actions to improve pathways and align to national best practice timed pathways.	

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 surplus position of £0.02m, this is £0.57m behind the £0.59m 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 £1.66m, £0.98m behind plan. The reasons for the year-to-date position being behind plan in month are: five days of resident doctor Industrial Action during Jul-25 of £0.40m, £4.14m adverse Cost Improvement Programme (CIP) performance, £0.30m adverse variable income performance, £4m benefit from rephased income, and £0.17m of other small pressures.

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, emergency care pathway growth, 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 5 saw a year-to-date (YTD) delivery of £12.86m against a YTD plan of £17m. New 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 £39.12m. Expenditure for month 5 totalled £1.07m, which was £0.18m above plan. Year to date expenditure totals £3.72m which is £3.32m below plan with the variance relating to the quarterly phasing of the Electronic Patient Record (EPR) system.

Closing cash on 31-August was £13.50m, a reduction of £1.28m in month and £13.02m 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 Aug-25 is £0.78m and YTD £4.19m which is 35% 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 Aug-25 is £2.12m and YTD is £9.69m which is 28% 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

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-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		✗ -£1.68				
	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£0.17	✗ -£0.79	✗ -£0.10	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✓ £0.01	✗ -£0.98				
Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £4.70	✗ -£1.97	✗ -£0.20	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✓ £0.08	✗ -£4.14				
	Risk adjusted efficiency forecast to plan (%)	n/a	100%							✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%		✗ 68.0%				
Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£0.78	£0.78	£13.70	£4.19				
	Reported bank expenditure	No Standard	No Standard	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£2.09	£2.12	£30.55	£9.69				
Rate of Productivity	Implied productivity growth (YTD compared to last year)	3.1%	2%	✓ 6.9%	✓ 5.4%	✓ 4.6%	✓ 3.3%	✓ 4.3%	✓ 3.1%	-	-	-	-	-		-				
Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%							✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 87.2%		✗ 59.2%				
	BPPC - Value of bills paid within target	n/a	≥95%							✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%		✗ 75.9%				
	Operating expenditure days	n/a	≥5							✓ 16	✓ 16	✓ 13	✓ 10	✓ 10		✓ 10				
Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£1.41	£1.01	£1.92	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✓ £33.58	✗ £3.74				

Indicator in Focus: Financial Performance

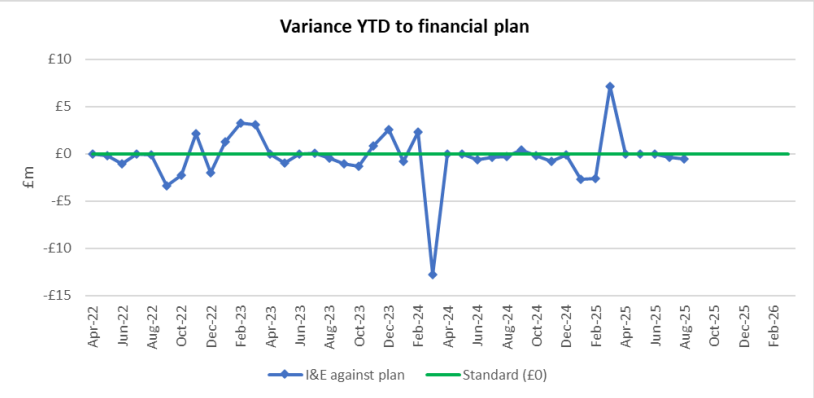
Sherwood Forest Hospitals NHS Foundation Trust

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 £1.66m deficit, which is £0.98m behind the planned deficit of £0.68m for the YTD position at month 5 2025/26.

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 5 the Trust is £4.14m behind the plan. Work continues with divisional and corporate areas being 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 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 in-line with 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 £4.10m. There is an expectation 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

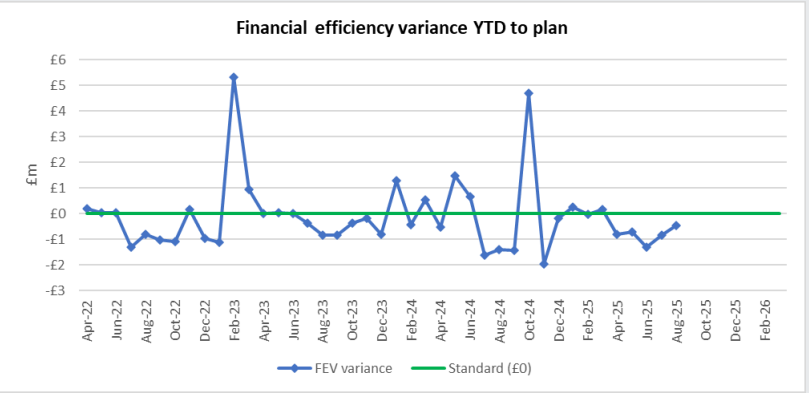
Sherwood Forest Hospitals NHS Foundation Trust

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 £4.14m behind plan YTD.

Root causes	Actions and timescale	Impact
Non-delivery of Financial Improvement Programme.	• A financial recovery plan is now in development.	Deliver annual plan.
	• Six workstreams have now been established, covering every pound spent and received.	
	• Control totals set for each programme and division / directorate, aligned to the Trust requirement to deliver a break-even plan.	
	• Ongoing support from PA Consulting is in place.	
	• Increased workforce controls established.	
	• Enhanced oversight and grip strengthened to support delivery within the financial year.	
Risk adjusted forecast.	• Currently the weighted target at month 5 is £31.16m, which is 68% 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



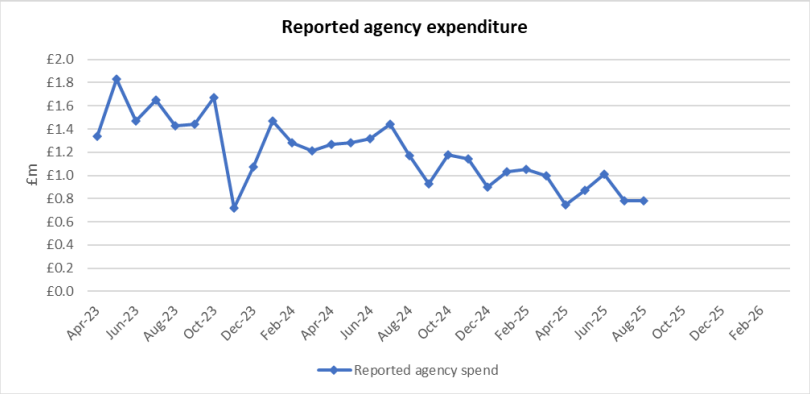
Indicator in Focus: Agency Pay

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 £4.19m YTD.
- Agency expenditure in accounts for 3% of our total pay bill YTD, a reduction from our 2024/25 run rate.
- The 40% agency reduction target for 2025/26 is currently 35% YTD.

Data



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 now in place with weekly workforce meetings with increased workforce controls established. • Ongoing support from PA consulting is in place. • 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. • From Jul-24, 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.

Indicators in Focus: Cash and Liquidity

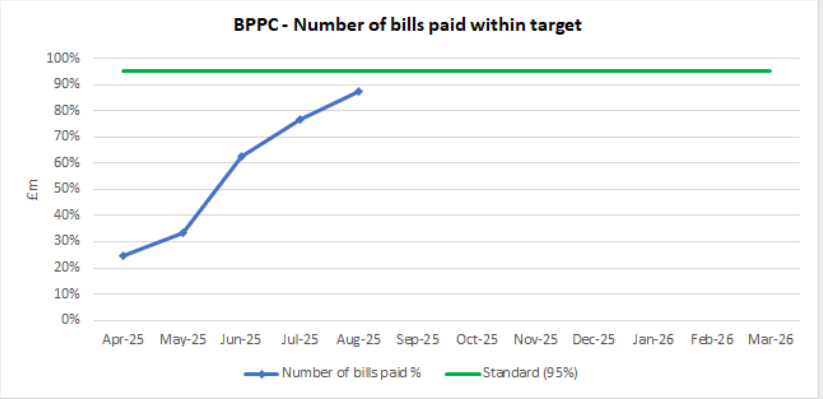
Sherwood Forest Hospitals NHS Foundation Trust

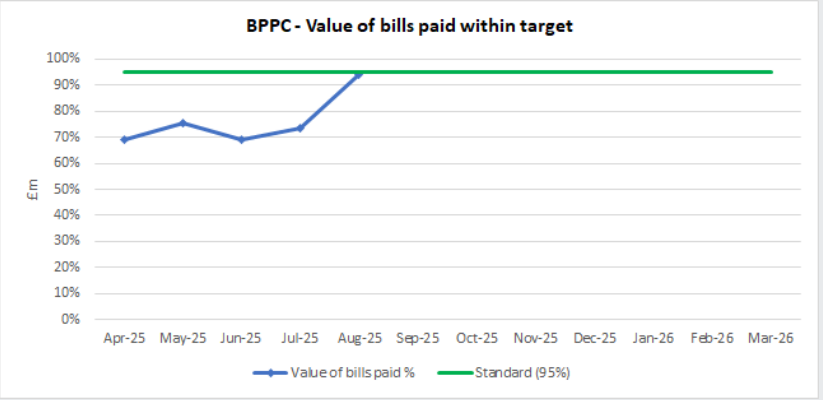
Performance observations

- 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 Aug-25, cash in bank was £13.5m which is on plan and was 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





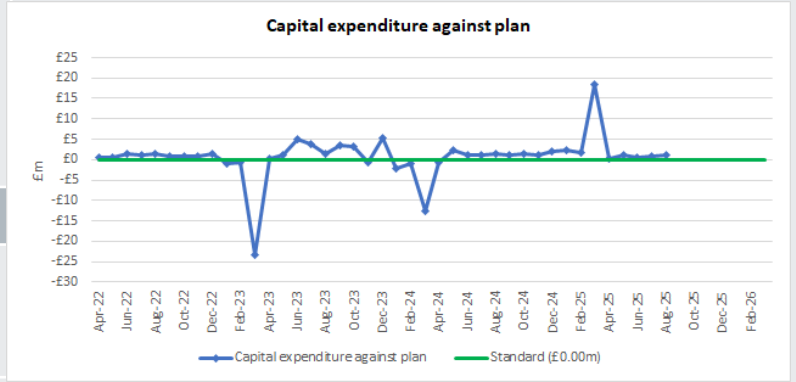
Indicator in Focus: Capital

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 submissions in 2025/26 quarter two and detailed monitoring to ensure delivery in-year to plan.

Data



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 ICS partners for 2025/26.	Delivery of Capital Expenditure Plan.
Requirement for Public Dividend Capital (PDC) to support ICB plan £15.23m and National Schemes £17.7m.	• 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.	• Submission of additional information in 2025/26 quarter one and two to enable Memorandums of Understandings to be issued in quarter two. One case still outstanding to be submitted Sep-25. • Monitoring of in-year spend to ensure delivery to funding envelope.	Overspends impacting in other capital delivery requirements.

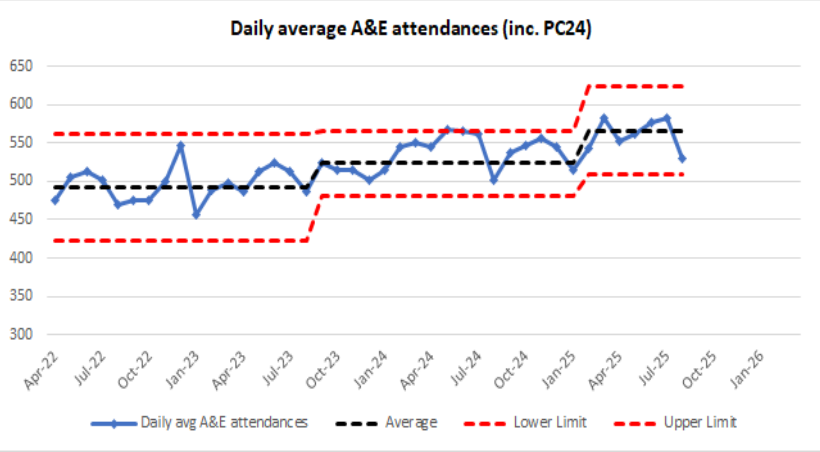
Outstanding Care,
Compassionate People,
Healthier Communities

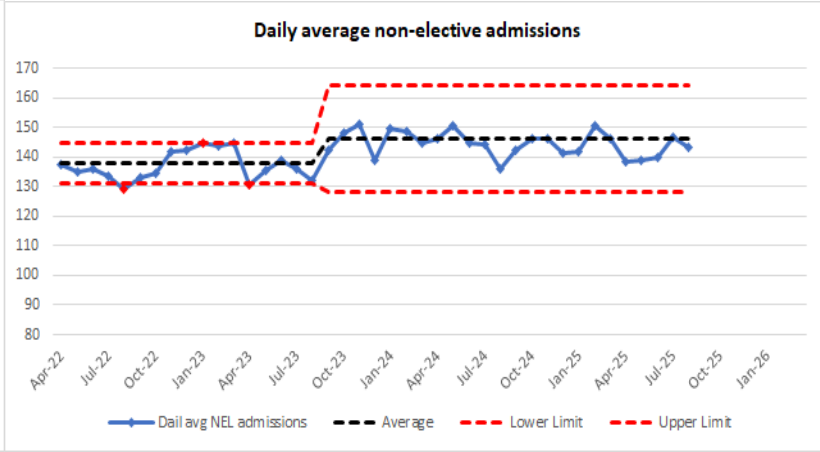
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

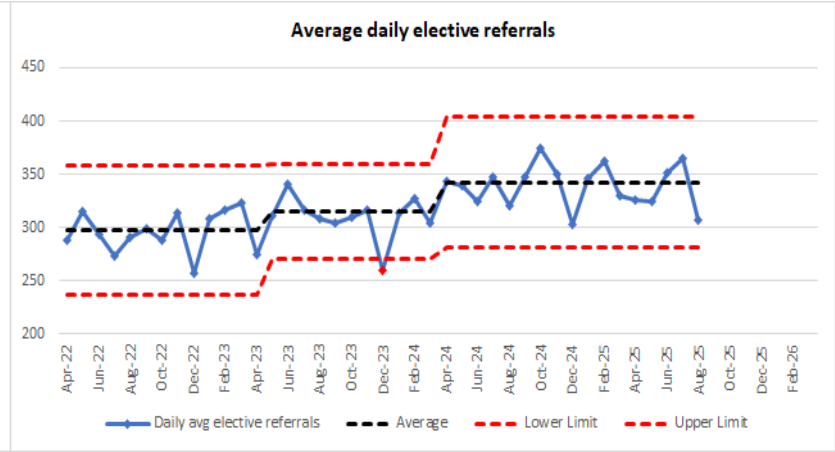
Activity Data and Trends (1/2)

Based on daily averages

At a Glance	Indicator	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	2024/25 Final	2025/26 YTD
Urgent Care	A&E attendances (inc. PC24)	547	557	544	515	543	582	552	562	577	582	530	547	561
	Non-elective admissions	146	146	141	142	150	146	139	139	140	147	143	145	142
Electives	Average daily elective referrals	374	350	304	346	362	330	326	325	352	365	307	341	342
	Outpatients - first appointment	349	347	294	327	339	323	318	308	335	355	273	347	317
	Outpatients - follow up	889	851	748	875	907	855	849	802	853	915	717	852	827
	Outpatients - procedures	278	258	236	287	278	254	257	254	267	293	240	265	262
	Day case	126	126	110	127	126	116	114	116	123	126	117	122	119
	Elective inpatient	16	15	12	12	13	13	13	14	15	15	11	14	14
Diagnostics	Diagnostics	506	514	462	496	518	490	476	464	477	494	461	479	474



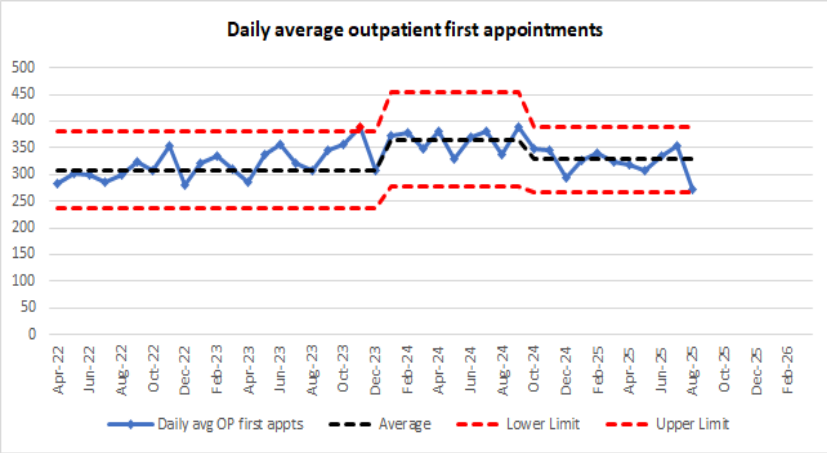


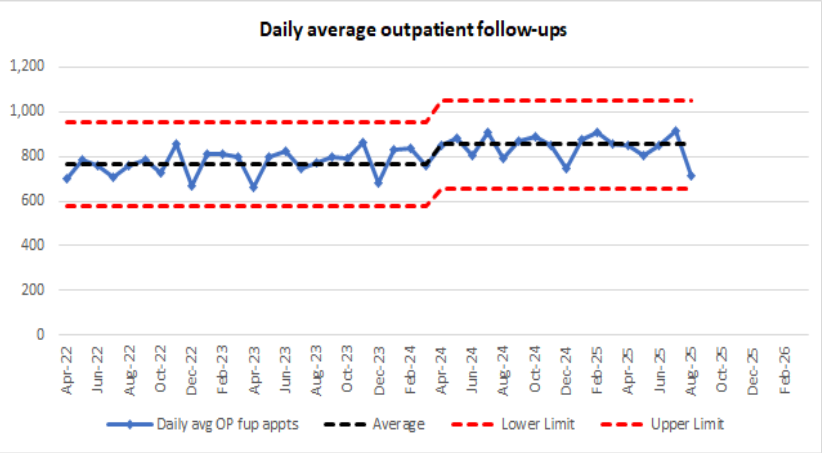


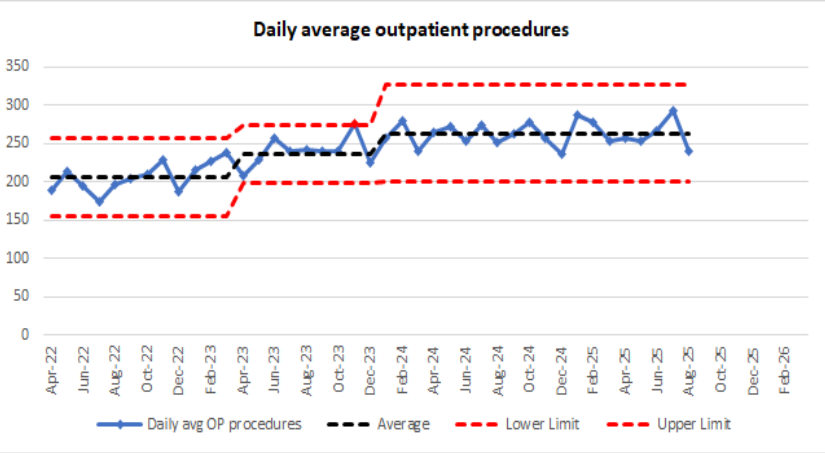
Outstanding Care,
Compassionate People,
Healthier Communities

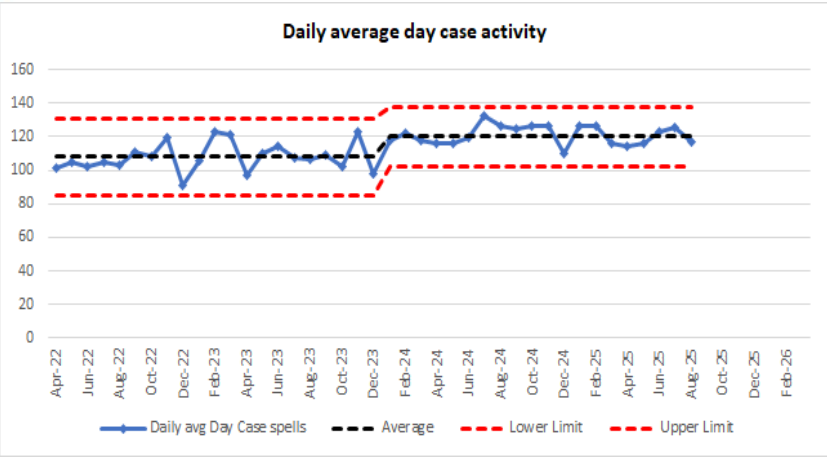
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

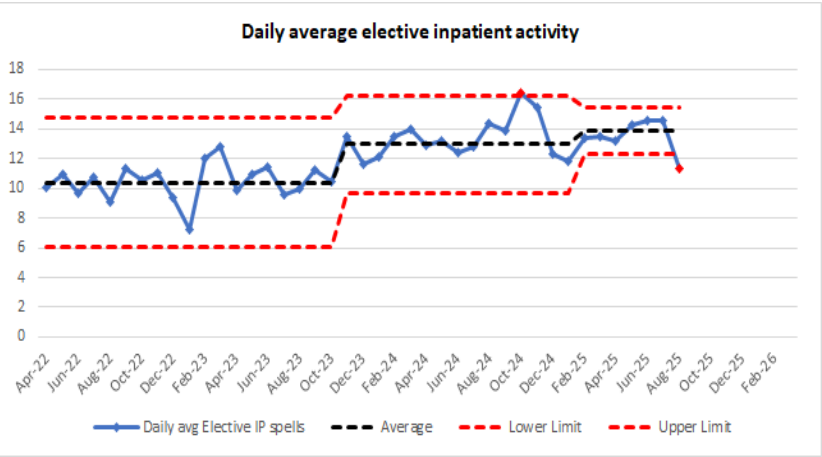
Activity Data and Trends (2/2)

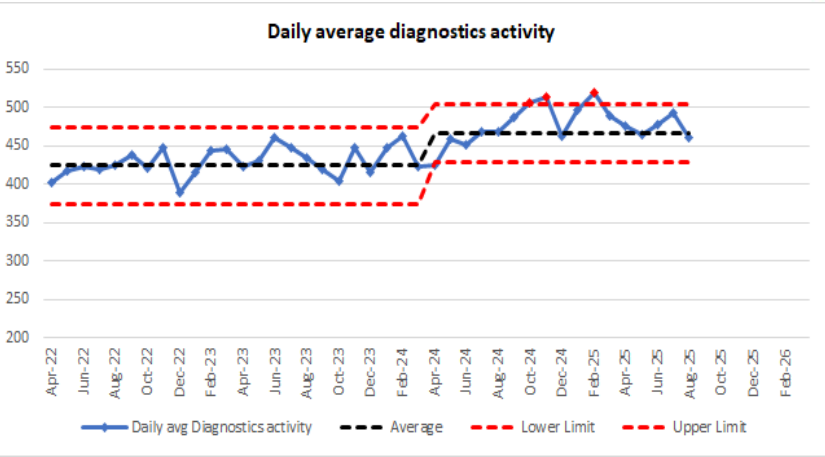












Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Appendix A: Integrated Scorecard & Graphs for each indicator

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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.

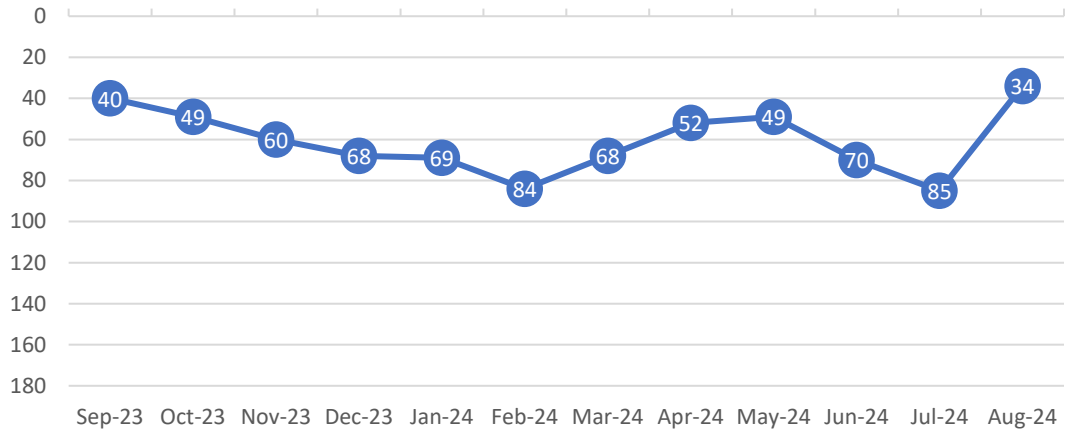
Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

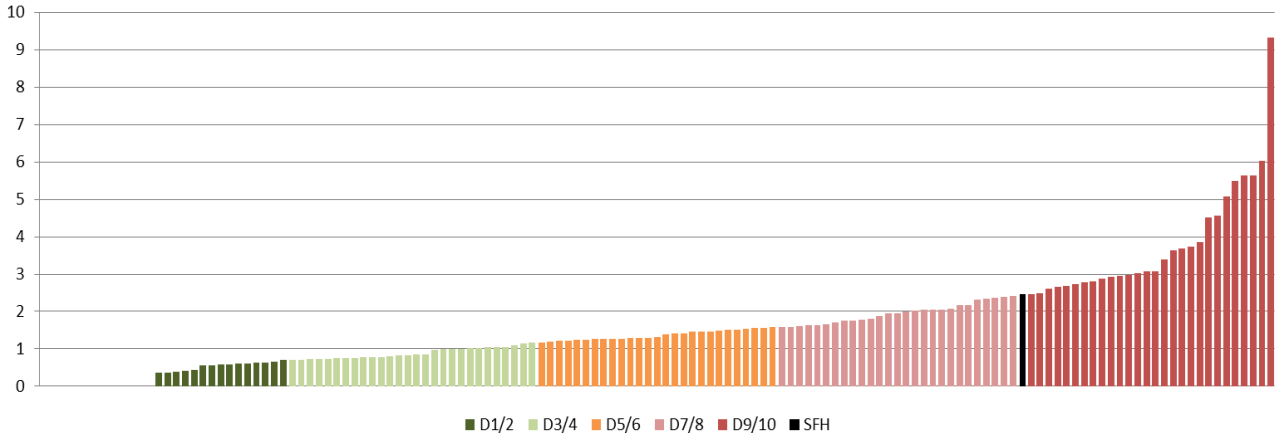
Appendix B: Benchmarking Guidance (2/2)

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).

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Appendix C: Data Quality Indicator Guidance

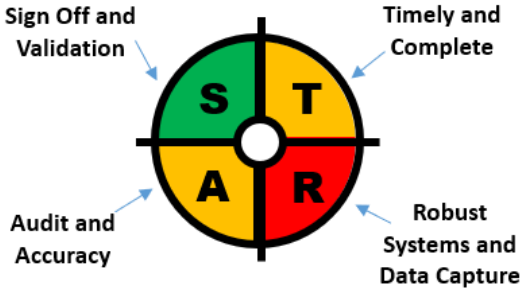
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

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

August 2025 (Qtr 2)

Cover Page | Charts | Definitions

Integrated Report

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

Category	At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-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	1.9	2.4	3.0	2.4	2.6	2.1	1.7	2.6	1.9	2.4	2.2		2.2				
		Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
		MRSA reported in month	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✗ 1	✗ 2				
		Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	7	4	6	4	5	5	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 55	✗ 31				
		Number of gram-negative bloodstream infections reported in month	n/a	8	5	8	0	5	1	5	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	50	✓ 22				
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.2	0.1	0.0	0.1	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1				
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 6	✗ 1				
		Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	1	0	2	2	1	0	5	13	10	2	11	17	41				
		Percentage of inpatient Service Users undergoing risk assessment for VTE	n/a	≥95%	✗ 94.2%	✗ 94.5%	✗ 84.6%	✗ 84.1%	✗ 85.1%	✗ 89.6%	✗ 90.5%	✗ 89.7%	✗ 89.4%	✗ 88.0%	✗ 85.3%		✗ 88.3%				
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 0.8	✓ 0.8	✓ 0.4	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 0.9	✓ 1.4				
		Compliments received in month	No Standard	No Standard	204	160	147	140	152	184	155	115	141	157	109	1831	677				
	Effective	SHMI	As Expected	As Expected	✓ 106	✓ 106	✓ 106	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 107				
		Still birth rate	≤4.4	≤4.4	✓ 3.4	✗ 10.3	✓ 0.0	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.1	✓ 4.3	✗ 5.5				
		Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 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	-	-	✓ 7.1	-	-	-	-	-	✓ 7.1	-				
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✗ 9.2%				
		Time to hire	n/a	≤53.1 days				✓ 49.0	✓ 34.0	✓ 27.0	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0		✓ 26.4				
		Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.7%	✓ 0.5%				
		Appraisals	≥90%	≥90%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 89.99%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 89.0%	✗ 88.8%				
		Mandatory & statutory training	≥90%	≥90%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 91.5%	✓ 92.9%				
		Medical job plan compliance	n/a	≥95%				✗ 57.0%	✗ 86.1%	✗ 76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%		✗ 73.0%				
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 5.0%	✗ 4.9%				
		Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	-	-	-	-	✗ 58.0%	-				
		Employee relations management	<17	<21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✗ 18	✗ 23	✗ 18	✗ 18	✗ 21	✗ 20				
	New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✓ 6.8%	✓ 7.1%	✗ 8.9%	✓ 6.5%				
		Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 4.0%	✗ 2.8%				
		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%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
		Agency (over price cap)	≤40.0%	≤40.0%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 52.9%	✓ 38.1%				
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 91.4%	✗ 88.8%				
		Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 0.7%	✗ 0.7%				
		ED 4-hour performance	≥76%	≥Plan	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 71.0%	✗ 74.9%				
		ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 3.4%	✓ 2.9%				
		Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	16	17	31	26	19	18	21	19	22	24	23	104				
		Adult G&A bed occupancy	≤92%	≤92%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 94.5%	✗ 95.5%				
		Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	3.1	3.2	2.9	2.7	3.1	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.0	✓ 3.3		✓ 3.3				
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 64	✗ 67				
	Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 11.0%	✓ 6.0%	✓ 10.8%				
		Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	62.9%	63.2%	63.8%	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%		✗ 63.2%				
		Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	2.2%	2.1%	1.7%	1.8%	1.6%	1.3%	✗ 1.3%	✗ 1.2%	✗ 1.1%	✗ 1.1%	✓ 1.0%		✗ 1.1%				
	Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✓ 93.1%	✗ 87.9%				
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	-	✓ 78.3%	✓ 80.1%				
		Cancer 31-day treatment performance	≥Plan	≥96%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	-	✓ 91.9%	✗ 90.6%				
		Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	-	✗ 64.4%	✓ 65.3%				
Best Value Care	Financial Performance	Financial surplus / deficit	n/a	≥£0.00m							✗ -£0.90	✗ -£0.70	✗ -£0.20	✓ £0.10	✓ £0.02		✗ -£1.68				
		Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£0.17	✗ -£0.79	✗ -£0.10	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✓ £0.01	✗ -£0.98				
	Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £4.70	✗ -£1.97	✗ -£0.20	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✓ £0.08	✗ -£4.14				
		Risk adjusted efficiency forecast to plan (%)	n/a	100%							✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%		✗ 68.0%				
	Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£0.78	£0.78	£13.70	£4.19				
		Reported bank expenditure	No Standard	No Standard	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£2.09	£2.12	£30.55	£9.69				
	Rate of Productivity	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✓ 6.9%	✓ 5.4%	✓ 4.6%	✓ 3.3%	✓ 4.3%	✓ 3.1%	-	-	-	-	-		-				
	Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%							✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 0.0%		✗ 47.6%				
		BPPC - Value of bills paid within target	n/a	≥95%							✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%		✗ 75.9%				
		Operating expenditure days	n/a	≥5							✓ 16	✓ 16	✓ 13	✓ 10	✓ 10		✓ 10				
	Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£1.41	£1.01	£1.92	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✓ £33.58	✗ £3.74				
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)			547	557	544	515	543	582	552	562	577	582	530	547	561				
		Non-elective admissions			146	146	141	142	150	146	139	139	140	147	143	145	142				
	Electives	Average daily elective referrals			374	350	304	346	362	330	326	325	352	365	307	341	342				
		Outpatients - first appointment			349	347	294	327	339	323	318	308	335	355	273	347	317				
		Outpatients - follow up			889	851	748	875	907	855	849	802	853	915	717	852	827				
		Outpatients - procedures			278	258	236	287	278	254	257	254	267	293	240	265	262				
		Day case			126	126	110	127	126	116	114	116	123	126	117	122	119				
		Elective inpatient			16	15	12	12	13	13	13	14	15	15	11	14	14				
	Diagnostics	Diagnostics			506	514	462	496	518	490	476	464	477	494	461	479	474				

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

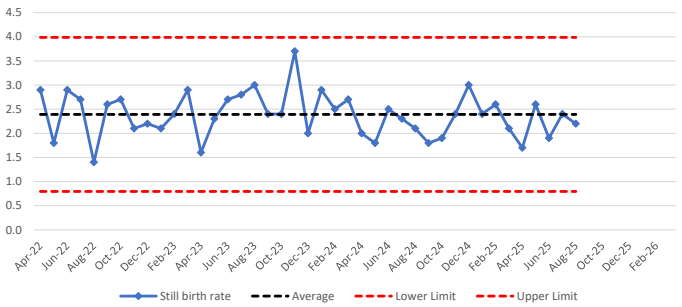
August 2025 (Qtr 2)

Cover Page | Definitions

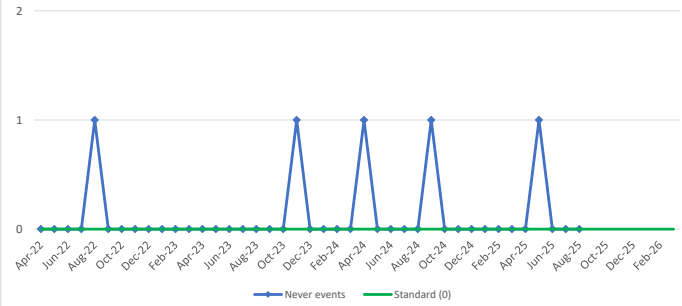
Charts

Quality of Care

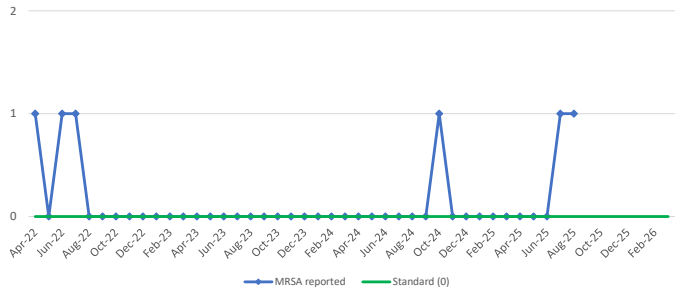
Rate of inpatients to suffer a new hip fracture



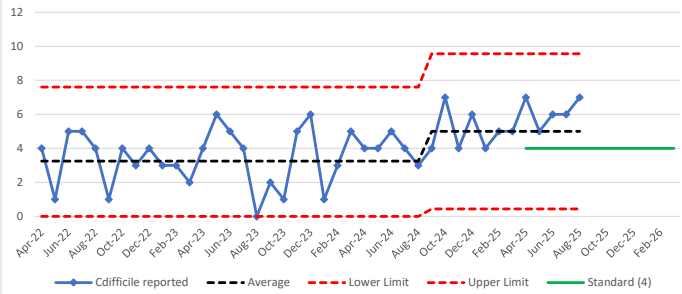
Never events



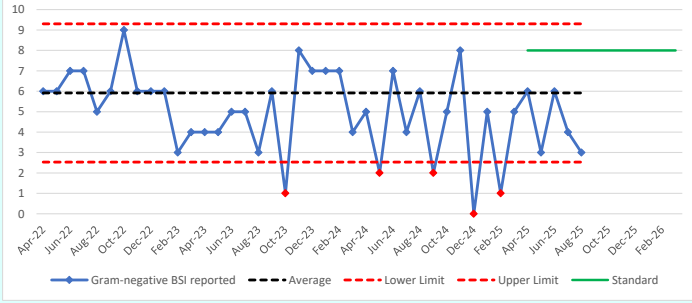
MRSA reported in month



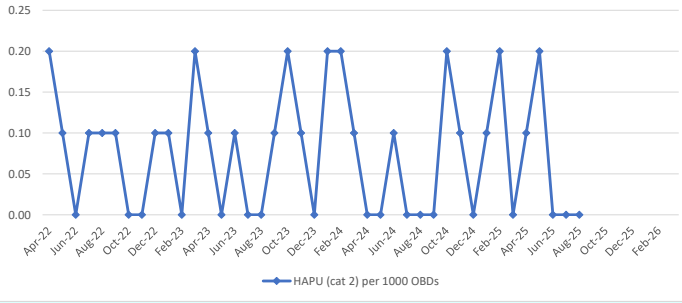
Cdifficile (hospital-acquired) reported in month



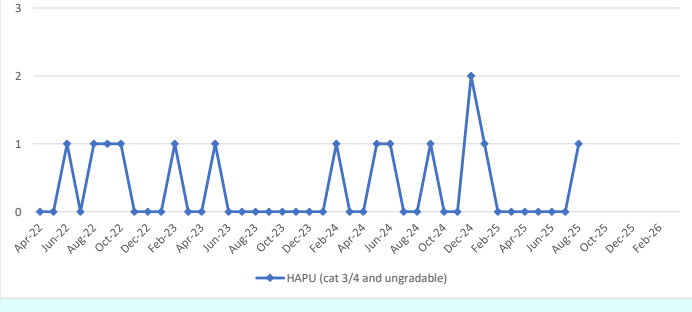
Number of gram-negative bloodstream infections reported in month



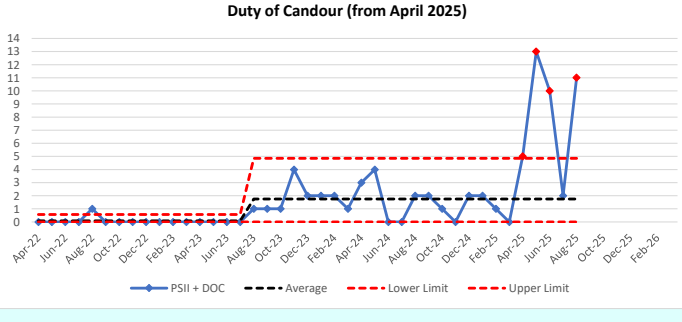
HAPU (cat 2) per 1000 occupied bed days with a lapse in care

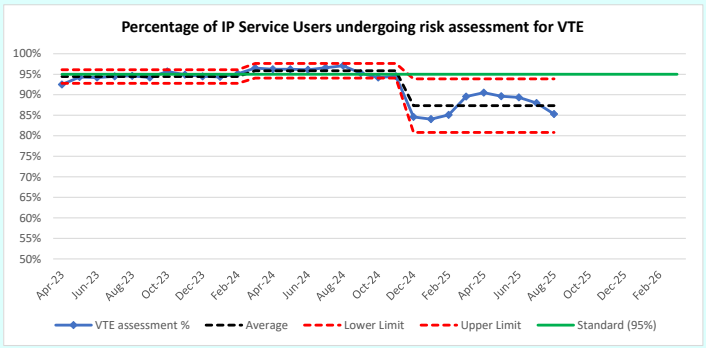


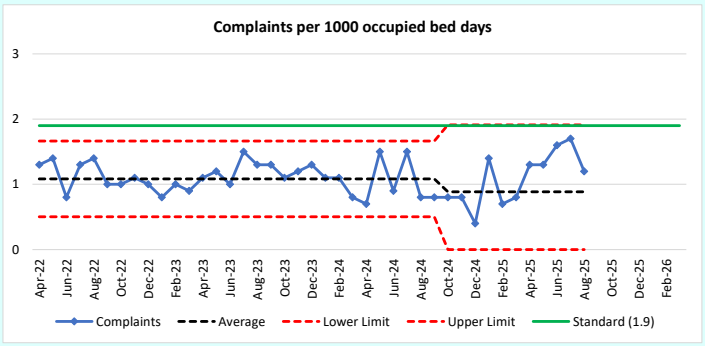
HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care

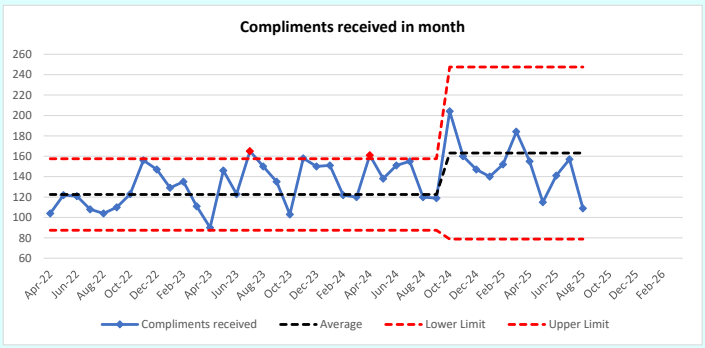


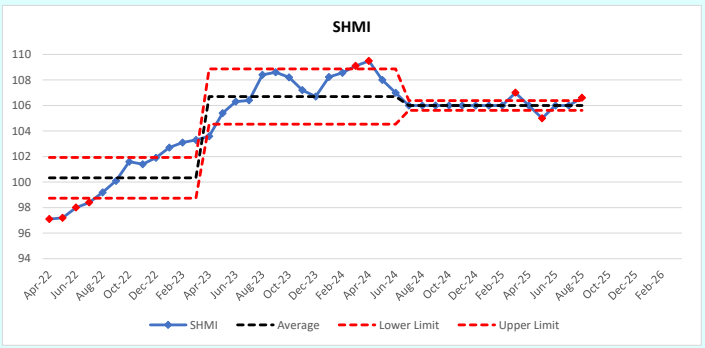
Patient Safety Incident Investigations (PSII) + Duty of Candour (from April 2025)

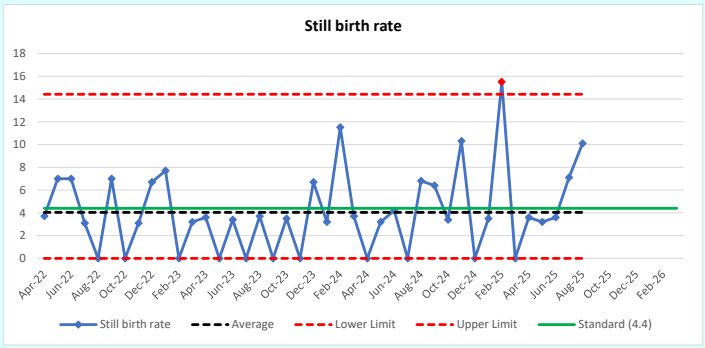


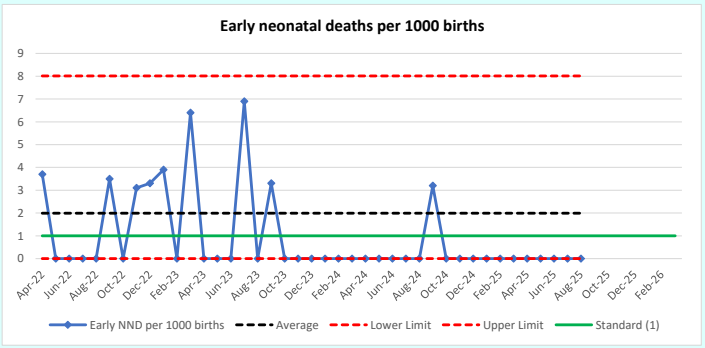

Percentage of IP Service Users undergoing risk assessment for VTE
VTE assessment %
Average
Lower Limit
Upper Limit
Standard (95%)


Complaints per 1000 occupied bed days
Complaints
Average
Lower Limit
Upper Limit
Standard (1.9)


Compliments received in month
Compliments received
Average
Lower Limit
Upper Limit

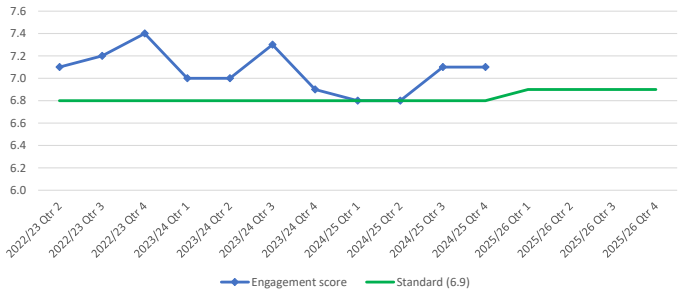

SHMI
SHMI
Average
Lower Limit
Upper Limit


Still birth rate
Still birth rate
Average
Lower Limit
Upper Limit
Standard (4.4)

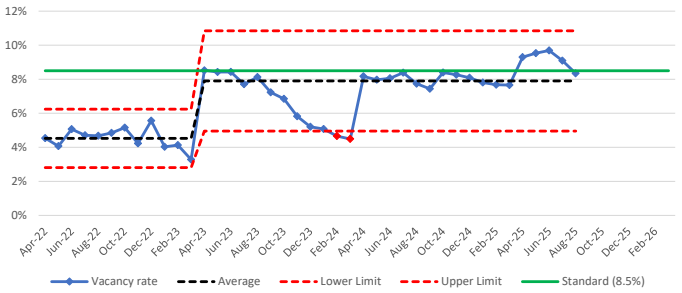

Early neonatal deaths per 1000 births
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard (1)

People and Culture

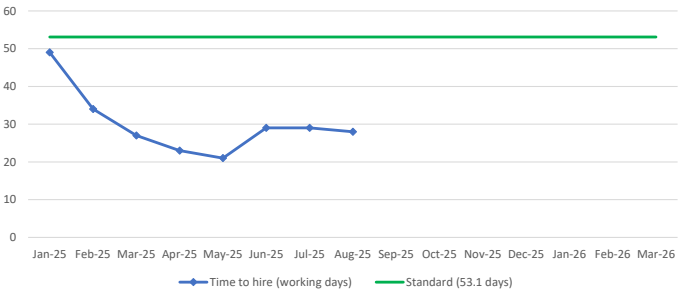
Engagement score



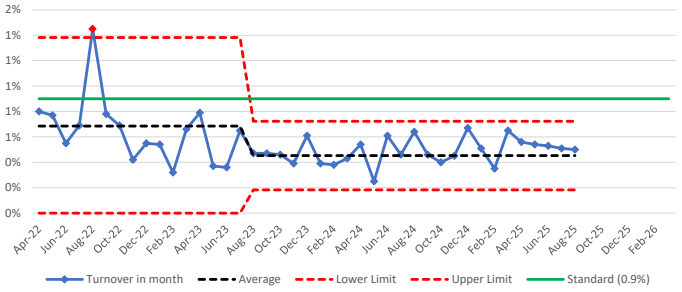
Vacancy rate



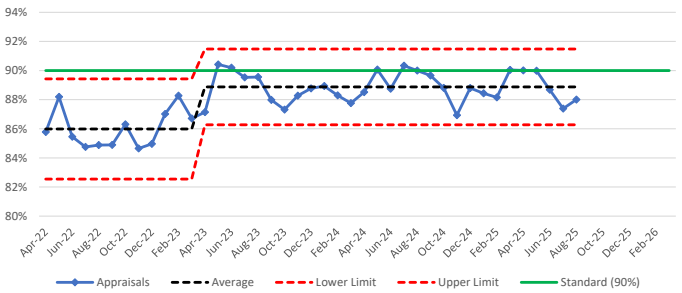
TIme to hire



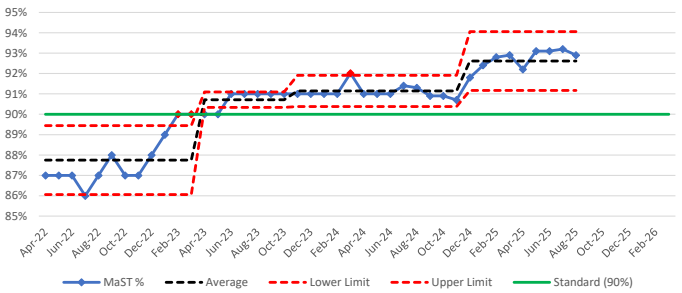
Turnover in month



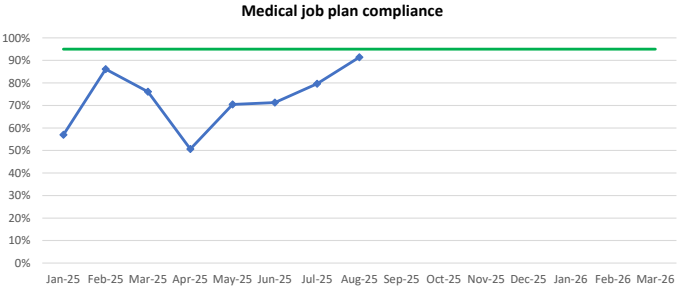
Appraisals



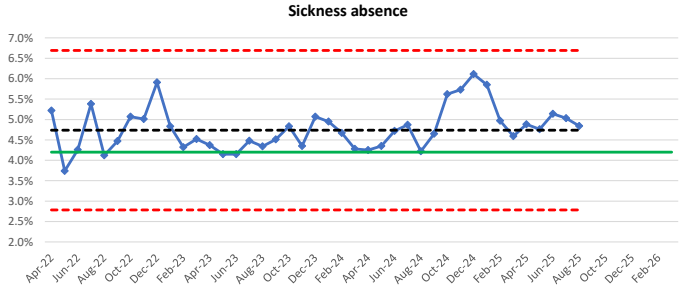
Mandatory & statutory training



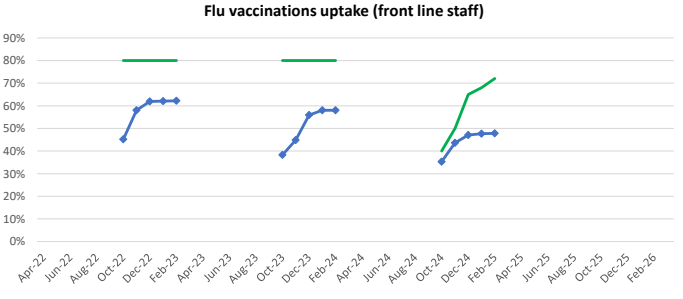
Medical job plan compliance



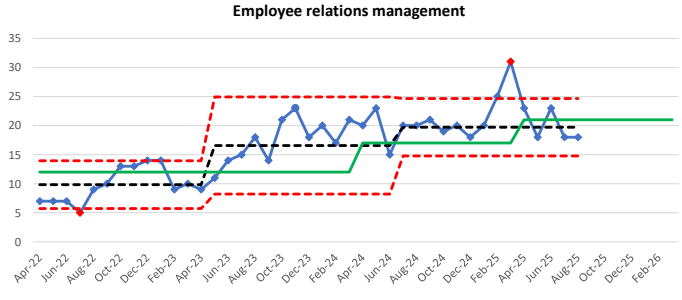
Sickness absence

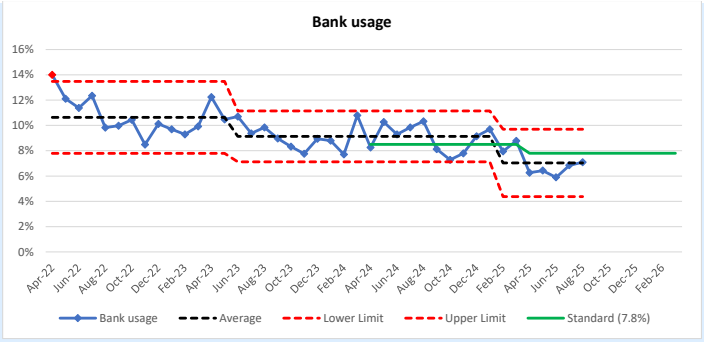


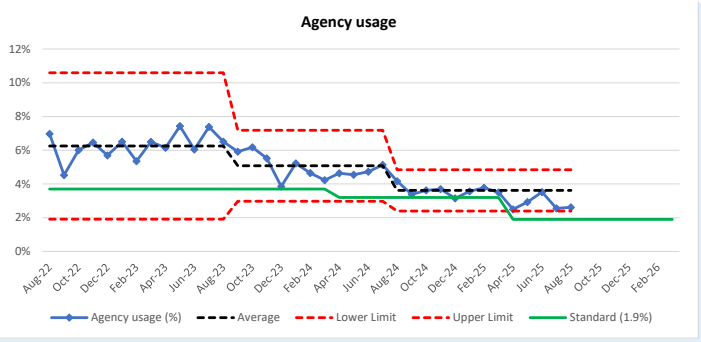
Flu vaccinations uptake (front line staff)

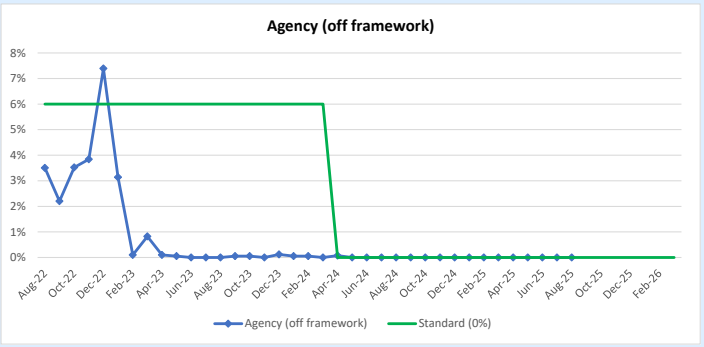


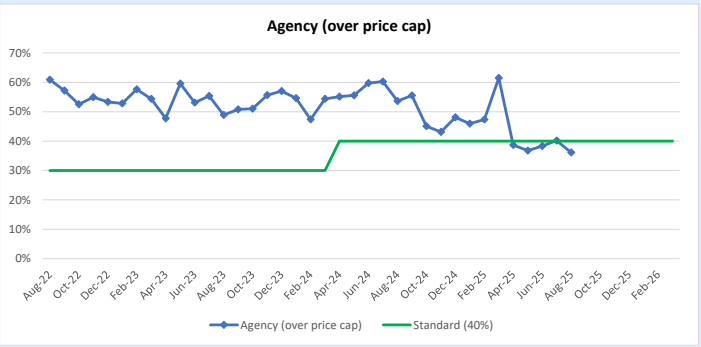
Employee relations management




Bank usage
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%)

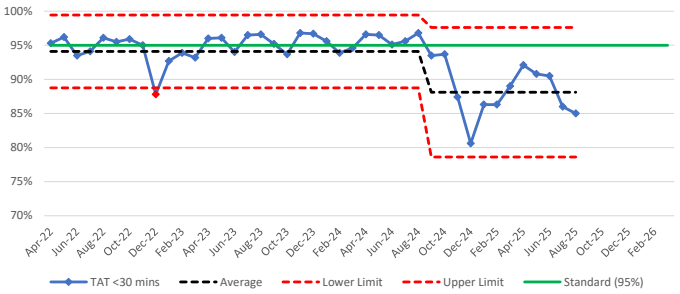

Agency usage
12%
10%
8%
6%
4%
2%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency usage (%)
Average
Lower Limit
Upper Limit
Standard (1.9%)


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%)

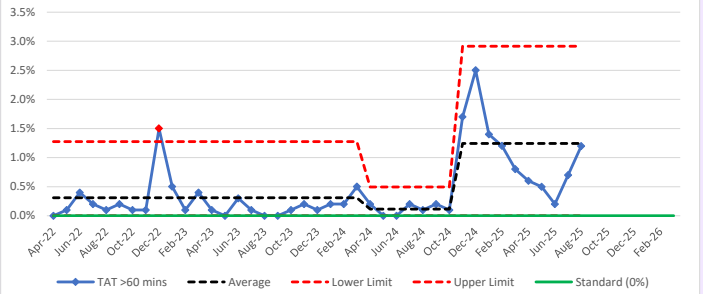

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency (over price cap)
Standard (40%)

Timely Care

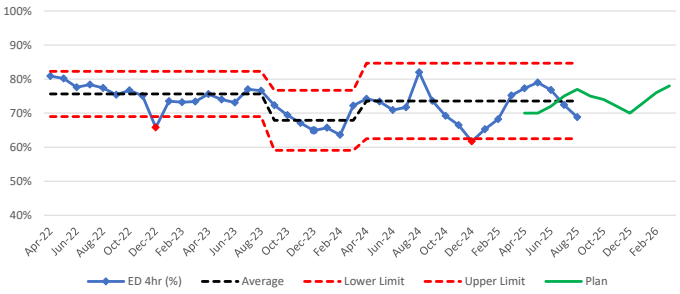
Ambulance turnaround times <30 mins



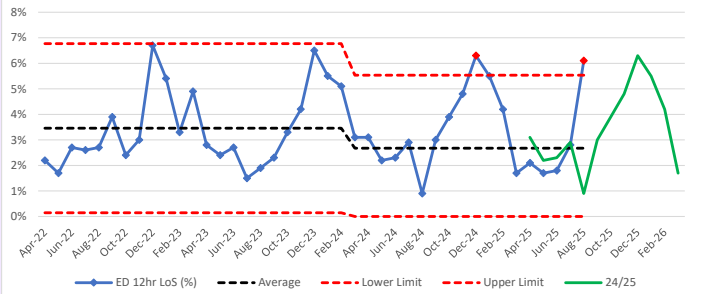
Ambulance turnaround times >60 mins



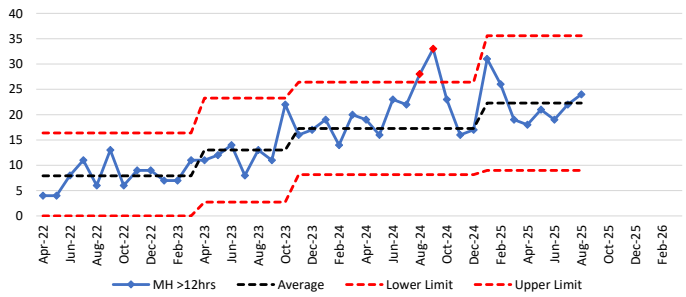
ED 4-hour performance



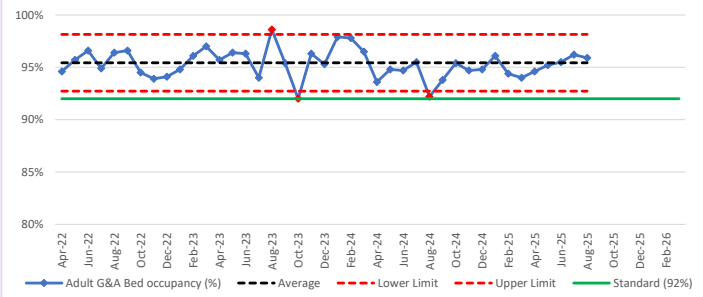
ED 12-hour length of stay performance



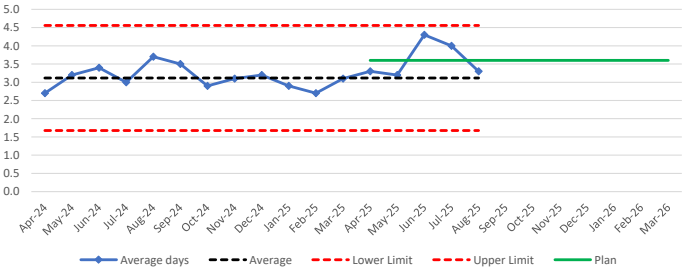
Mental health patients spending over 12 hours in A&E



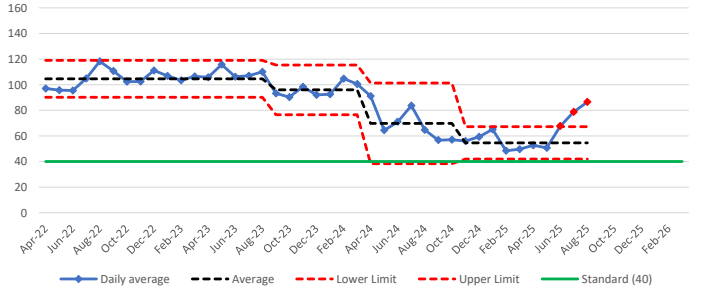
Adult G&A bed occupancy

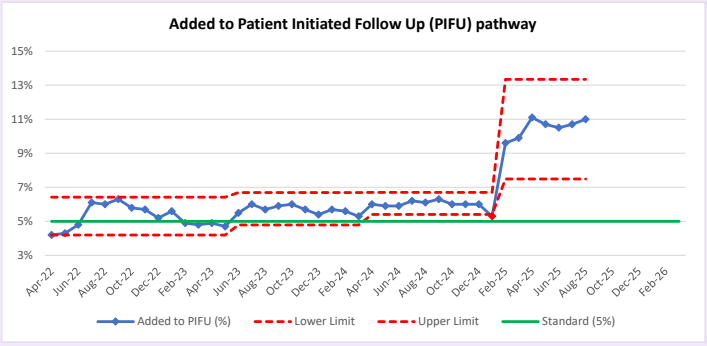


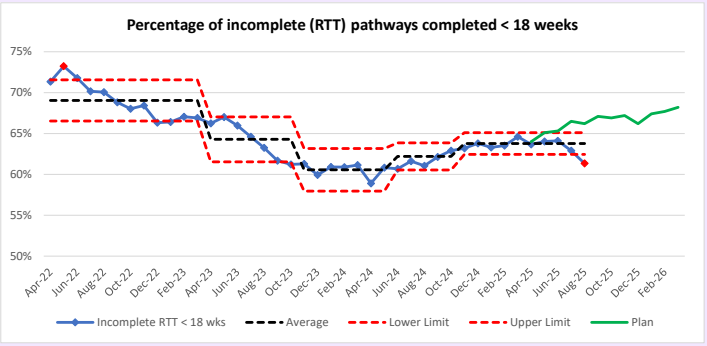
Average number of days between planned and actual discharge date (excluding patients with 0 day delay)

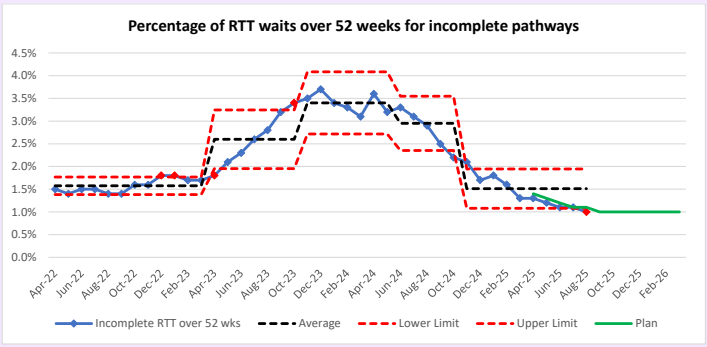


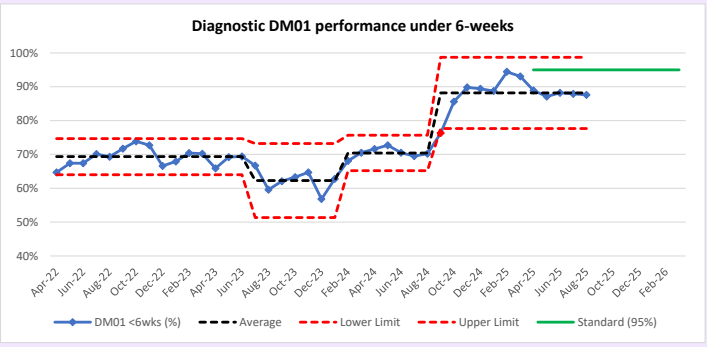
Inpatients medically safe for transfer for greater than 24 hours

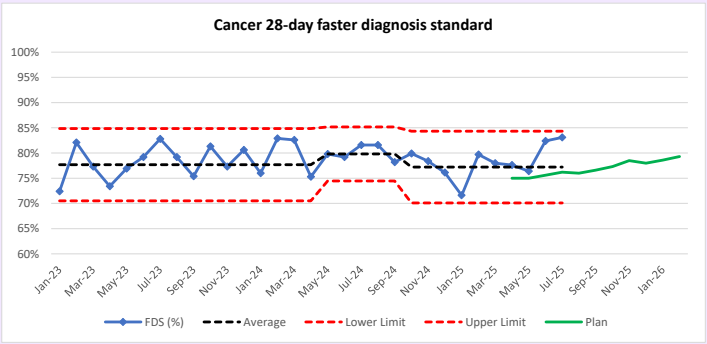


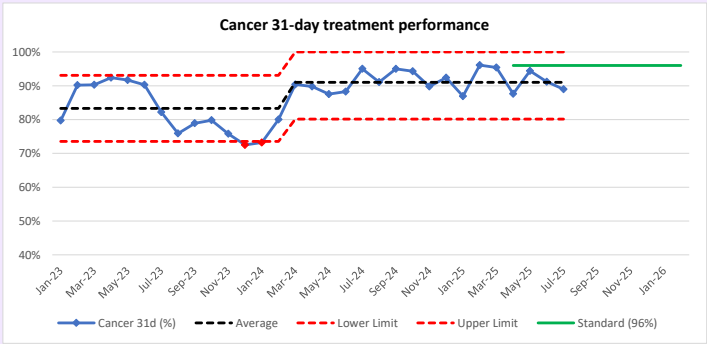

Added to Patient Initiated Follow Up (PIFU) pathway
Added to PIFU (%)
Lower Limit
Upper Limit
Standard (5%)

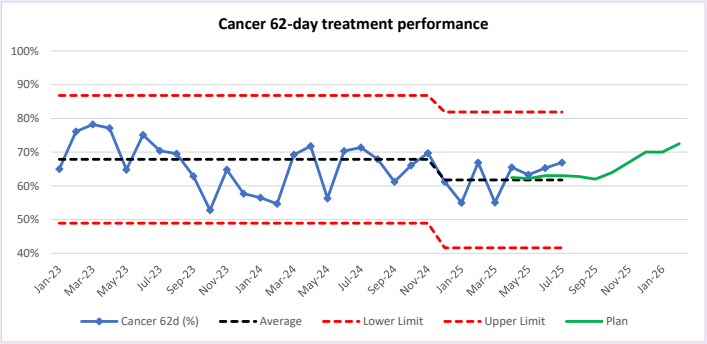

Percentage of incomplete (RTT) pathways completed < 18 weeks
Incomplete RTT < 18 wks
Average
Lower Limit
Upper Limit
Plan


Percentage of RTT waits over 52 weeks for incomplete pathways
Incomplete RTT over 52 wks
Average
Lower Limit
Upper Limit
Plan


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

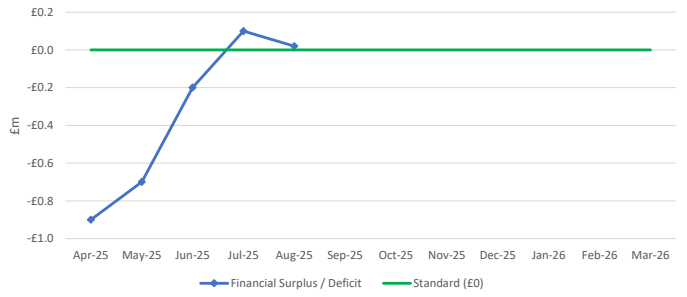

Cancer 28-day faster diagnosis standard
FDS (%)
Average
Lower Limit
Upper Limit
Plan


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

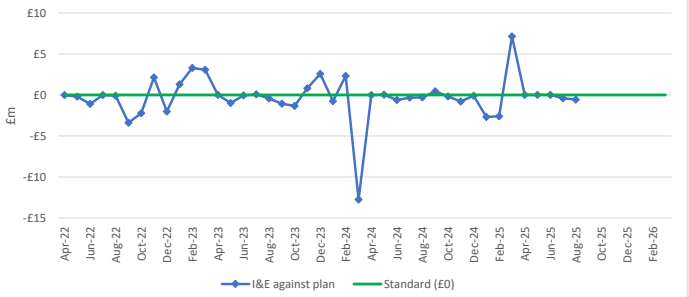

Cancer 62-day treatment performance
Cancer 62d (%)
Average
Lower Limit
Upper Limit
Plan

Best Value Care

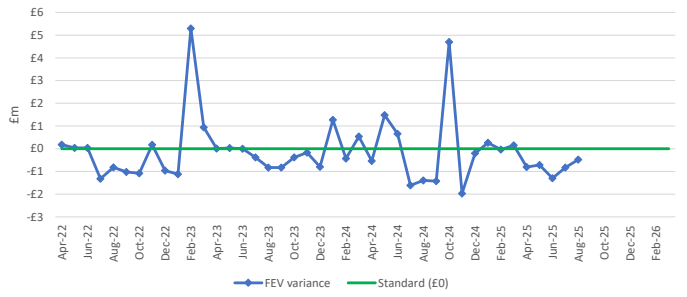
Financial Surplus / Deficit



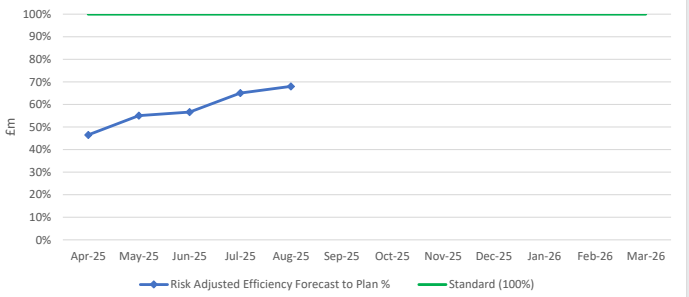
Variance YTD to financial plan



Financial efficiency variance YTD to plan

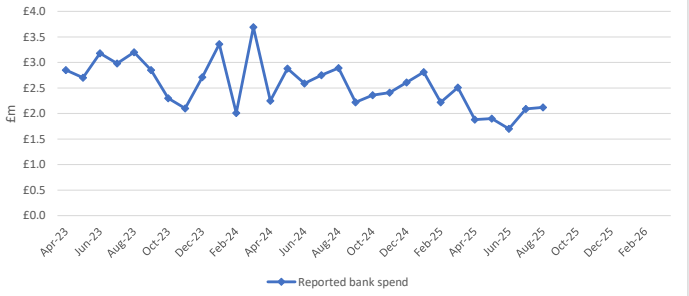


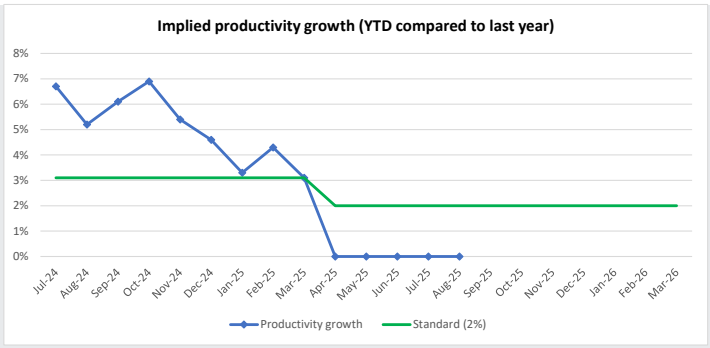
Risk adjusted efficiency forecast to plan (%)

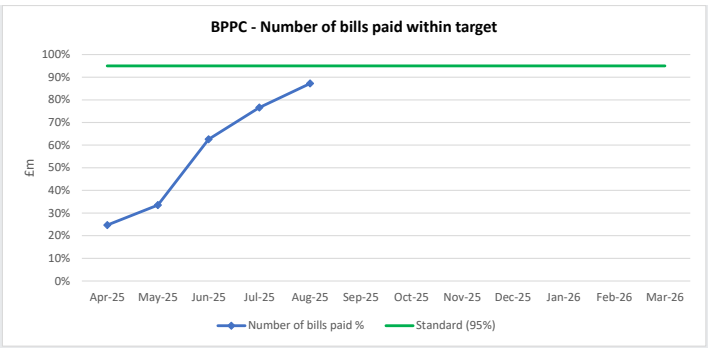


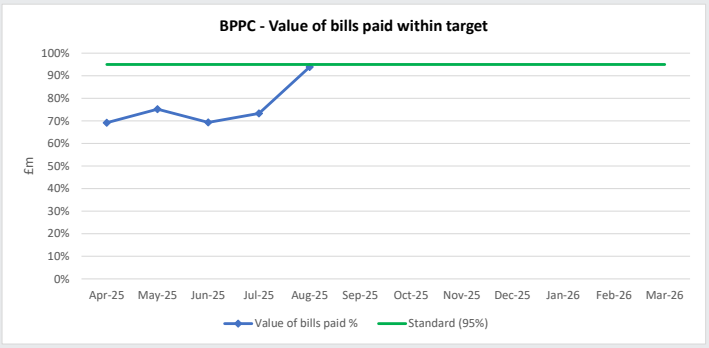
Reported agency expenditure

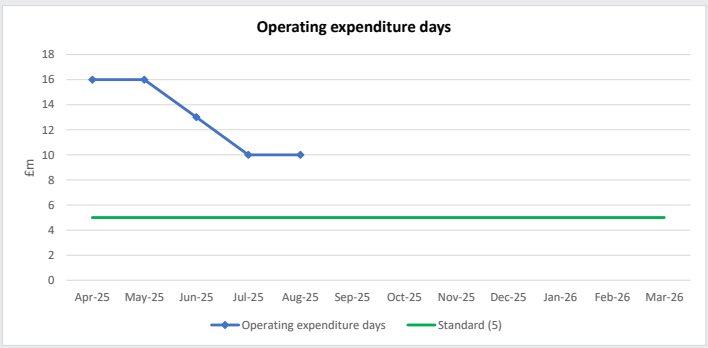
Reported bank expenditure

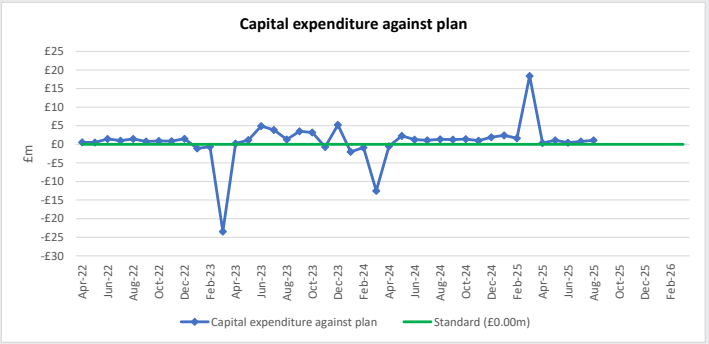



Implied productivity growth (YTD compared to last year)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Productivity growth
Standard (2%)


BPPC - Number of bills paid within target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
£m
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%)

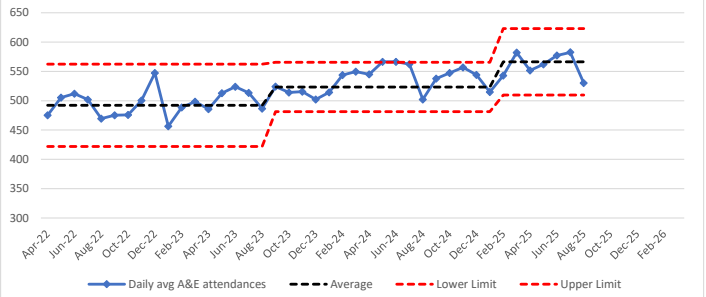

BPPC - Value of bills paid within target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
£m
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Value of bills paid %
Standard (95%)


Operating expenditure days
18
16
14
12
10
8
6
4
2
0
£m
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)

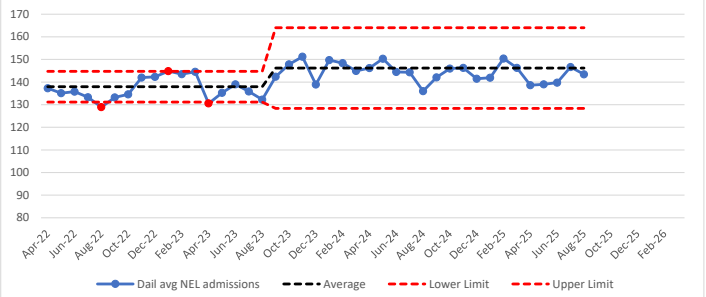

Capital expenditure against plan
£25
£20
£15
£10
£5
£0
-£5
-£10
-£15
-£20
-£25
-£30
£m
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Capital expenditure against plan
Standard (£0.00m)

Activity (for context)

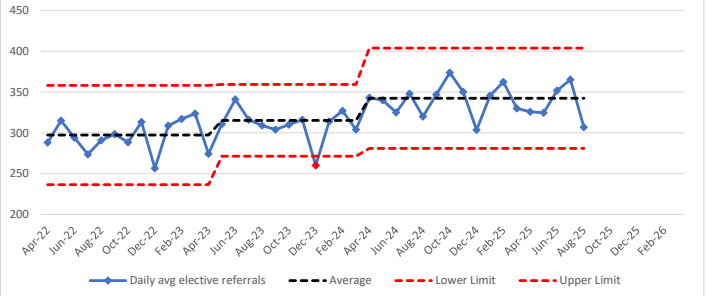
Daily average A&E attendances (inc. PC24)



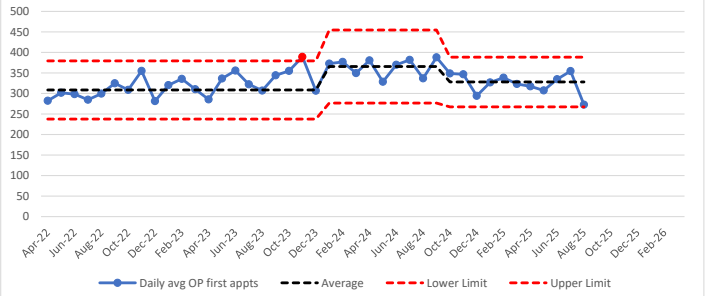
Daily average non-elective admissions



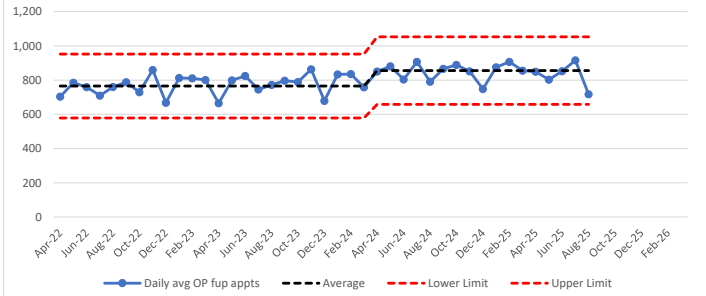
Average daily elective referrals



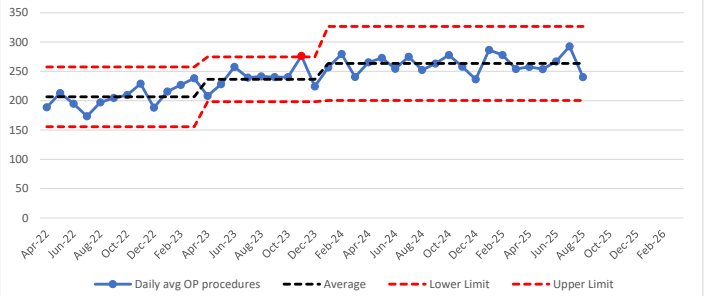
Daily average outpatient first appointments



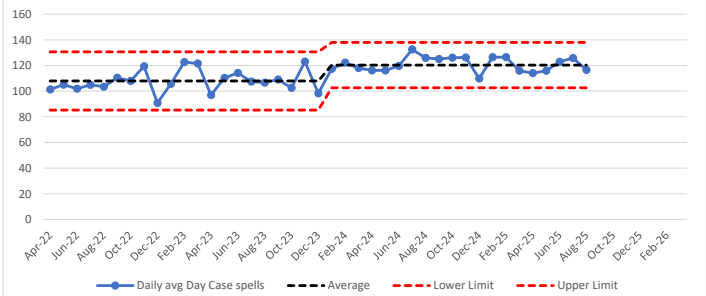
Daily average outpatient follow-ups



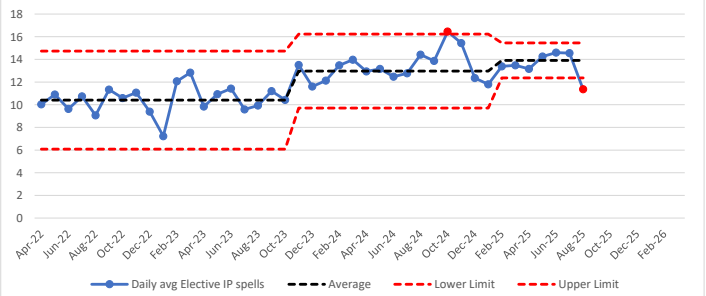
Daily average outpatient procedures



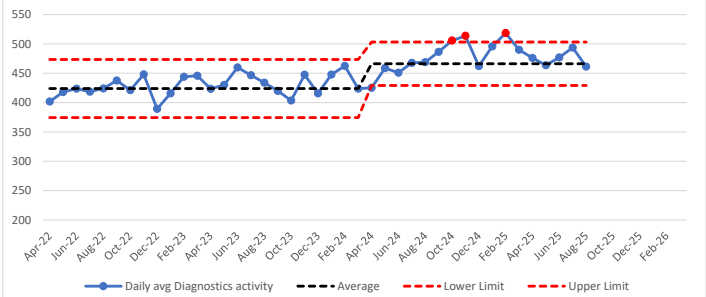
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

August 2025 (Qtr 2)

Timely Care Benchmarking

Jul-25

At a Glance	Indicator	Source	Rate	Rank	Of	Decile
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	86.5%	70	176	4
	Ambulance turnaround times >60 mins	Summary Emergency Department Indicator Table (SEDIT)	0.8%	62	176	4
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	72.4%	96	141	7
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	2.9%	43	174	3
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	95.4%	120	179	7
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	10.9%	4	134	1
	Incomplete RTT pathways +52 weeks	RTT waiting times data	1.1%	48	151	4
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	87.9%	42	134	4
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	83.1%	21	132	2
	Cancer 31-day treatment performance	Cancer Waiting Times standards	89.0%	113	132	9
	Cancer 62-day treatment performance	Cancer Waiting Times standards	66.9%	91	132	7

Sherwood Forest Hospitals NHS Foundation Trust

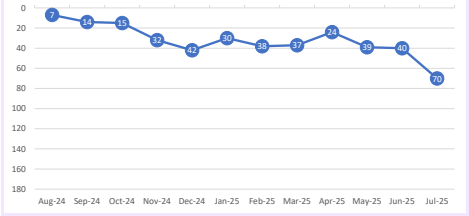
Integrated Performance Report 2025/26

August 2025 (Qtr 2)

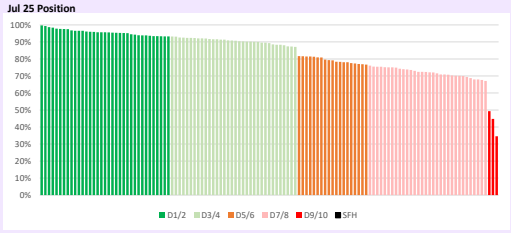
Timely Care Benchmarking Charts

Timely Care Benchmarking

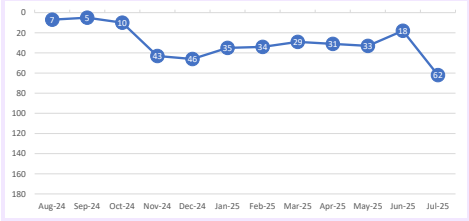
Ambulance turnaround times <30 mins



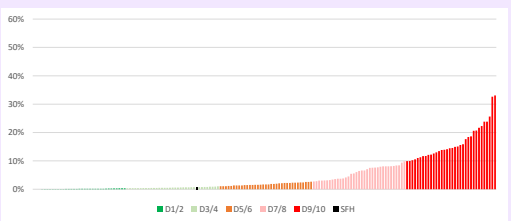
Jul 25 Position



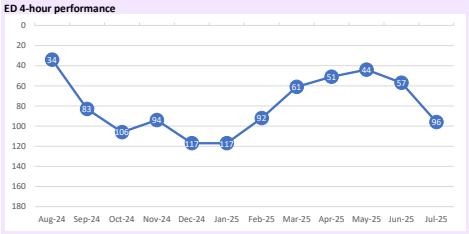
Ambulance turnaround times >60 mins



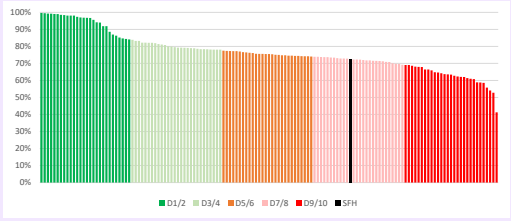
Jul 25 Position



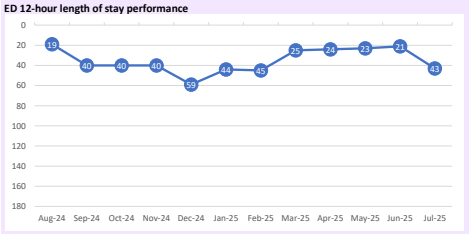
ED 4-hour performance



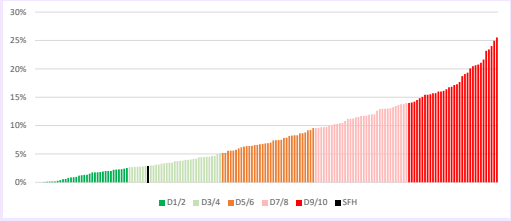
Jul 25 Position



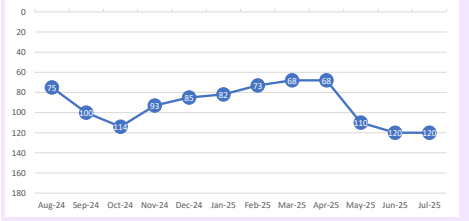
ED 12-hour length of stay performance



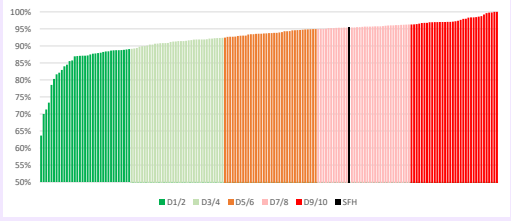
Jul 25 Position



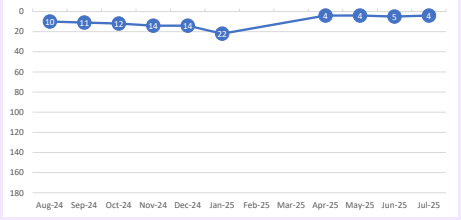
Adult G&A bed occupancy



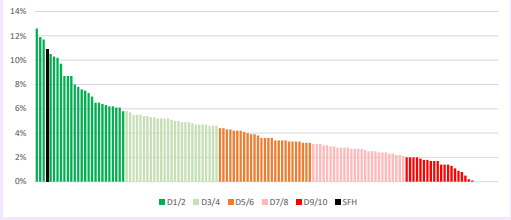
Jul 25 Position



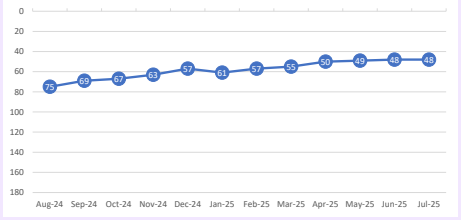
Added to Patient Initiated Follow Up (PIFU) pathway



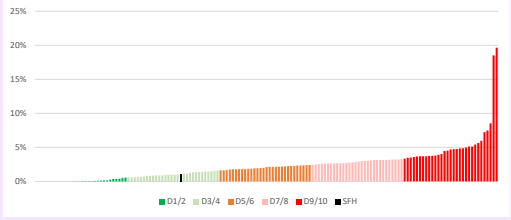
Jul 25 Position



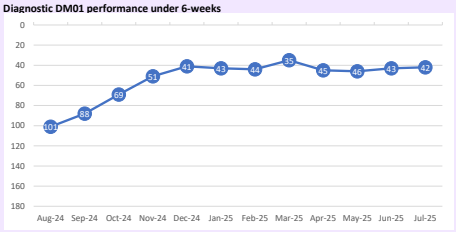
Incomplete RTT pathways +52 weeks



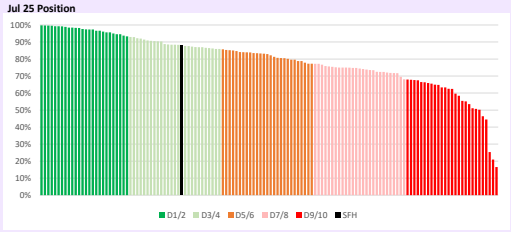
Jul 25 Position



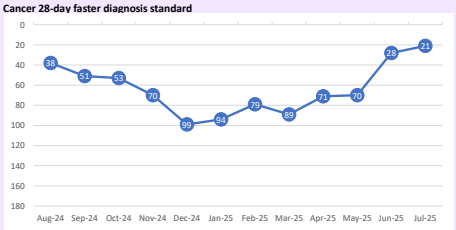
Diagnostic DM01 performance under 6-weeks



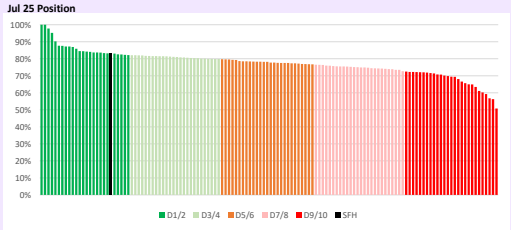
Jul 25 Position



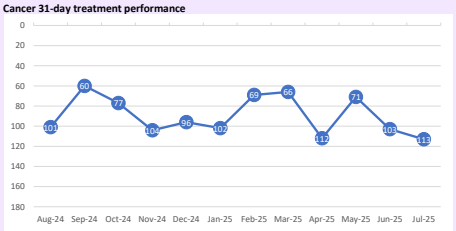
Cancer 28-day faster diagnosis standard



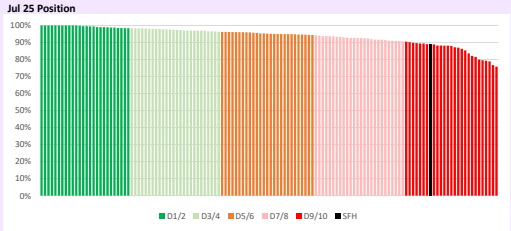
Jul 25 Position



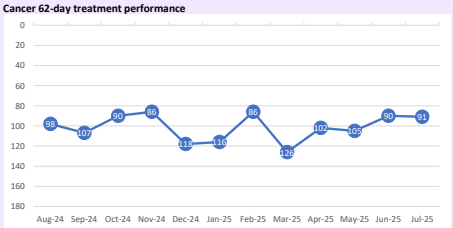
Cancer 31-day treatment performance



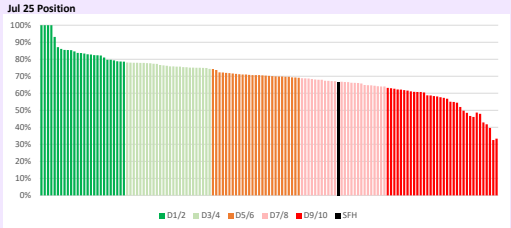
Jul 25 Position



Cancer 62-day treatment performance



Jul 25 Position



Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Winter Plan	**Date:**	2nd October 2025
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Simon Illingworth, Chief Operating Officer		
Presented By:	Mark Bolton, Associate Director of Operational Performance		

Purpose		
Trust Board is requested to review and approve our 2025/26 Winter Plan.	**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

Draft considered by Trust Board in August and our Trust Management Team. Document developed by our Winter Planning Group.

Acronyms

CARE – SFH values (Communicating and working together; Aspiring and improving; Respectful and caring;
Efficient and safe).
D&V: Diarrhoea and Vomiting
EMAS: East Midlands Ambulance Service
GP: General Practitioner
NEMS: Nottingham Emergency Medical Services (provider)

All other acronyms are defined within the paper.

Executive Summary

The attached presentation describes our key principles and approach to Winter Planning at SFH in 2025/26 and is based on the Integrated Emergency Management approach structured under the four headings:

1. Anticipate and assess
2. Prevent
3. Prepare
4. Respond and recover.

Our Winter Plan has been developed with engagement across corporate and divisional teams via our Winter Planning Group. We have learnt from previous years and incorporated learnings into our plan.

Outputs of our annual bed modelling exercise are presented together with proposed mitigations. The proposed schemes represent ‘best offer’ available that fit within the funding cap. The schemes together with some exceptional actions (such as running bed occupancy at 96%) leave us with a residual peak bed gap of 20 beds in Jan-26 against our nominal state. This level of gap should be able to be mitigated by allowing bed occupancy to exceed 96% and through the deployment of escalation actions. Successful delivery of the plan would allow elective operating to continue over Winter and patient outlying would be reduced.

Summary information is also presented around vaccination plans, our communications approach, areas of system focus, and escalation and contingency plans.

We have completed and submitted (on the 30 September) to NHS England a Board Assurance Statement. This is included in appendix A.

Trust Board is asked to review and approve our 2025/26 Winter Plan and our Board Assurance Statement. Work will continue to operationalise and monitor the plan. Specific Christmas and New Year plans will be developed in Nov-25 and early Dec-25. An update to the Council of Governors will take place following Trust Board approval.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Winter Plan 2025/26

This document describes the SFH winter plan for 2025/26.

Trust Board: 2 October 2025

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Key Principles for Winter Planning

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised, and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (inc. Covid-19)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment due to infectious disease outbreaks e.g. Influenza, Covid-19, Strep A, Norovirus, Carbapenem-resistant Enterobacterales (CRE) etc.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Approach to Winter Planning

SFH winter plan based on the Integrated Emergency Management approach:

1. **Anticipate and assess** issues in maintaining resilient services:
    - Key winter pressure drivers identified – likely epidemiology of winter 2025/26
    - Lessons learned from 2024/25
    - Demand modelled
    - Risks identified
2. **Prevent** the likelihood of occurrence and effects of any such issues:
    - Prevent and manage infection including vaccination and patient/staff testing
    - Effective population, patient and staff communications (system approach)
3. **Prepare** by having appropriate mitigating actions, plans and management structures in place:
    - Mitigating actions and flow priorities inc. staff and support service plans; staff well-being
    - Extent to which elective activity is protected, and patient outlying is reduced
    - Specific plans for Christmas and New Year period
4. **Respond and recover** by enacting plans and contingencies as required:
    - Escalation triggers and actions
    - Contingency plans for surges in demand beyond anticipated levels in our ‘nominal’ state.

Key Winter Pressure Drivers

Traditionally, key drivers for our winter pressures relate to:

- Higher acuity as evidenced by National Early Warning Scores (NEWS2) leading to longer hospital average length of stay
- High prevalence of influenza
- Increase in attendance/admissions in Respiratory (inc. Respiratory Syncytial Virus) and Healthcare of the Elderly
- Increase instances of infection (norovirus, D&V, CRE etc)
- Increase in number of beds occupied for patients that have been medically safe for transfer (MSFT) for greater than 24 hours awaiting discharge

In the ‘living with Covid-19’ era there is a degree of uncertainty around what the epidemiology of winter may be like in 2025/26.

We will learn from the Southern Hemisphere.

Australia Influenza Season

Figure 6: Notified influenza cases and five-year average* by year and week of diagnosis, Australia, 2022 to 7 September 2025

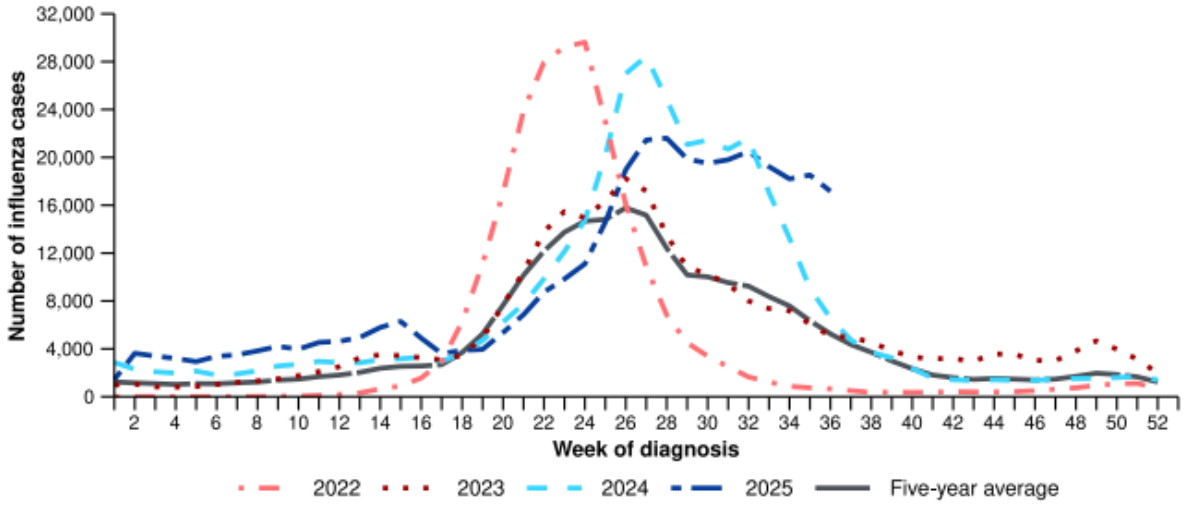
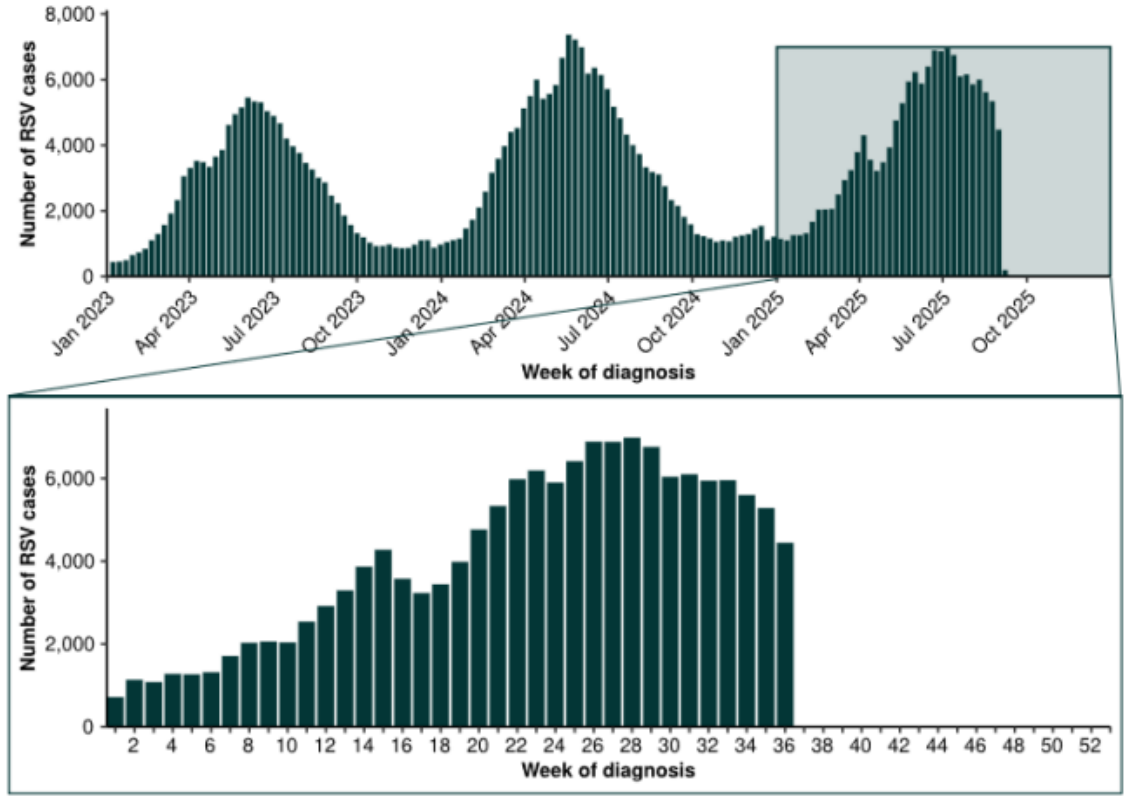


Figure 10: Notified RSV cases by year and week of diagnosis*, Australia, 2023 to 7 September 2025



Source: National Notifiable Diseases Surveillance System (NNDSS).
* RSV became notifiable in all states and territories on 1 September 2022 and comprehensive national notification data became available after this point. For this reason, RSV notification trends are only presented from 1 January 2023.

- In Australia they have seen:
  - Influenza tracking higher in 2025 in the ‘off-peak’ period than previous year. The main peak marginally later and at a lower level than 2024; however, increased levels continuing for longer in 2025
  - RSV tracking at similar levels to 2024 and higher than 2023
- Modelling assumes equivalent levels and timing to winter 2024/25.

Source: Australian Respiratory Surveillance Report

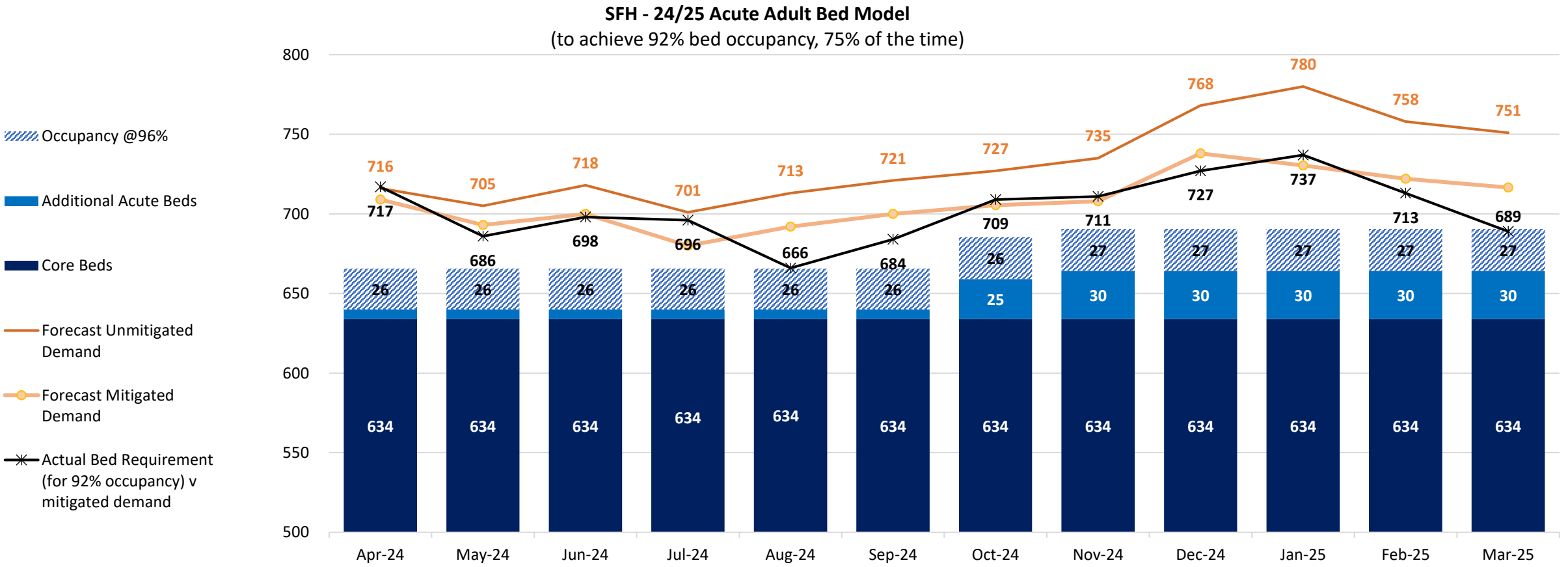
Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2024/25 Bed Model



Actual bed requirement (black line) tracked closely to forecast mitigated demand (light amber line) providing confidence in our modelling.

Variance in Aug-24 was driven by lower-than-expected admission demand. Mar-25 was driven by reduced length of stay mainly for >65-year-olds.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2024/25 Spend

- The winter reserve for 2024/25 was £2,364,200 of which £2,276,800 was to spend over the winter period (£87.4k spent in Apr-24)
- £1.71m spent between Oct-24 and Mar-25 against a plan of £2.27m
- The underspend was driven by:
  a) Two large schemes were not able to be mobilised in line with the original plan:
     1. Expansion of surgical Same Day Emergency Care (SDEC)
     2. Surgical day case overnight use
  b) Two approved schemes were not mobilised:
     1. Cardiology afternoon Percutaneous Coronary Intervention (PCI)
     2. Bridging of packages of care over Christmas and New Year

  Staffing challenges were the primary reason for the difficulty in mobilising all schemes
- As a result of the curtailment of some schemes, circa £562k was returned to support Trust financial bottom line.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2024/25 Schemes

Scheme evaluations have taken place for all non-bedded schemes. A summary is below:

Seek to mainstream as business as usual (if not, repeat/modify for 2025/26)

- **Complex endoscopy pathway improvement.** *Uplifted a Nurse to become a Specialised Nurse for clinical vetting and pre-op. Qualitative feedback strong.*
- **Orthogeriatric resident doctors.** *This scheme provided cover during periods of leave for existing resident doctors and helped reduce Hospital Out of Hours requests and reduced length of stay in the patient cohort.*
- **Acute Frailty Unit/Frailty Same Day Emergency Care (SDEC).** *Part of geriatrics transformation business case. Supported timely geriatric reviews and reduced cohort length of stay.*
- **Additional weekend Consultant on Short Stay Unit (SSU).** *Looking to mainstream dedicated weekend SSU Consultant until 16:00 (instead of finishing at 12 noon).*
- **Additional Radiology support.** *Looking to mainstream keeping X-Ray open an extra hour (until 6pm) during weekdays.*

Desire to repeat in Winter 2025/26

- **Doubling of respiratory physicians at weekends.** *Mobilised for the past 3-years and supports increased seasonal demand in this specialty. Increased weekend discharges across wards 21 and 43 over winter.*
- **Weekend trauma theatre operating lists.** *Provision of additional trauma capacity over the winter period added value, improved patient experience and reduced bed demand by treating patients sooner.*
- **Children's Assessment Unit (CAU) increased opening hours.** *Reviewing year-round opening; however, will still be need to expand further over winter to meet seasonal demand and support our Emergency Department (ED). Mobilised for the past 2-years and supported increased admissions to CAU from both GPs and ED.*
- **Bedded schemes.** *Schemes to seasonally increase our bed base were enacted fully over winter with all beds well utilised. It is recognised that the seasonal use of additional Stroke beds adversely impacts on the rehabilitation space for Stroke.*

Modify for Winter 2025/26

- **Increase medical bed base by temporarily reducing elective orthopaedic activity.** *We need to consider how interdivisional working can take place to allow flexibility in our bed base without having to reducing elective orthopaedic activity in this manner.*
- **Expansion of surgical SDEC.** *Insufficient demand to justify extending opening hours of existing surgical SDEC offer. Consider the surgical SDEC offer i.e. widen to other specialities. Also, consider the overnight and weekend opening of surgical SDEC spaces for inpatient care.*

Do not repeat or modify

- **Discharge Coordinator on SSU.** *Difficult to build relationships required and embed to be impactful when in post for a short timeframe.*
- **Additional portering for Discharge Lounge.** *No longer required due to change of model.*
- **Surgical day case overnight use.** *Challenging to find appropriate patients to occupy beds meant that use was limited. Recommend reviewing the use of the Surgical SDEC beds for potential weekend/overnight opening instead.*

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Performance Observations from 2024/25 (1/2)

Headline performance observations from winter 2024/25 are:

- Ambulance handover performance deteriorated significantly from Nov-24. This linked to increased crowding in ED together with changes to Clinical Frailty Scoring and STREAM processes (the latter two designed improve patient experience and outcomes). The deterioration in handover performance was worse in winter 2024/25 than previous years. However, SFH still benchmarked well regionally and nationally.
- ED attendances were very high through 2024/25, consistently above levels seen in the previous three years. Mar-25 saw extremely high growth across type 1 and type 3 (the latter driven by unprecedented demand at our Newark Urgent Treatment Centre).
- Maximum occupancy in ED at King's Mill Hospital (KMH) reached high levels for an unprecedented, sustained period during early winter. This is linked to outflow challenges as patients waited in ED for admission to a hospital bed.
- 4-hour performance has deteriorated each winter, continuing in 2024/25 with a record low in Dec-24 when outflow challenges peaked with patients on average waiting over 4-hours for admission from the decision to admit. 12-hour length of stay showed similar seasonality to 4-hours. Improvements in Mar-25 have been seen which were sustained as hospital flow improved. Reduced length of stay for patients aged 65 and over (particularly in their medically safe element of their stay), eased bed pressures and enabled patients to transfer out of ED in a timely basis.
- Non-elective activity has remained stable throughout 2024/25, albeit at high levels. Feb-25 saw a significant increase, like the previous year. The improved position in Mar-25 was not driven by reduced attendance or admission demand – it was driven by reduced length of stay.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Performance Observations from 2024/25 (2/2)

- NEWS2 scores indicate seasonal rise in acuity. Winter 2024/25 saw a more severe rise than the previous year.
- Bed occupancy remained well above 92% (circa 95%) throughout the last few years, averaging close to 96% on weekdays. In Winter 2024/25 we had more beds open than ever before driven by using one-over spaces. The number of open beds reduced as we came out of the peak Winter period of Dec-24/Jan-25.
- Medically safe for transfer patient numbers reduced significantly through 2024/25 to low levels not seen since the pandemic. This reduction in discharge delays has supported reduced length of stay, releasing beds when they are needed to provide timely outflow to ED.
- Elective and day case activity has been high during Winter 2024/25; however, sometimes activity levels were not as high as our plan.
- Increased validation has helped to reduce the Patient Tracking List (PTL) size. Referral To Treatment (RTT) long wait reductions seen earlier in the year levelled off over the winter period.
- The curtailment of Orthopedics for six weeks in Dec-24/Jan-25 presented significant challenges in the specialty. Maintaining activity was not possible, and while urgent pathways were facilitated, progress on reducing elective long waits was adversely impacted.
- Cancer performance has been challenged, with histopathology capacity issues. Diagnostic performance improved significantly this Winter as recovery plans (unrelated to our Winter plan) delivered.
- Further detail (graphs and evidence) supporting the performance observations is available as a separate pack on request.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Lessons Learned from 2024/25

What worked well

- **Bed model was accurate** and should be regarded as reliable for future planning
- **Bedded schemes opened as planned** with wrap around services
- We survived winter with **significantly less spot purchased beds from Ashmere** (peak of 16 this winter; 39 last winter)
- **Surge and escalation plans** (including full capacity protocol [FCP]), when enacted, **supported de-escalation**
- Extending **weekend trauma operating lists** supported our response to increased trauma demand **preventing patients waiting in beds for surgery**
- **Clinician feedback very positive regarding medical** (acute frailty unit), **paediatric** (CAU increased hours), and **surgical schemes** (trauma lists)
- Some **smaller schemes** such as an additional weekend consultant on SSU **were successful**
- We **recovered hospital flow** from Mar-25 which was delivered through **length of stay reductions** as we sustainably **reduced discharge delays**. This enabled improvement in Accident and Emergency (A&E) 4-hour performance

Areas for improvement

- The planned **expansion of Surgical SDEC** and **Surgical Day Case overnight use** schemes were not mobilised in line with our plan, and therefore did not produce the anticipated impact. The underspend (circa £450k) was used to support the Trust financial bottom-line
- Due to bed constraints during peak winter periods, our **wards** at times were **required to go 'one and two-over'.** We require capacity to be able to flex up and down our bed base at KMH to meet patient needs during peak periods
- Some of our people chose to work **additional hours** over and above contract, including clinical bank shifts and overtime. Look to agree 2025/26 schemes early to support recruitment to support wellbeing of existing staff
- **Newark UTC attendance surge** (12% growth) was beyond levels forecasted and was challenging to respond to. Work undertaken by the System Analytical Intelligence Unit (SAIU) has revealed that challenges in accessing same day GP access is likely to be driving this increased demand
- We were required to **curtail elective orthopaedic operating for 5-6 weeks** to release capacity for non-elective (NEL) demand. Preference is to maintain year-round elective operating. While urgent Orthopaedic pathways were facilitated, **long elective waits were adversely impacted** by the curtailment

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Lessons Learned from Regionally-led Stress Test Exercise

Key areas of learning for providers and systems that NHS England identified include:

- The need for robust plans to maximise vaccination rates across all cohorts, including health and social care workers, and achieve our collective aim of improving frontline staff uptake by at least five percentage points
- Having a paediatric specific plan for when respiratory viruses cause a surge in demand for primary care, 111 and A&E departments
- Ensuring primary care access is maintained over the Christmas period
- Engaging with local authorities and social care providers so that discharge capacity surges at times of peak demand
- Having senior clinical decision-maker enhanced rotas in place ready to be activated
- Targeted occupancy reductions in the run-in to the Christmas period
- Stepping up personal visibility and leadership, including from Chief Executive Officers (CEOs), Chief Medical Officers (CMOs), and Chief Nursing Officers (CNOs), to help lead and support our people through a challenging winter.

Bed Model: 2025/26 Approach

- Separate models in place for adult, paediatric, maternity, critical care and day case demand/bed bases
- Bed requirement in our adult model is based on:
  - 75th percentile of hourly demand
  - Goal to achieve 92% bed occupancy. We also consider a 96% bed occupancy scenario (which is operationally deliverable at SFH whilst still maintaining flow)
- **Capacity:** Operational view of core capacity based on beds that were consistently open in 2024/25. Beds that flex up and down in line with demand are considered as escalation beds and not part of core bed stock. Note: as in 2024/25 there is no provision in our baseline for a decant ward due to no physical space being available; deep cleaning will be facilitated through a rolling bay-by-bay programme
- **Demand Assumptions:** 2024/25 outturn adjusted as follows for the initial version of the adult bed model ('nominal' state):
  - 0% growth in elective; 4.9% growth in overnight non-elective; and 3.7% growth in zero-day non-elective activity on 2024/25 actuals (aligned to operational plan)
  - Winter orthopaedic demand maintained during Jan-26 at the average level seen in 2024/25
  - No change in Length of Stay (LOS)
  - Medically Safe for Transfer (MSFT) during Apr-25 to Jul-25 adjusted down to reflect reductions observed and sustained in MSFT since Aug-24
  - Accident and Emergency (A&E) bed waiters capped at 30-minutes from decision to admit. Balance of bed wait added to Urgent and Emergency Care demand
  - Where day case length of stay exceeds 16 hours, demand included in our inpatient bed model
  - Aug-25 and Mar-26 are adjusted to reflect more typical seasonality, after unusually low bed demand in those months in 2024/25
- Further detail relating to the bed model is available as a separate pack on request.

Outstanding Care, Compassionate People, Healthier Communities

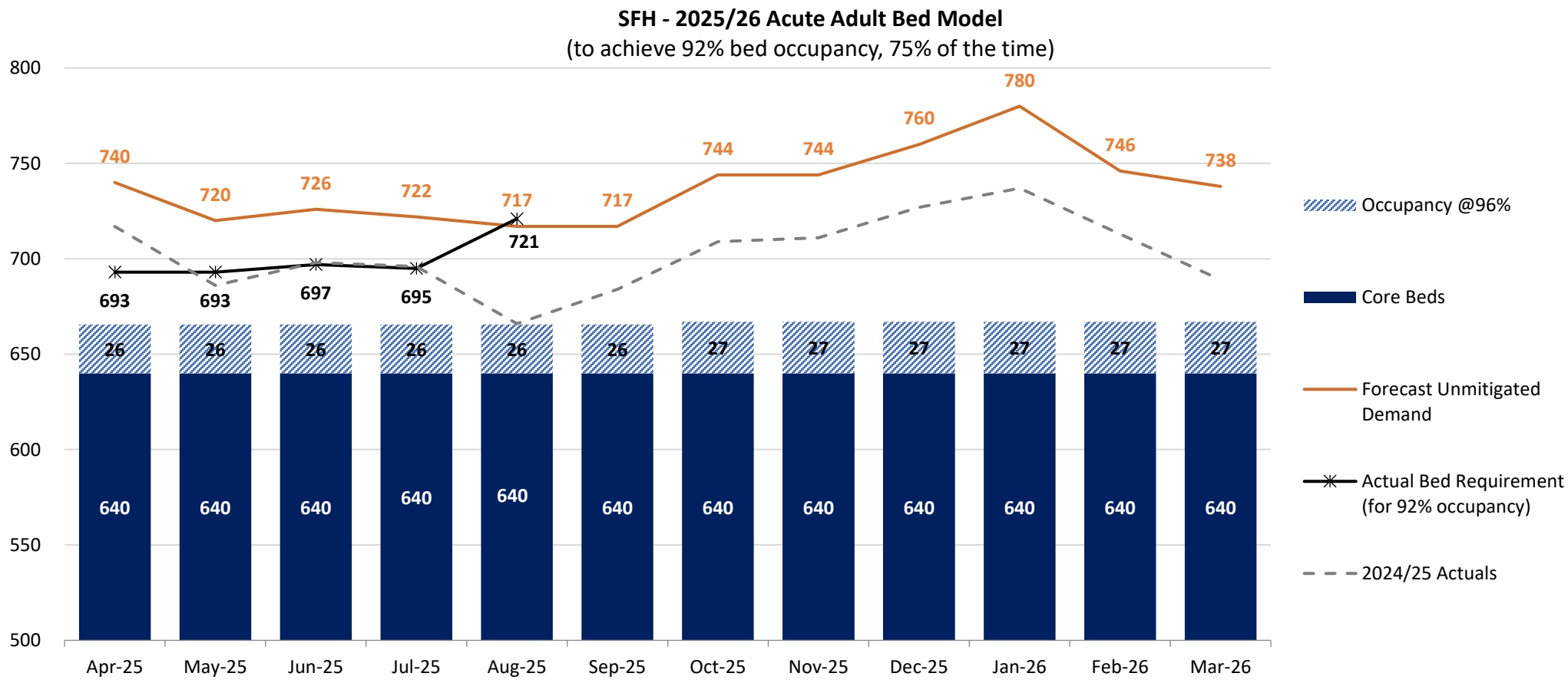
Winter Plan Area

Anticipate & Assess | Prevent | Prepare | Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Adult Bed Model: 2025/26 Pre-Mitigated Chart

Significant year-round bed gaps exist to meet forecast unmitigated demand at both 92% and 96% bed occupancy based on a do-nothing scenario (without any mitigations).
Peak demand month is Jan-26 which includes continued elective operating.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bed Gaps @92% occupancy	-100	-80	-86	-82	-77	-77	-104	-104	-120	-140	-106	-98
Bed Gaps @ 96% occupancy	-74	-54	-60	-56	-51	-51	-77	-77	-93	-113	-79	-71

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Bed Model: Paediatric and Critical Care

Occupied beds in paediatrics, Neonatal Intensive Care Unit (NICU) and Critical Care Unit (CCU) is projected on the basis that **2025/26 is a repeat of 2024/25**

At the end of Aug-25, the projections are broadly in line with actuals.

	2025									2026		
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paeds (Ward 25)	23	22	21	22	17	24	25	28	24	20	22	23
NICU	11	13	13	13	12	12	13	15	14	13	13	14
Critical Care Unit	14	13	14	12	13	12	13	13	14	14	15	14

Bed Model: Day case

- This table shows the capacity requirements in each of the day case wards. It is based on the 75th percentile of demand at midday
- Only patients with a length of stay of 0-16 hours are included within the analysis
- As of Aug-25, the projections are the projections are broadly in line with actuals with a level of variance that can be managed operationally.

	2025									2026		
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Day Case Unit	26	27	23	27	24	26	27	26	24	30	24	25
Medical Day Case Unit	2	3	3	4	3	5	5	5	4	7	4	5
Minster	10	9	8	10	8	11	10	11	11	10	10	9

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Risks

IF

- Physical space is insufficient to meet demand
- Unable to provide sufficient medical, nursing or support services staff to meet demand
- Unable to maintain a resilient workforce
- Insufficient equipment to meet demand
- Insufficient system capacity to maintain system flow and the timely transfer of medically safe patients (including impact of any decommissioning discussions)
- Experience an influenza pandemic or significant norovirus or CRE outbreak (or any other infectious disease)
- Experience any significant issues with the fabric of our buildings or other infrastructure e.g. ICT

THEN

May not deliver resilient services over winter

RESULTING IN

- Adverse impact on patient safety
- Inability to deliver appropriate services to our patients (particularly on elective pathways)
- Adversely impact on our reputation causing undesirable media coverage and a loss in confidence from the population we serve
- Reduced staff morale, resilience and retention
- Lack of compliance with national performance standards or local planning commitments causing undesirable regulatory action

Existing dashboards, systems and process exist to identify when the risk items are triggering a live issue. Issues will be managed operationally through five-times daily Capacity and Flow meetings. Quality Impact Assessments (QIAs) will be complete for all approved winter schemes and supplement existing QIAs that exist around capacity and flow.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Prevent and Manage Infection

- SFH has in place a series of guidance and policies that are followed throughout the year to avoid, manage and contain infections including any cases of Diarrhoea and Vomiting (D&V), Influenza and Norovirus

Influenza vaccination plan

- Led by Occupational Health, based on previous seasons with trained teams of peer vaccinators
- Focused approach to Health Inequalities to improve uptake amongst related groups within our workforce
- Strong Communication strategy which will be responsive to the progress with uptake
- Drop-in ‘grab a jab’ pop-up flu clinics in high traffic staff areas
- Plan based on delivery of five percentage point improvement on last year
- Vaccines offered to patients with a length of stay greater than 21 days and to patients being discharged to care homes

Flu Plan 2025-26

Covid-19 vaccination

- There has been no national communication around any intent to offer healthcare staff Covid-19 vaccinations in 2025/26

RSV vaccination plan

- As advised in Jul-25, we will adopt national policy which is to offer the Nirsevimab passive immunisation for at risk infants in line with the Green Book criteria

Respiratory mask fit testing

- Focus on improving compliance in high-risk areas for appropriate mask fit testing to be complete on one mask and recorded and reported
- Levels of Personal Protective Equipment (PPE) stock deemed to be sufficient for the anticipated winter pressures will be in place.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Communications

SFH will work with system partners to deploy consistent messaging over winter

The focus will be on the Influenza vaccination campaign and supporting people to get the help they need at the right time, in the right place. Educating the public about which services are most appropriate for their needs will empower the public to keep well this Winter, and support a reduction in pressure on services

SFH communications will:

- Draw on national and system-produced material wherever possible
- Mobilise our system and place partners to support our activity
- Be bold and proactive in how we communicate pressures – encourage and support understanding of operational pressures among all audiences
- Support Team SFH colleagues' wellbeing and show we CARE (our values).

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Reserve

- The Winter reserve for 2025/26 was **£2.495m**. We were initially working to an allocation of **£1.8m** to allow **£695k** cost avoidance (a similar level of spend to 2024/25). In early September, we moved to a revised spend cap of **£700k** to allow a further **£1.1m** cost avoidance to support the challenging Trust financial position
- Based on our learning and reflections on 2024/25, we identified a desire to repeat/enhance the following schemes in 2025/26:
  - Acute frailty service
  - Doubling of respiratory Physicians at weekends
  - Children's Assessment Unit increased opening hours
  - Additional weekend Consultant on Short Stay Unit
  - Weekend trauma theatre operating lists
  - Bedded schemes (Lindhurst and Stroke escalation beds but **not** the medical cover to convert a surgical ward in Jan-26)
- Within the revised spend cap, we cannot support all schemes outlined above.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Elective Activity over Winter

- Our ambition is that any adverse impact/compromise on elective care/activity and associated patient experience, income and performance is minimised and assessed on a patient-risk basis
- It is recognised that in 2023/24 and 2024/25 it was necessary to reconfigure the surgical bed base and transfer elective orthopaedic beds to Medicine in the peak of winter (from Christmas to end of January). This was enacted in a planned manner
- Our intention in 2025/26 remains to provide sufficient mitigation against anticipated demand pressures to enable elective operating to continue year-round. To do this, we need to provide sufficient mitigation of the ‘nominal’ state in the bed model and the ‘nominal’ state forecast assumptions to be correct e.g. level of patient demand on our services
- Our ambition is to significantly reduce patient outlying from medicine into surgery, which will be supported by bed reconfigurations.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations for Bed Deficit

- There are limited options and insufficient space within our adult bed base to mitigate the forecast winter bed deficits without reconfiguration/changes
- Our 2025/26 plan for our adult bed base includes:
    - Reconfiguration of areas of our adult bed base creating an Acute Frailty service and a Transitional Care Unit; and transferring a ward between our Surgery and Medicine divisions. The reconfiguration will be achieved in our existing footprint, consolidating services and making better use of our medical day case facility
    - Creating additional bed spaces by improving privacy and dignity of temporary escalation spaces across our medical bed base by installing curtains, services and equipment for an additional bed space per bay. This requires capital (and a small amount of revenue) investment and will support patient experience year-round. The revenue investment requirements will be met from the winter reserve
    - Enhancing the use overnight of the discharge lounge in Jan-26 and Mar-26 to 16 patients from the 2025/26 level of demand at the 75th percentile. This would impact on any cost savings derived from any planned overnight/weekend closures
    - Investing in schemes to reduce length of stay (demand avoidance)
- There is sufficient flexibility within our paediatric bed base to flex the number of beds to match anticipated demand. In winter 2025/26 we have two paediatric high dependency unit beds. There is risk to timely outflow from ED for paediatrics if we do not seasonally extend the Children's Assessment Unit opening hours.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Flow Schemes

The following schemes are proposed to support patient flow over the winter period and reduce length of stay:

1. Delivering an Acute Frailty service with our existing footprint by cohorting patients and delivering enhanced early interventions to reduce length of stay as evidenced from the trial in winter 2024/25 and referenced in the Geriatrics Transformation case.
2. Doubling respiratory Physicians at weekends*
3. Increasing the opening hours of the Children's Assessment Unit*. This scheme will need to be curtailed compared to 2024/25 due to financial constraints and will focus on the period of peak forecast paediatric demand
4. Enhancing our Virtual Ward offer. This links to the national Urgent and Emergency Care priorities and will strengthen existing work in this area.
5. Bridging capacity for Pathway 1 discharges recognising the seasonal pressure we face over the Christmas and New Year period

We have secured circa £233k of external funding via the Health Innovation Network to develop an Integrated Neighbourhood Respiratory Health Service in mid-Nottinghamshire over the Winter period to support early and accurate diagnosis and risk stratification and optimisation

Further schemes are collated should additional funds become available i.e. from regional or national monies

A summary of bed and flow schemes together with the timeframe, impact and cost is on the next page.

**Repeated scheme from 2024/25*

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Bed & flow scheme summary

Scheme	Impact						Cost
	Oct-25	Nov-25	Dec-25	Jan-25	Feb-25	Mar-25	
Pre-mitigated bed position @ 96% occupancy	**-77**	**-77**	**-93**	**-113**	**-79**	**-71**	
Bed schemes (increasing capacity)							
Transitional Care Unit	30	30	30	30	30	-	£500k
Discharge Lounge enhanced overnight use (to 16 patients overnight)	-	-	-	4	-	7	No cost, but no cost saving
Flow schemes (reducing demand)							
Reverse modelled demand growth (not experienced by M5)	33	33	34	35	33	32	N/A
Acute Frailty service	8	10	12	14	14	14	N/A
Children Assessment Unit (CAU) increased opening hours for 2.5 months	In baseline and does not mitigate adult bed deficits						£100k
Doubling respiratory Physicians at weekends	In baseline						£23k
Enhancements to our Virtual Ward offer	-	-	6	6	6	6	£16k
Bridging capacity for Pathway 1 discharges	-	-	4	4	-	-	£26k
Additional bed spaces revenue items	Spaces to be used when in escalation						£35k
Post-mitigated bed position @ 96% occupancy	**-6**	**-4**	**-7**	**-20**	**+4**	**-12**	
						Total cost	**£700k**

Our baseline position entering 2025/26 included delivery of weekend trauma theatre operating lists. Last winter five additional lists were provided over a two-month period operating on 22 patients at a cost of £76k. Based on a two-day length of stay saving per patient, the overall bed impact is 44 bed days (less than one bed equivalent). As such, the scheme is not as financially viable as other options.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

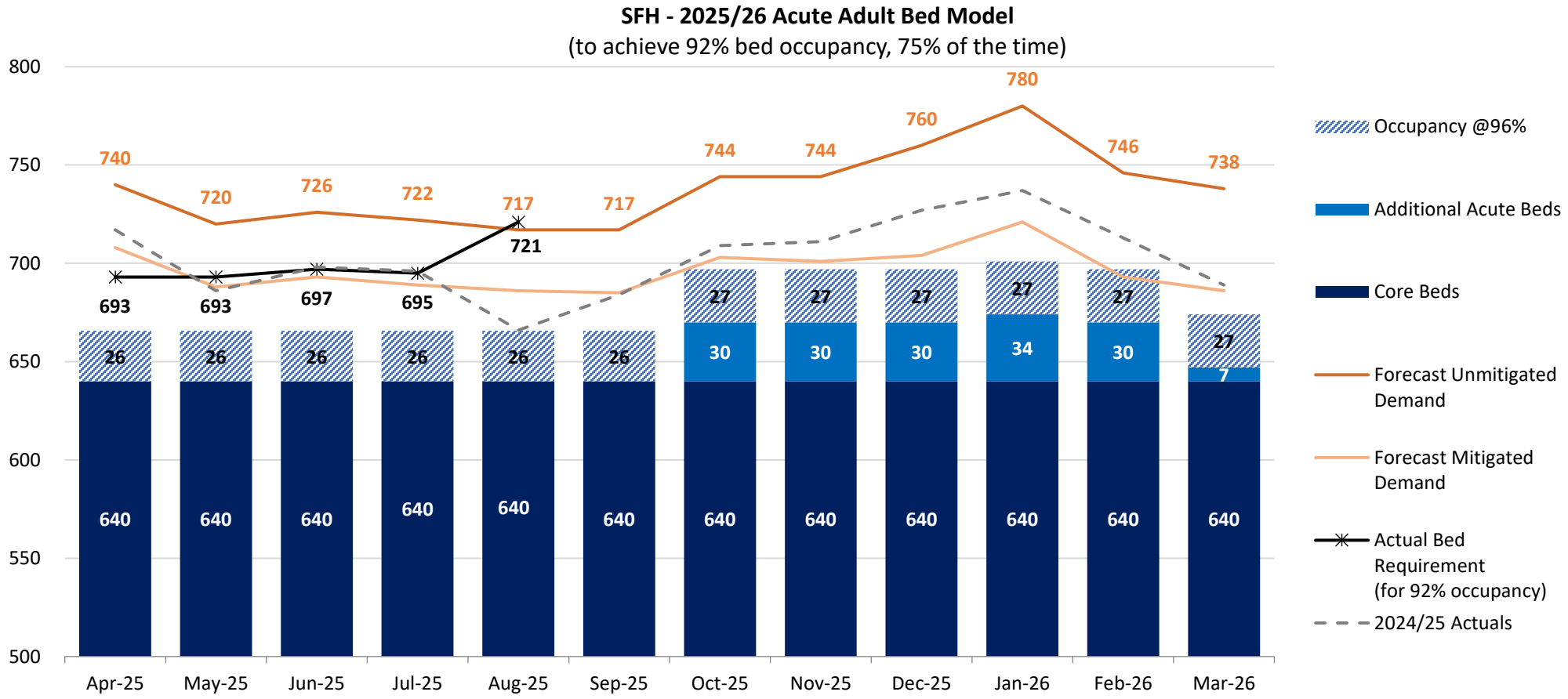
Anticipate & Assess | Prevent | **Prepare** | Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Adult Bed Model: 2025/26 Mitigated Chart

The proposed schemes together with exceptional actions (96% bed occupancy) leave us with a peak bed gap over winter of 20 beds (Jan-26).

FCP actions could provide a bridged position if bed occupancy was also raised beyond 96%. This assumes no non-elective demand growth (as seen to month five).



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bed Gaps @92% occupancy	-68	-48	-53	-49	-46	-45	-33	-31	-34	-47	-23	-39
Bed Gaps @ 96% occupancy	-42	-22	-27	-23	-20	-19	-6	-4	-7	-20	4	-12

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Key Areas of System Focus

- Nottingham and Nottinghamshire Integrated Care System/Board (ICS/ICB) are overseeing the system Winter plan
- Initial drafts of provider ‘plans on a page’ have been shared
- Key features of system partner plans that could support SFH are:
    - Increase Urgent Care Coordination Hub (UCCH) activity in system by 72 calls per day by Mar-26 with refined exclusion criteria for category three calls manually passed between EMAS and UCCH and use of code automation pathway to reduce errors and standardise processes. Expansion of direct access pathways to UCCH to all care homes
    - Improve catheter and ‘long lie’ patient pathway with refinements to referral process to District Nurses for UCCH
    - Increase use of SFH ‘call before convey’ advice line by EMAS, NEMS and GPs to increase overall ‘call before convey’ activity and reduce referrals to ED for ‘non-emergency’ patients
    - Targeted education programme to GP practices with high referrals to ED
    - Increase percentage of appropriate patients on end of life register with Respect with EMAS able to view via Notts Care Record.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Existing Interventions that Support Maintaining Quality of Care

- Enhanced Emergency Department staffing to support increased attendance demand including paediatric Registered Nurses 24/7
- Same Day Emergency Care offering across medical and surgical pathways
- Hospital Out Of Hours team
- Discharge Coordinators
- Discharge Lounge
- Getting basics right improvement programme with a focus on board rounds

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Staff Wellbeing

Psychologically safe teams

- Encourage good, meaningful conversations to show support to colleagues and enable teams to develop strong working relationships
- Ensure colleagues have access to free Wellbeing Conversations training to help them navigate difficult times
- Encourage an empathetic approach to colleagues during challenging events

Rest, Refuel, Rehydrate

- Lead by example by taking breaks, planning breaks and supporting colleagues to rest, refuel and rehydrate
- Promote all aspects of health and wellbeing related training and specifically coping under pressure
- Ensure areas are supported in the lead up to winter to have access or knowledge of available rest areas and ensure essentials are available in all areas

Burnout and Stress

- Target promotion and support areas with high anxiety, stress depression sickness absence and high burnout score in Staff Survey
- Promotion of financial wellbeing resources and support to reduce and address money worries
- Raise awareness of VIVUP and other support services for staff to access throughout and following difficult times

"Boost" Vaccinations

- Continue to encourage all staff to access a free Flu vaccine from the Occupational Health and Peer Vaccinator teams
- Ensure colleagues are aware of how to access a Covid-19 vaccine through the National Booking System or on site offers as eligibility dictates.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Escalation Plans and Contingencies

- **Full Capacity Protocol** (FCP) and **Operational Pressures Escalation Levels (OPEL) 4 action cards** in place that include:
  - Identified areas of surge capacity (suite of options dependent on level/type of pressure/risk)
  - Actions for clinical teams to undertake to regain patient flow
  - Review of the balance between urgent and emergency care and planned care pathway activity
- **SFH command centre** six times daily email status updates shared seven days a week and viewable 24/7 by SFH colleagues in SQL Server Reporting Services (SSRS). The command centre provides real-time monitoring and reporting of pressures
- **System control centre** in place; OPEL escalation status of system partners visible
- **On call structure** in place 24/7 to provide senior oversight and support to 24/7 Duty Nurse Management team
- The SFH named **Executive accountable for the winter period** is Simon Illingworth, Chief Operating Officer
- **Industrial action** planning takes place to deal with any notified instances of action throughout the year; this will sit alongside our winter plan for any instances over the winter period.

Concluding Remarks

- This document summarises the key components to our 2025/26 Winter plan and is the cumulation of work undertaken by Divisional and Corporate colleagues over the Spring and Summer period
- Winter mitigations have been presented that will fit within the funding cap that has been requested by Executives under the winter reserve. This should be regarded as our ‘best offer’
- The proposed schemes, together with working to a bed occupancy of 96%, leave us with a peak bed gap of 20 beds in Jan-26. We have not yet achieved a route to bridging the whole gap over winter. The consequences of not bridging the bed gap include:
    1. Bed occupancy being higher than 96%
    2. Patients waiting for admission in ED with associated patient experience and safety concerns
    3. The need to enact Full Capacity Protocol actions which include the use of additional bed spaces on our wards

  The proposal does assume elective operating continues over Winter
- Specific Christmas and New Year plans will be developed in Nov-25
- Trust Board is requested to approve the 2025/26 Winter Plan
- An update to the Council of Governors will take place following Trust Board approval in Oct-25.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board Assurance Statement

The NHS England mandated Board Assurance statement has been completed and is embedded below.

For PDF versions of this document, the Board Assurance statement will be appended.

Board Assurance Statement

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Sherwood Forest Hospitals NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Draft plan reviewed at Trust Board in Aug-25 and final plan to be considered on 2-Oct-25 at Trust Board.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Quality Impact Assessments (QIAs) are in place for each winter scheme and are available for review on request. These supplement existing QIAs which are under Board oversight as appropriate via Trust Board sub-committees.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The Trust is an active member of the ICB Winter Planning Group.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	We attended a local stress-test exercise in Aug-25 and the regional winter event in Sep-25.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	The Accountable Executive is Simon Illingworth, Chief Operating Officer.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Moderate to extreme scenarios will require increased additional oversight and may require the mobilisation of additional OPEL 4/Full

Provider:	Sherwood Forest Hospitals NHS Foundation Trust

		Capacity Protocol actions/mitigations.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	Several of the stated trajectories are off-track as we enter the Winter period. Recovery action plans (that are separate to our winter plan) are in place. Extreme winter pressures could place additional pressure on key UEC and RTT metrics that will require increased, additional oversight.

Provider CEO name	Date	Provider Chair name	Date
Dr David Selwyn		Graham Ward	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Moderate to extreme surges will require the implementation of OPEL 4/Full Capacity Protocol actions/mitigations.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Rotas are set 6-weeks in advance and are periodically reviewed to maximise decision-making capacity within the context of availability/financial constraints.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Discharge profiles are well understood with targets in place for P0 and P1-3 discharges. Daily engagement at system level to escalate and resolve discharge-related delays.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	We have and continue to focus on planned care activity levels to maximise the number of patients seen in the approach, and during, the winter period.

Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Plan reviewed by IPC colleagues.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Our clinical divisions are continuing to ensure that all relevant staff in high-risk areas have fit testing for at least one mask.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Reviewed by our Infection, Prevention and Control committee.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	In place 365 days a year.
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Business as usual item reporting in an automated manner at Trust and system-level.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public – Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date:**	2nd October 2025
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	David Selwyn, Acting Chief Executive Officer		

Purpose

To enable the Board to review the effectiveness of risk management within the Board Assurance Framework (BAF) and approve the proposed changes agreed by the respective Board committees, and for oversight of significant operational risks.	**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

Lead Committees review individual principal risks at each formal meeting (Quality Committee; People Committee; Finance Committee; Partnerships & Communities Committee; Risk Committee). Risk Committee reviews the full BAF quarterly.

Acronyms

See below

Executive Summary

Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable the Board to maintain effective oversight of strategic risks through a regular process of formal review.

Lead committees have been identified for specified principal risks and consider these at each meeting, providing a rating as to the level of assurance they can take that the risk treatment strategy will be effective in mitigating the risk.

The Risk Committee further supports the Lead Committees in their role by maintaining oversight of the organisation's divisional and corporate risk registers and escalating risks that may be pertinent to the lead committee's consideration of the BAF.

To provide Board oversight, a report of significant operational risks is available in the reading room. This report outlines significant risks on the Trust's risk register at the time of the last Risk Committee, and the respective principal risks on the Board Assurance Framework to which they apply.

The Risk Committee reviews all significant risks recorded within the Trust's risk register every month. This process enables the Committee to take assurance as to how effectively significant risks are being managed and to intervene where necessary to support their management, and to identify risks that should be escalated.

Proposed amendments to the BAF, agreed by the respective Lead Committees, are on the attached document - additions to the text are in red type and removals are in blue type (struck out).

Schedule of BAF reviews since last received by the Board of Directors on 5th June:

- Quality Committee: PR1, PR2 and PR5 – July and September
- People Committee: PR3 – July and September
- Finance Committee: PR4 and PR8 – June, July, August and September
- Partnerships and Communities: PR6 – July
- Risk Committee: PR7 – June, July and September

PR1, PR2, PR3, PR4 and PR7 remain significant risks. All risks except PR5 are above their tolerable risk ratings.

As this report was prepared before the 29th of September Quality Committee and 30th of September People Committee meetings, there may be further changes agreed at those meetings that are not on the attached BAF report.

Board members are requested to:

- Review the principal risks in light of proposed changes agreed by the respective lead committees
- Consider the implications of any current risk ratings being above tolerable levels
- Agree any further changes
- Approve the BAF subject to any further changes identified

Acronyms used in the Board Assurance Framework

Acronym	Description
AHP	Allied Health Professional
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BSI	British Standards Institution
CAS	Central Alerting System
CBRNe	Chemical, biological, radiological, nuclear, explosive
CFO	Chief Financial Officer
CQC	Care Quality Commission
CYPP	Children and Young People's Plan
DoF	Director of Finance
DPR	Divisional Performance Report
ED	Emergency Department
EoLC	End of Life Care
ePMA	Electronic Prescribing and Medicines Administration
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
eTTO	Electronic To Take Out (medications)
FC	Finance Committee
FIP	Financial Improvement Plan
FM	Facilities Management

Acronym	Description
GIRFT	Getting it Right First Time
HQIP	Healthcare Quality Improvement Partnership
HSE	Health and safety Executive
HSIB	Healthcare Safety Investigation Branch
HSJ	Health Service Journal
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IGAF	Information Governance Assurance Framework
IPC	Infection prevention and control
JAG	Joint Advisory Group
LGBT	Lesbian, gay, bisexual and trans
MEMD	Medical Equipment Management Department
MFFD	Medically fit for discharge
MHRA	Medicines & Healthcare products Regulatory Agency
MSFT	Medically safe for transfer
NEMS	NEMS Community Benefit Services (formerly Nottingham Emergency Medical Services)
OD	Organisational development
PC&IC	People, Culture and Improvement Committee
PCI	People, Culture and Improvement
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-Led Assessments of the Care Environment
PMO	Programme Management Office
PPE	Personal protective equipment
PSC	Patient Safety Committee
PSC	Patient Safety Culture
QC	Quality Committee
QIPP	Quality, Innovation, Productivity and Prevention
SDEC	Same Day Emergency Care
SFFT	Staff Friends and Family Test
SI	Serious incident
SLT	Senior Leadership Team
SOF	Single Oversight Framework
TIAN	The Internal Audit Network
TMT	Trust Management Team
TTO	To Take Out (medications)
UEC	Urgent and Emergency Care
UKAS	United Kingdom Accreditation Service
UKHSA	UK Health Security Agency
WAND	We’re Able aNd Disabled
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Board Assurance Framework (BAF): September 2025

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, which forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – current (residual), tolerable and target levels
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low-risk options; **Cautious** = preference for low-risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance** functions (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales

Key to lead committee assurance ratings:

Green = Significant assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity

- no gaps in assurance or control AND current exposure risk rating = target
  OR
- gaps in control and assurance are being addressed

Amber = Moderate assurance: the Committee is not assured that the current risk treatment strategy fully addresses the gaps in assurance or control

Red = Limited assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

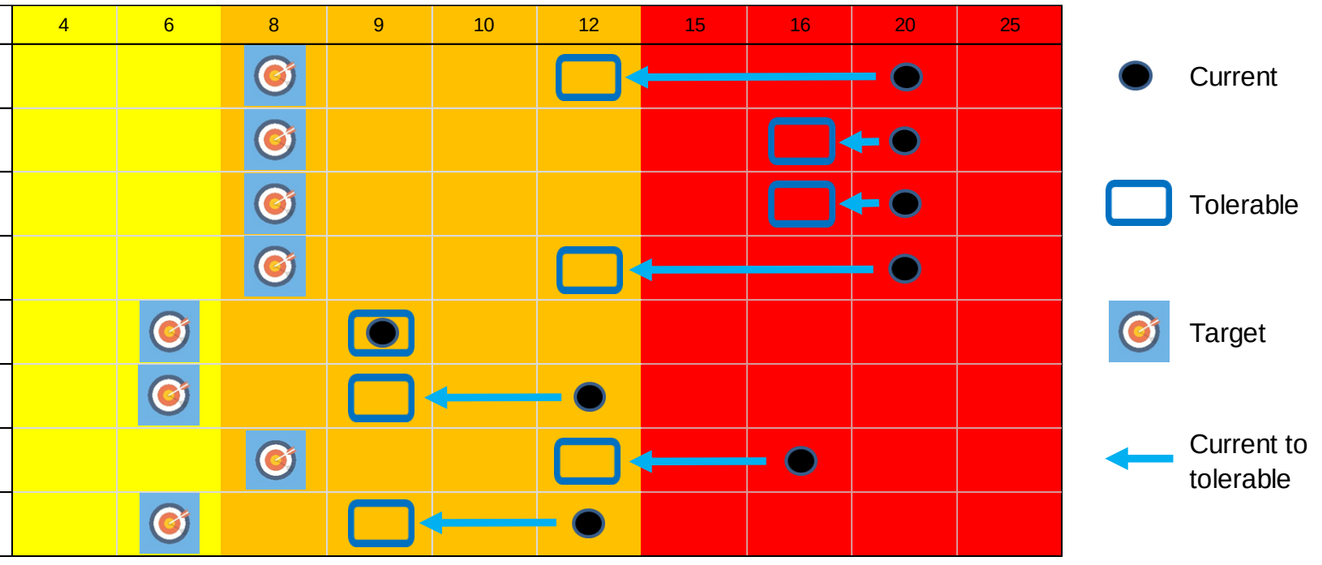
Likelihood score and descriptor

	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 necessarily 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%)

Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating

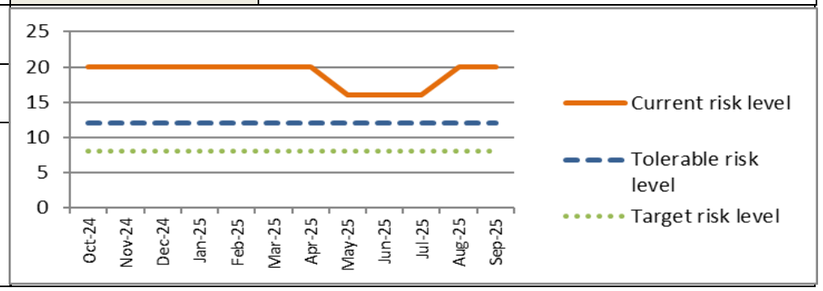
This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities and the risk scores:

		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Chief Medical Officer Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Chief People Officer	People
PR4	**Insufficient financial resources available to support the delivery of services**	Chief Financial Officer	Finance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Chief Medical Officer	Quality
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	Partnerships and Communities
PR7	**Major disruptive incident**	Chief Executive Officer	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance



Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm	
Lead directors	Chief Medical Officer Chief Nurse	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal	
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 5. Very likely	3. Possible	2. Unlikely			
Last reviewed	15/09/2025	**Risk rating**	~~16~~20. Significant	**12. High**	**8. Medium**			
Last changed	15/09/2025							



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to maintain patient safety and quality of care leading to increased incidence of avoidable harm and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ IPR metric reviewed annually and agreed by Board ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Patients Safety Incident Response Framework (PSIRF) ▪ Review, oversight and learning from patient safety incidents Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC quarterly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight	Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care Lack of knowledge and application of skills and behaviour related to the treatment of children and young people Insufficient capacity, particularly beds, to maintain safe standards of care ~~Bi-monthly Quality Committee meetings may not be responsive and agile enough respond to emerging risks~~	Review the existing reporting metrics used to monitor patient safety and identify improvements to ensure consistency of the values used across different reports across governance groups, including the development of a quality dashboard **SLT Lead:** Chief Medical Officer / Chief Nurse **Progress:** Dashboard in ongoing development, but making progress~~delayed due to capacity within the Information Services team~~ **Timescale:** ~~August~~ December 2025 Further development and implementation of the UEC improvement plan, tracked through the Patient Safety Committee **SLT Lead:** Chief Medical Officer / Chief Nurse **Timescale:** ~~September~~ November 2025 Review of bed capacity and conversion of unconventional bed space **SLT Lead:** Chief Medical Officer / Chief Nurse **Progress:** Scoping work completed – ~~further discussion at DLT~~ paper to be presented to TMT **Timescale:** October 2025 Quality Committee members to consider the frequency of meetings and the opportunity to hold ad-hoc meetings to address emerging risks **SLT Lead:** Quality Committee Chair **Timescale:** ~~May 2025~~Complete	**Management:** Learning from deaths Report to Quality Committee and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board quarterly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC - Sepsis report to Quality Committee and Patient Safety Committee quarterly Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports; Digital risks reported to Risk Committee 6-monthly and DSG monthly **Risk and compliance:** Quality Dashboard and IPR to Quality Committee bi-monthly; Quality Account Report qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC quarterly; Significant Risk Report to RC monthly; Exception reporting to System Quality Committee bi-monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services	Palpable harm to staff due to work pressures, and the longevity and impact of the ongoing demands Running at OPEL4 for a protracted length of time and full capacity protocol, exceeding full capacity protocol and system-wide critical incidents Full capacity protocol does not fully address bed capacity requirements during winter, leading to overcrowding in the Emergency Department Financial restraints, including the need to reduce bank and agency spend, may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing The impact of financial restrictions on Corporate teams may result in reduced responsiveness to governance and regulatory requirements Potential impact of industrial action on quality operational performance and finances	Moderate Last changed January 2025

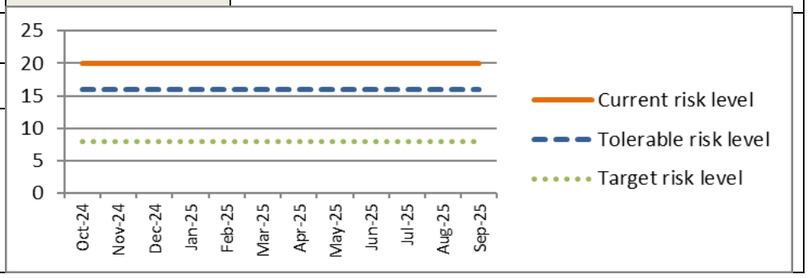
Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
	▪ Digital Strategy Group ▪ Enhanced actions to full capacity protocol			External Accreditation/Regulation annual assessments and reports of: - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)		
An outbreak of infectious disease that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Reintroduction of enhanced respiratory virus testing during winter ▪ Public communications re: norovirus and infectious diseases ▪ Infectious disease identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions	~~FIT mask testing compliance rate below required rate~~ ~~Influenza vaccination uptake is below target levels~~	Increase compliance to target rate **Progress:** Fit Testing Data is now included in Divisional Performance Review Packs Compliance increased, but not yet to target rate, and targeting high-risk clinical areas **SLT Lead:** Director of People / Chief Nurse **Timescale:** ~~May 2025~~superseded – the strategy has been re-assessed to a focus on target FIT testing in higher risk areas Review influenza vaccination programme to understand the reasons for low take-up **Progress:** update to TMT on 23/07/2025 **SLT Lead:** Director of People **Timescale:** ~~August 2025~~Complete	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan; NHSE external review Sep 25 which will be used to support existing action plan		Moderate Last changed March 2025

Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely		
Last reviewed	15/09/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	15/09/2025						

Strategic objective	Provide outstanding care in the best place at the right time



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population and increasing complexity of health needs • Further waves of admissions driven by Covid-19, flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ System programme boards with responsibility for oversight and delivery of transformation programmes that include Frailty, End of Life, Long Term Conditions, and Care Coordination aim at demand management and pathway improvements ▪ UEC Improvement Programme focussing on internal flow, and Getting the Basics Right with internal oversight at the Emergency Care Steering Group ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Emergency admission avoidance schemes across the system under oversight of the Urgent and Emergency Care (UEC) Board and the System Oversight Group ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place ~~(and expanding in winter 2024/25)~~ to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with Nottingham Emergency Medical Services (NEMS) ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework and Full Capacity Protocol ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ SFH annual capacity plan with specific focus on the Winter period via the Winter Planning Group ▪ Referral management systems shared between primary and secondary care ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Planned Care Steering Group with oversight of performance and improvement activities (including work of the Cancer Steering Group) ▪ System support in place (mutual aid) with regular meetings via the System Elective Hub	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our full capacity protocol e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Develop a transformation business case for Geriatrics services **SLT Lead:** Chief Operating Officer **Timescale:** ~~July 2025~~Complete Operationalise the Acute Frailty Unit **SLT Lead:** Chief Operating Officer **Timescale:** October 2025 Undertake an options appraisal to increase bedded capacity at King's Mill Hospital **Progress:** Full appraisal of inpatient bed capacity to be presented to TMT in September **SLT Lead:** Chief Operating Officer **Timescale:** ~~October~~ September 2025	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board ~~quarterly~~ bi-monthly; System Intelligence Report on Urgent & Emergency Care Demand, and Key Programmes of Work, presented to Board Development session Feb 25 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board ~~quarterly~~bi-monthly **Independent assurance:** ~~Performance Management Framework internal audit report Jun 22;~~ Operational Planning internal audit report Jul 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25	Some transformation schemes overseen by the System programme boards are not currently preventing increases in the number of patients presenting to SFH, although we are starting to see early indications of reduced numbers of non-elective admissions Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** throughout 2025	Moderate Last changed September 2024

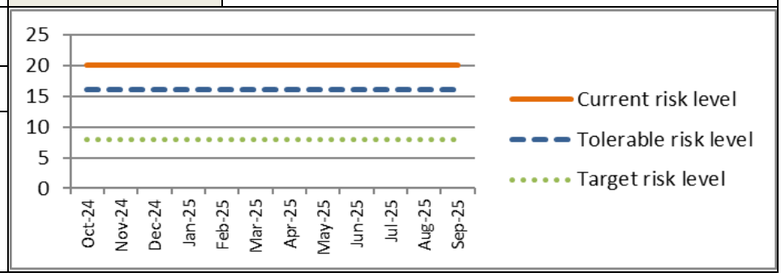
Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Constraints in availability of hospital bed capacity caused by elevated numbers of MSFT (medically safe for transfer) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group ▪ Multidisciplinary Transfer of Care Hub in place that undertakes twice-daily reviews of patients awaiting Nottinghamshire packages of care ▪ Full use of our bed base across our 3 sites with further capacity purchased from Ashmere Group Care Homes (at reduced levels in 2024 and 2025) ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Re-introduction of Discharge Co-ordinators across inpatient wards			**Management:** Daily and weekly themed reporting of the number of MSFT patients in hospital beds - reports into the ICS UEC Delivery Board and ICS Demand and Capacity Group monthly **Risk and compliance:** Exception reporting on the number of MSFT into the Trust Board via the Integrated Performance Report ~~quarterly~~bi-monthly, which is showing ~~positive progress in 2024/25 Q1 and Q2~~a deterioration in the latter stages of 2025/26 Q1 due to a lack of availability in packages of care	Challenges in the provision of the ICS-commissioned transport contract to deliver timely patient discharge Supplement the contract with commissioners with locally commissioned additional transport services **SLT Lead:** Chief Operating Officer **Timescale:** ~~June~~ throughout 2025/26 ~~Emerging risk of~~ lLack of packages of care to meet demand – System conducting a demand and capacity review to inform commissioning	~~Significant~~ Moderate Last changed ~~January~~ July 2025
Failure of Primary Care to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly System Oversight Group meetings across ICS ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan ▪ Nottingham Emergency Medical Services-run 24/7 primary care service within our Emergency Department			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand; ICS reports available on the System Analytical Intelligence Unit portal; System Intelligence Report on Urgent & Emergency Care Demand, and Key Programmes of Work, presented to Board Development session Feb 25	~~Adverse impact due to potential GP collective action~~ Monitor and review the potential impact of GP collective action **SLT Lead:** Chief Operating Officer **Timescale:** ~~Throughout 2025~~Complete Deep dive being undertaken by the ICS into specific identified issues with inequity of same-day GP access – no specific areas of concern identified – complete Shortages in GP provision in PC24 following the removal of additional capacity introduced in March 2025	Moderate No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ System programme boards with responsibility for oversight and delivery of transformation programmes ▪ Engagement in relevant Integrated Care System (ICS) groups/boards ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS ▪ Regular meetings in place with EMAS and commissioners to review and discuss appropriate flow of patients to our hospitals			**Management:** A&E attendance demand report (including post code analysis of ambulance conveyance) to Finance Committee Feb 24, and shared with System partners **Independent assurance:** Weekly reports provided by NHSE Regional Team showing performance against key Urgent and Emergency Care metrics; System Analytical Intelligence Unit (SAIU) Drivers of Urgent Care Demand report Sep 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25; System Intelligence Report on Urgent & Emergency Care Demand, and Key Programmes of Work, presented to Board Development session Feb 25	Lack of control over the flow of patients from the surrounding area, including decisions by EMAS to undertake strategic conveyancing Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** throughout 2025 System discussions under way as part of the 2025/26 planning round relating to shifts in activity across the system – complete – will be picked up again in the 2026/27 planning round	Moderate Last changed January 2025

Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care						
Lead committee	People	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Chief People Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely		
Last reviewed	16/09/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	16/09/2025						

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



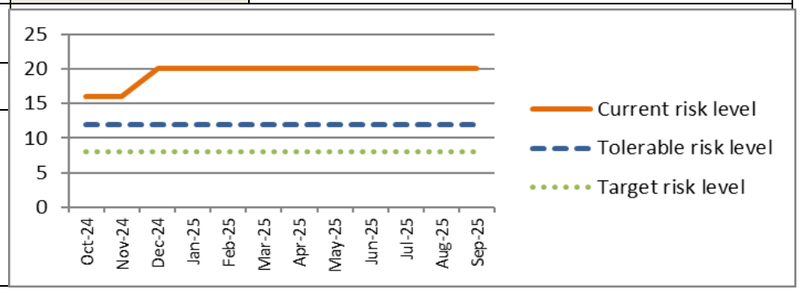
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Activity, Workforce and Financial plan ▪ 5-year strategic workforce plan supported by associated Tactical People Plans ▪ ICS People and Culture Strategy (2019 to 2029) and Delivery Group ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Medical Transformation Board ▪ Nursing & Midwifery Transformation Board ▪ ICB Agency Reduction Group ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Communication of daily SitReps (Situation Reports) for workforce gaps ▪ CDC Workforce Group ▪ CDC Steering Group ▪ People Promises Exemplar Organisation ▪ Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, which may impact on the quality and standard of care Lack of consistency across the system about recruitment and retention, creating competition and not maximising opportunities Fragile services, including workforce gaps, in some services/specialties	Deliver the 2025-28 People Strategy – Year 1 **SLT Lead:** Chief People Officer **Timescale:** March 2026 Develop processes to minimise the use of premium pay and deliver the agreed workforce plan expenditure and whole-time equivalent reduction **SLT Lead:** Chief People Officer **Timescale:** March 2026 Develop a Clinical Services Strategy, including an associated workforce plan **SLT Lead:** Chief Medical Officer **Timescale:** December 2025	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to People Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People and Culture to People Committee; Recruitment & Retention report monthly; Strategic People Plan to People Committee May24; Employee Relations Quarterly Assurance Report to People Committee; People Plan updates to People Committee bi-monthly; Leadership Development Strategy Assurance Report to People Committee quarterly; NHSE Planning – Workforce Perspective Report to People Committee May 24, Strategic Partnership Compact SFH & WNC Mar 25 **Risk and compliance:** Risk Committee significant risk report monthly; HR & Workforce planning report Risk Committee; IPR – Workforce Indicators to People Cabinet (monthly) - quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Recruitment of agency staff audit report Jun 23; Appraisals internal audit report Jun 24	Impact on staff of the Trust workforce financial efficiency programme Consideration of the impact on our people to form part of the implementation of the workforce plan **SLT Lead:** Chief People Officer **Timescale:** ~~May 2025~~Complete Support teams across the Trust to deliver the workforce plan and the potential associated impact on staff morale **SLT Lead:** Chief People Officer **Timescale:** March 2026 Potential impact of an anticipated decline in staff survey results, resulting in reduction of staff retention, recruitment and organisational reputation Potential impact of industrial unrest due to the job matching and profile review for Nursing and Midwifery staff Engage with regional groups to ensure consistency of approach principles **SLT Lead:** Chief People Officer / Chief Nurse **Timescale:** March 2026	Moderate Last changed September 2024

Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Wellbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community ▪ Winter Wellness Campaign ▪ Sexual safety working group ▪ Violence Prevention and Reduction Working Group	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users ~~Influenza vaccination uptake is below target levels~~ Cultural concerns in theatres highlighted in the cultural review undertaken by Value Circle	Include actions to address inequalities in staff inclusivity within the new People Strategy **SLT Lead:** Director of People **Timescale:** ~~April 2025~~Complete Implement the WRES and WDES action plans **SLT Lead:** Chief People Officer **Timescale:** March 2026 Revise and implement the Violence Reduction and Prevention action plan **SLT Lead:** Chief People Officer **Timescale:** ~~September 2025~~Complete Revise the ToR for the Violence Reduction and Prevention Working Group to incorporate both clinical and people elements of the plan **SLT Lead:** Chief People Officer **Timescale:** December 2025 Review the influenza vaccination programme to understand the reasons for low take-up **SLT Lead:** Chief People Officer **Timescale:** ~~September 2025~~Complete Detailed action plan to be developed and monitored by an assurance group chaired by a non-Executive Director **SLT Lead:** Chief Nurse **Timescale:** March 2026	**Management:** Staff Survey Action Plan to Board Apr25; Staff Survey Annual Report to Board Apr25; Equality and Diversity Annual Report Jul 24; WRES and WDES report to People Committee Jul 24; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, Committee Mar 24; People Plan updates to People Committee quarterly; Leadership Report to People Committee Jul 24; Diversity in the Trust – Senior Leadership Roles report to People Committee May 24; Violence and Aggression Improvement Plan update to People Committee Mar 25; Sickness deep dive to People Committee Mar 25 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Jul 24; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to People Committee Mar 25; NHS Long Term Workforce Plan to People and Culture Committee Sep 23 and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar24; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22; Staff Wellbeing internal audit report Jan 24	Potential impact of cost-of-living issues, and the impending job matching and profile review for Nursing and Midwifery staff, on staff morale and wellbeing Impact on staff morale and engagement, potentially leading to increased sickness levels, due to increasing capacity and demand issues, and perceived reduction in resources to undertake roles Develop and implement a Staff Survey Action Plan **SLT Lead:** Chief People Officer **Timescale:** ~~September 2025~~Complete Develop a communications plan to engage the workforce regarding the current financial and operational challenges **SLT Lead:** Chief People Officer **Timescale:** ~~September 2025~~Complete Continued concerns over sexual safety in the workplace Implement the 10 principles of the NHS Sexual Safety Charter SLT Lead: Chief People Officer Timescale: December 2025 Potential industrial action, including strike action, of resident doctors Review plans to address potential workforce gaps in the event of strike action **SLT Lead:** Chief People Officer / Chief Medical Officer **Timescale:** ~~July 2025~~Complete	Moderate Last changed March 2025

Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Insufficient financial resources available to support the delivery of services** Financial funding allocated to and generated by the Trust does not cover the costs of services provided							**Strategic objective**	Sustainable use of resources and estate
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
Lead director	Chief Financial Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	3. Possible	2. Unlikely				
Last reviewed	23/09/2025	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**				
Last changed	23/09/2025								



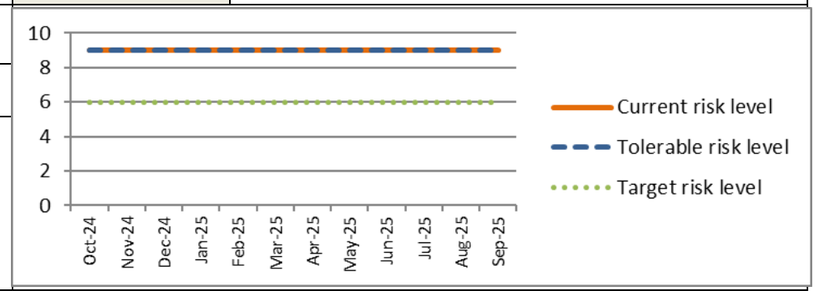
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Regulatory action due to a failure to deliver NHS England financial targets	▪ 2025/26 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return, monthly regional finance lead meetings, and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established ▪ Financial Resources Oversight Group (FROG) meeting monthly ▪ Executive level Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Financial Recovery Cabinet (monthly) meetings		Review of NHSE 2025/26 Financial Management expectations tools, interventions and oversight guidance **SLT Lead:** Chief Financial Officer **Timescale:** October 2025	**Management:** Monthly Finance Report to Finance Committee ~~Quarterly~~; Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); NHSE updates to Finance Committee; Monthly ~~variable pay~~efficiency programme reports to Financial Recovery Cabinet; divisional representation at Finance Committee on a cyclical basis~~; Financial Efficiency reports to Executive Team weekly~~ **Risk and compliance:** **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2023/24 NHSE Performance Assessment Framework and Risk of Non-Delivery Assessment (RONDA) Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Key Financial Systems – Pay Expenditure (Jul 23) - Financial Governance - Financial Ledger and Reporting (Mar-24) - Budget Setting, Reporting and Monitoring (Jun-24) - Operational Planning (Jun-24) - Financial Improvement Plan – Efficiency & Productivity (Jun-24) - System Financial Controls (Jun-24)	2025/26 Financial Plan includes a number of challenges and risks, including under-developed efficiency plans. The plans require de-risking in 2025/26 Quarter 1 **Progress:** Financial Efficiency Delivery & Sustainability team established and work-programme in development De-risking exercise continues to reduce the risk-adjusted forecast gap PA Consulting engaged to support this work **SLT Lead:** Chief Financial Officer **Timescale:** ~~July~~ November 2025	Moderate Last changed January 2025
Cash availability leads to delays in paying suppliers and workforce	▪ Daily cash flow forecasts prepared ▪ Cash Management Policy to protect cash balances and establish prioritisation of payments ▪ NHS England process followed to access Revenue Support PDC ▪ Regular liaison with NHSE to support cash applications ▪ Financial ~~Improvement~~Efficiency Programme in place to deliver cash-releasing efficiencies ▪ Budgetary control processes and Scheme of Delegation in place to prevent overspends ▪ No Purchase Order, No Pay policy in place ▪ Escalation process to CFO/Deputy CFO for suppliers indicating restrictions on supply ▪ Weekly creditors report reviewed by Deputy CFO ▪ Risks relating to the cash position reported to Risk Committee monthly		NHSE Cash support guidance received late August. Review of requirements and cash forecast scenario and sensitivity analysis to be completed **SLT Lead:** Chief Financial Officer **Timescale:** September 2025	**Management:** Monthly Finance Report to Finance Committee includes details on cash flow, debtors and creditors **Independent assurance**: NHS England Financial Controls Assessment (Sep 23) Internal Audit reports: - Key Financial Systems – Accounts Payable and Treasury and Cash Management (Mar-24) - Financial Governance – Financial Ledger and Reporting (Mar-24)	Limited access to additional cash support Develop and gain approval of a cash management plan for 2025/26 **Lead:** Chief Financial Officer **Timescale:** ~~May 2025~~ Completed – presented to May-25 Finance Committee Internal Audit on Cash Management scheduled for 2025/26 Q2 **SLT Lead:** Deputy Chief Financial Officer **Timescale:** January 2026	Moderate Last changed May 2025

Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
ICB system financial performance challenge leads to disinvestment in SFH	▪ 2025/26 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ICS Financial Recovery Group meeting weekly ▪ ICS System ~~Opportunities~~ Delivery & Efficiency Group meets bi-weekly, with SFH representation ▪ ICS Operational Finance Directors Group established and attended by SFH Deputy Chief Financial Officer ▪ ICB Financial Framework ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions	2025/26 NHS Standard Contract not yet signed between SFH and ICB	NHS Standard Contract to be signed by all parties, providing security on financial flows and expected service delivery. Progress: Contract negotiation meetings ongoing. **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~June~~ September 2025	**Management:** Income Maximisation Programme established and reporting into Financial Recovery Cabinet **Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun 24)		Moderate Last changed January 2025
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks ▪ Approved 2025/26 Capital Expenditure Plan	~~2025/26 Capital Expenditure Plan requires Finance Committee and Board approval~~	2025/26 Capital Expenditure Plan requires Finance Committee and Board approval Progress: ~~2025/26 Capital Expenditure Plan on the agenda for approval at Finance Committee (May 2025) and Board (June 2025).~~ Approved (Board June-25) **SLT Lead:** Chief Financial Officer **Timescale:** ~~June 2025~~Completed	**Management:** Board approved ~~2024/25~~2025/26 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team; Divisional risk reports to Risk Committee (bi-annually); Monthly Finance Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report **Independent assurance**: Capital Int'l Audit report Jul 24 Capital Audit Report (May-25) – Limited Assurance	Recommendations and actions arising from Capital Internal Audit Report to be completed to agreed timescales~~.~~ **Progress:** On-Track **SLT Lead:** Chief Financial Officer **Timescale:** ~~August 2025~~Complete	Moderate Last changed May 2025
Reliance on non-recurrent funding and efficiencies threatens long-term sustainability of services	▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Financial Efficiency Delivery & Sustainability team established to support the delivery of efficiency schemes ▪ Weekly Financial Efficiency ~~update report to the Executive Team (and Monthly to Trust Management Team), detailing recurrent and non-recurrent savings~~ programme governance structure in place to ensure SRO focus on efficiency and sustainability ▪ Financial Recovery Cabinet in place to support longer-term decision making ▪ ~~-~~Financial Strategy in place with longer-term priorities	Current operational plans only cover the period to March 2026	Medium-term financial plan to be developed, to cover 36-month period. **SLT Lead:** Deputy Chief Financial Officer **Timescale:** March 2026	**Management:** Monthly Finance Report to Finance Committee includes details on financial efficiency; Divisional Performance Reviews (bi-monthly); Divisional risk reports to Risk Committee bi-annually; Improvement Cabinet highlight reports to Trust Management Team and Finance Committee **Independent assurance**: Internal Audit reports: - Improving NHS financial sustainability (Dec-22) - Financial Improvement Plan – Efficiency and Productivity (Jun-24)	2025/26 Financial Plan includes a number of challenges and risks, including under-developed efficiency plans. The plans require de-risking in 2025/26 Quarter 1 **Progress:** Financial Efficiency Delivery & Sustainability team established and work-programme in development De-risking exercise continues to reduce the risk-adjusted forecast gap PA Consulting engaged to support this work **SLT Lead:** Chief Financial Officer **Timescale:** ~~July~~ November 2025	Significant New threat added July 2024

Board Assurance Framework (BAF): September 2025

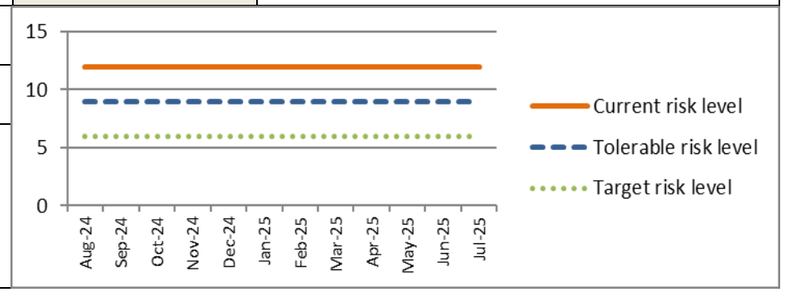
Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of capacity, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective**	Continuously learn and improve
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Chief Medical Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	15/09/2025	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	15/09/2025								



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of embedded improvement culture across the Trust resulting in suboptimal efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy – overview of strategic digital improvement ▪ People Strategy – overview of strategic people development ▪ Quality Strategy – overview of strategic quality development ▪ Quality Committee - Executive Director oversight on all aspects of quality (including quality improvement) ▪ Leadership development programmes - opportunity for Trust leaders to gain improvement skills ▪ Talent management map ▪ ~~Strategy & Partnerships~~ Chief Medical Officer Cabinet – Executive Director oversight on all aspects of Improvement activity ▪ Ideas generator platform - easy-to-access mechanism to seek improvement support and advice ▪ Improvement Faculty - Single point of contact for all colleagues seeking improvement support ▪ Financial Recovery Cabinet - Provides Executive Director oversight on all aspects of financial improvement activity ▪ Trust Board 'Improvement Showcase' - Increased awareness of improvement activity and sharing of good practice ▪ Quality, Service Improvement and Redesign Networks and Service Level Quality Improvement Leads - informal forums to share knowledge, skills and experience	Continuous Quality Improvement Strategy not yet approved	Develop a process for clinical input for public and colleague engagement in improvement and transformation activities **Progress:** Process under development with the support of key stakeholders Recruited to key roles to support the process and plans in place to complete the documented process. To be reviewed to encompass the pending recommendations in the Darzi report ~~Funding for 8 clinical PAs identified – expressions of interest to be communicated – interviews held 20/05/2025~~3 clinical transformation leads appointed **SLT Lead:** Chief Medical Officer **Timescale:** ~~May 2025~~January 2026 Develop and roll out a Continuous Improvement Strategy **Progress:** ~~Paused until the new structure is in place~~We will now commence the development of a Continuous Quality Improvement Strategy **SLT Lead:** Chief Medical Officer **Timescale:** ~~September~~ November 2025	**Management:** Monthly ~~Transformation and Efficiency report to FC;~~ Improvement report to Quality Committee bi-monthly; NHS Impact Self-Assessment **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:** ~~Financial Improvement Plan – Efficiency and Productivity internal audit Jul 24~~	~~Strategy & Partnerships Cabinet to be discontinued~~ Improvement Faculty now sits under the Chief Medical Officer's portfolio – governance arrangements to be reviewed **SLT Lead:** Chief Medical Officer **Timescale:** ~~September 2025~~Complete Develop and implement a CMO Cabinet to be the forum where decisions relating to Quality Improvement developments will be made **SLT Lead:** Chief Medical Officer **Timescale:** ~~September 2025~~ Complete Availability and capacity of staff to undertake improvement activities due to financial and vacancy controls, MARS and operational pressures Independent external review to be commissioned to determine the required model of Quality Improvement Support for the Trust based on priorities and expectations **SLT Lead:** Chief Medical Officer **Timescale:** October 2025	Moderate Last changed October 2022

Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with health, care and educational partners, does not deliver the Trust's Improving Lives strategic objectives**							**Strategic objective**	Work collaboratively with partners in the community
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	21/07/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	21/07/2025								



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)		**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Competing priorities within SFH could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Alignment of Trust's Strategy with the ICS Joint Forward Plan ▪ Clinical Services Strategy established guiding principles and priorities ▪ Partnership Strategy and delivery plan with oversight on delivery by Strategy and Partnership Cabinet ▪ People Strategy identifies key people partnership priorities and priority partners ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Partnership database and annual evaluation ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ ~~Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure~~ ▪ NUH/SFH Committee in Common oversees partnership working between the two trusts, supported by the Acute Services Oversight Group ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group			**Management:** Strategy and Partnership Cabinet chair's report to PCC Provider collaborative effectiveness updates to PCC Partnership Delivery Plan updates to Strategy and Partnership Cabinet Supporting strategy reporting to relevant sub committees 6-monthly MNPBP highlight reports to Health Inequalities Steering Group quarterly Monthly HISG chair's report to Strategy and Partnership Cabinet **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance			Significant Threat updated August 2024

Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)		**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
	▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities and agreed actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources						
Competing priorities within our partners could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ ~~Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure~~ ▪ NUH/SFH Committee in Common oversees partnership working between the two trusts, supported by the Acute Services Oversight Group ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities, aligning resources and agreeing actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership			**Management:** Partnership Delivery Plan updates to Strategy and Partnership Cabinet MNPBP highlight reports to Health Inequalities Steering Group as appropriate HISG chair's report to Strategy and Partnership Cabinet Monthly highlight reports from Notts Provider Collaborative to SFH executive lead East Midlands Acute Providers monthly update reports to EMAP Executive Group **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance			Significant Threat updated August 2024

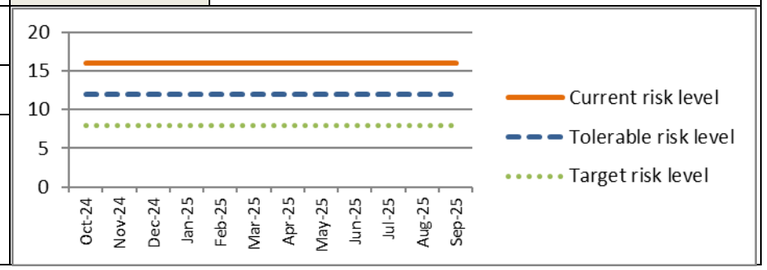
Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)		**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
	▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources ▪ Formal partnership arrangements with Vision West Notts College and Universities of Nottingham						
Limited SFH partnership engagement capacity could result in a missed opportunity to bring in a wider patient and citizen voice to shape future healthcare services	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the Mid-Nottinghamshire PBP (MNPBP) and the district level Place Boards. ▪ ICS Clinical Services Strategy and Quality Strategy set priority re coproduction and personalised care ▪ ICS Health and Equality Strategy ▪ Nottingham and Nottinghamshire Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ SAIU dashboards and themed reports to focus on key priority areas for inputs and provide assurance of outputs and outcomes ▪ Clinical Directors and PCN Directors clinical partnership working ▪ Partnerships and Communities Committee (PCC) oversees delivery and receives assurance ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ SFH Health Inequalities Steering Group (HISG) linked to Mid Notts Health Inequalities Oversight Group to build relationships, share population health information and agree priorities and ICS Health Inequalities Steering Group, which facilitates sharing of patient/citizen voice and provides oversight of delivery			**Management:** Strategy and Partnership Cabinet chair's report to PCC Partnership Delivery Plan updates to Strategy and Partnership Cabinet Supporting strategy reporting to relevant sub committees MNPBP highlight reports to HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet **Independent assurance**: None currently in place			Significant Threat updated August 2024

Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Chief Executive Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely		
Last reviewed	09/09/2025	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	09/09/2025						

Strategic objective	Provide outstanding care in the best place at the right time

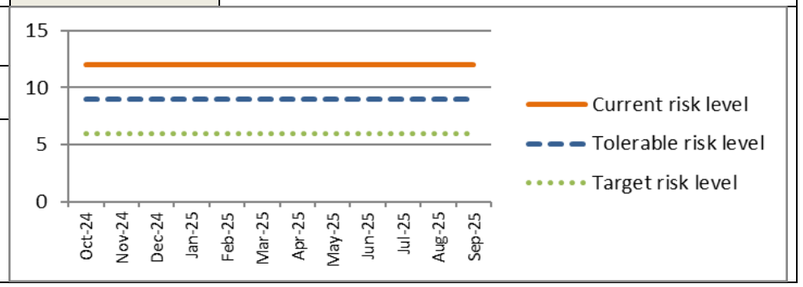


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & ~~NHIS~~ ICS-wide Cyber Security Strategy ▪ Cyber Security Assurance Programme Board & Cyber Security ~~Project~~ Delivery Group and work plan ▪ National Cyber Security Centre updates to Cyber Delivery Group ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after ~~50~~30 days of inactivity – disabled after ~~80~~60 days if not used ▪ Devices that have failed to take the most recent security patch checked after 21 days of inactivity – disabled after 28 days ▪ Major incident response plan in place ▪ Periodic phishing exercises carried out by the IG Team ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead ▪ Common approach to cyber security vulnerability across the ICS ▪ Medical equipment cyber screening tool		Implementation of Maple (logging monitoring system) **SLT Lead:** Director of NHIS **Timescale:** September 2025 Implementation of ControlUp (network health tool) **SLT Lead:** Director of NHIS **Timescale:** September 2025 Connection to the National Cyber Security Centre to enable real-time monitoring of devices on our systems **SLT Lead:** Director of NHIS **Timescale:** September 2025	**Management:** Data Security and Protection Toolkit submission to Board Jul ~~23~~24 - compliant on all 113 elements; DSPT updates to Information Governance Committee bi-monthly and Risk Committee 6-monthly; Hygiene Report to Cyber Security Board bi-monthly; Cyber Security Assurance Highlight Report to Cyber Security Board bi-monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; ~~Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine Mar 22;~~ NHIS Cyber Strategy approved at DSG May 24; ICS Cyber Strategy to Board Nov 24 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar 24; 360 Assurance Data Security and Protection Toolkit audit Jun ~~23~~25– ~~moderate~~ high assurance; Cyber Essentials Plus accreditation (NHIS) Dec ~~23~~24	NHS-targeted cyber-attacks continue to be increased and there are inherent risks which are almost impossible to mitigate	Limited Last changed January 2025
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Policy ▪ Health Technical Memorandum governance structure ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) and other HTM Specialties ▪ Major incident response plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report to Risk Committee; Fire Safety reports to Risk Committee quarterly **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance:** Centre of Best Practice Survey (ARUP) reported to Risk Committee within the periodic Fire Safety Reports	Inconclusive evidence of buildings cladding and structures compliance with fire regulations Determine the remedial work required to ensure that the cladding is compliant with fire regulations **Progress:** It has now been agreed by Project Co. that the existing cladding will be replaced in full, programme currently being updated to take into account the new Building Safety Act (BSA). ~~Program is on track due for completion June 2025~~(BSA approval still awaited) – decision extended by 2 months **SLT Lead**: Director of Estates & Facilities **Timescale:** ~~June~~October2025	Moderate Last changed March 2024

Board Assurance Framework (BAF): September 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
					Trust actions required from the ARUP Milestone 2 (Fire) Report **Progress:** An overarching risk assessment produced for each site highlighting the common themes/issues that have come out of the draft report and to be discussed with all areas. Risk assessment to be updated following further works **SLT Lead**: Director of Estates & Facilities **Timescale:** ~~June 2025~~Complete	
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, ICS, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies, including new Business Continuity Management system ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident response plan in place ▪ Industrial Action Group ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three-yearly internal audit of EPRR arrangements with report to Board ▪ Incident Response and command and control training to all tactical and strategic leads across the organisation carried out annually ▪ Testing and exercising of service level plans carried out annually ▪ Health Risk Management Group for EPRR			**Management:** Monthly Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating 2024 – Substantial Compliance; EPRR Business Continuity internal audit report Nov 24 – Significant assurance; CBRN Audit carried out in March 2024 by EMAS		Significant New threat added May 2023

Board Assurance Framework (BAF): September 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable							**Strategic objective** Improve health and wellbeing within our communities
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action	
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious	
Initial date of assessment	22/11/2021	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely			
Last reviewed	23/09/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**			
Last changed	29/07/2025							

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community (may be due to capacity and/or capability)	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Operational Group (SDOG) and Sustainability Development Strategy Group (SDSG) ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support ▪ Process in place for gathering and reporting statistical data ▪ Adoption of NHS Net Zero building standard 2023 for all works ~~from October 2023~~ ▪ Awareness to, and applications for, funding sources both internally and externally such as the Public Sector Decarbonisation Scheme and grants from Salix Ltd ▪ Annual Travel Survey ▪ Display energy certificates ▪ Building Research Establishment Environmental Assessment Methodology ▪ Net Zero Strategy ▪ Regular updates through Comms on the screen savers (included lighting, bees, waste etc.) ▪ Sustainability funding bidding process (including Public Sector Decarbonisation Scheme and NHS Energy Efficiency Fund)	Insufficient capital resource available to realise Trust ambition Support from our PFI partners in developing 'green' solutions	PFI Partners: Engage with our PFI provider and relevant parties to develop a combined energy reduction plan associated with the financial close out of the deed, retained estate upgrades, lifecycle developments and how all these aspects will support SFH in its energy/sustainability targets. **Progress:** Awaiting PFI settlement & changes in Skanska personnel **Lead:** Sustainability Officer **Timescale:** ~~June 2025~~Complete Continue to work with partners to maximise opportunities for green solutions for life-cycle replacements in both the retained areas and the PFI estate **Lead:** Director of Estates and Facilities **Timescale:** throughout 2025/26	**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Implement the schemes we have in place for 2025/26 to help to reduce our energy consumption including LED lighting, building management system controls and smart metering **Lead:** Sustainability Officer **Timescale:** October 2025 Refreshing of the Green Plan following new guidance from NHSE – strategy being developed **Lead:** Sustainability Officer **Timescale:** September 2025	Moderate Last changed December 2023

Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

Audit and Assurance Committee Chair's Highlight Report to Board of Directors

Subject:	Audit and Assurance Committee Chair's Highlight Report	**Date:**	02/10/25
Prepared By:	Laura Webster, Corporate Secretariat Team Leader (via Copilot production)		
Approved By:	Manjeet Gill, Committee Chair / Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Manjeet Gill, Committee Chair		
Purpose:			
To provide the Board with a clear, concise summary of key issues, assurances, risks, decisions, and actions arising from the Audit & Assurance Committee meeting held on 29th September 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
The Committee escalated for action the assurance gap and resourcing decision for the Electronic Patient Record (EPR) programme; this has been escalated to the Board, with Risk Committee consideration deferred to October and a verbal update expected. The Committee also noted rising operational pressures across emergency care and maternity, compounded by workforce caps and financial constraints; principal risk PR1 was increased to a significant risk (score 20), with PR2 remaining significant. Medical staffing (agency/locum) received a limited assurance internal audit rating with four high-risk actions; the Committee commissioned further scrutiny (see actions) and agreed referral to other committees. Healthcare Support Worker vacancies (circa 120) were noted as causing unsafe staffing; the Committee requested ongoing oversight via the People Committee and triangulation with Quality Committee where appropriate.	The Committee agreed that Internal Audit's limited assurance report on medical staffing (agency/locum) will return to Audit & Assurance in December with the Chief Medical Officer present; in parallel it should be considered by the People Committee (and triangulated with Quality Committee) to ensure comprehensive oversight of controls and mitigations. The EPR programme risk will be taken verbally to the October Risk Committee; the Audit & Assurance Committee requested a progress reminder and update at its next meeting. On financial systems, management will bring the SBS financial ledger implementation and migration plan (target go-live 1st April 2026) to the Committee following discussion at the forthcoming Board (private) session, to provide detailed assurance on controls and governance during transition. On procurement and single tender waivers (STWs), management will submit in November a combined report covering (i) all contracts >£250k (including insourcing/outsourcing and Channel 3 consultancy spend linked to EPR) and (ii) an overarching

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

	due-diligence and contract-management assurance report. The Clinical Procurement Engagement Group will review the Hologic contract in good time before renewal. Future STW reports will separately identify NHS contracts. For outstanding audit actions on fire safety, revised due dates will be set; while delays relate to documentation alignment, this is **not** assessed as a significant safety or regulatory risk and remains under active Risk Committee oversight. External Audit has commenced planning; KPMG's NHS update paper was circulated on the day and will be tabled for discussion at the next Committee. Early dialogue was requested on managed equipment service accounting to avoid adverse impacts on metrics. Conflicts of Interest compliance continues to be actively managed: non-compliant declarations reduced materially since July; personal statements will be sought from persistent non-compliers. The Corporate Secretariat team is overseeing the bespoke system that triggers automated emails to colleagues who remain non-compliant with Conflicts of Interest requirements.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Internal Audit reported significant assurance for both e-rostering and tissue viability (pressure ulcers); e-rostering included one medium and three low-risk actions, and ward manager feedback was largely positive. The first-time implementation rate for internal audit actions improved to 78% (from 68% in 2024/25), meeting the Head of Internal Audit threshold (>75%) and evidencing strengthened follow-up. On conflicts of interest, non-compliant staff reduced from 606 in July to 106 at the time of reporting (six on long-term absence), reflecting sustained effort and targeted follow-up.	The Committee noted and supported the increase of PR1 to significant risk (score 20), with PR2 remaining significant; PR4 and PR8 remained unchanged. It agreed to; (i) receive the SBS ledger migration implementation plan for assurance; (ii) route the medical staffing limited assurance report to People Committee as well as back to Audit & Assurance in December (and triangulate with Quality Committee work on e-rostering and workforce pressures); and

Losses and special payments were scrutinised with clear rationale: total £57,822 for July–August 2025 (principally one redundancy just under £30k and overseas patient write-offs of £19k across nine cases), with evidence of appropriate controls and cost-effectiveness tests. STWs reduced to three for the period; rationales were evidenced (e.g., warranty-linked OEM maintenance; VAT consultancy continuity; and a direct award for Orion yielding >£2k discount versus framework pricing), with further system-level collaboration opportunities being explored.	(iii) receive in December the combined contracts-over-£250k and due-diligence/contract-management assurance reports.

Comments on effectiveness of the meeting

Members considered the meeting effective, supported by high-quality pre-reads, comprehensive management presentations, and efficient chairing. The Committee concluded that Audit & Assurance continues to function as a central forum for directing deeper scrutiny to sub-committees on cross-cutting risks (workforce, quality, finance) while maintaining appropriate focus on assurance and internal control.

Items recommended for consideration by other Committees

The Committee requested the People Committee to oversee (i) the medical staffing limited assurance actions and (ii) the wider workforce position, including Healthcare Support Worker vacancies and the balance between financial constraints (including bank/agency controls) and safe staffing, with updates back to Audit & Assurance. Quality Committee triangulation was endorsed where clinical risk is engaged. The Risk Committee will take a verbal update on the EPR programme risk in October and maintain oversight of fire safety actions.

Progress with Actions

The Committee reviewed its action tracker. Several items were carried forward to December, including circulation of the stock-take policy implementation update, the combined >£250k/due-diligence procurement reports, and the update on the external audit procurement process (noting governors' involvement).

Number of actions considered at the meeting – 7
Number of actions closed at the meeting – 1
Number of actions carried forward – 5
Any concerns with progress of actions – No

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

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 Meeting (Deep Dive)	**Date:**	26th August 2025
Prepared By:	Richard Cotton, Finance Committee Chair		
Approved By:	Rich 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) meeting of 26th August 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• The position at Month 4 is £0.4m worse than the budget of a planned surplus of £0.5m. The cumulative YTD position is also £0.4m worse than the budgeted £1.3m planned deficit. • The YTD position reflects adverse revenue and net cost effects of Industrial Action during Month 4. In addition, it reflects a £3.6m shortfall in the financial efficiency program, and a £0.5m shortfall in planned revenue. • The YTD shortfall is offset by the release of £2.5m of non recurring provisions to income to partially offset the adverse operational performance. • Income is behind budget by £0.5m, partly due to Industrial Action. However whilst the Trust is currently operating at Opel 4, this will not result in increased revenue as this is funded through block contracts, though will almost certainly result in additional costs. • Whilst the FY forecast anticipates achievement of Budget, the YTD shortfall position adds further risk to the challenges already embedded in the Budget.	• Management (Finance and HR) are modelling workforce WTE trajectory and pay cost scenarios and will present an interim update at the Board meeting on 4 September on potential actions to enable achievement of Budget, the achievement of a headcount run rate of 5555 WTE's at 31 March 2026, and to model what would be required to remove the need for deficit support funding.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
• Good progress is being made in the reduction of Bank (28% YTD reduction vs 15% target) and some progress in the reduction of Agency (36% YTD reduction vs 40% target). • At Month 4 the cash position is £14.85m, helped by capital inflows, however this surplus position is expected to unwind in the next 2-3 months. • The Committee was briefed on Productivity metrics for the Trust, and how these compare to NHS benchmarks. These KPI's will be progressively integrated into management reporting and decision making. • The project to market test the provision of soft FM has commenced.	• Approval request papers were presented, debated and approved for the extension of the Allocate Contract, the MRI Contract, and the EPR hardware infrastructure and EPR Partnership. • An approval request paper was presented, debated and approved in principle for the migration of the Trust's ledger system. **The implementation details, planning, timing and associated risks need significant detailed work, and will be submitted for further approval before the project starts.** • The BAF was reviewed in light of the current performance and PR4 (Finance) was left unchanged at 20 (target 8) reflecting the continuing heightened state of risk in the Trust's financial operations. PR8 (Sustainability) was left unchanged at 12 (target 9).

Comments on effectiveness of the meeting

- Papers were of a high quality and circulated in a timely fashion. Papers were well presented, and there was a good quality of debate and scrutiny.
- ICB Joint CFO Bill Shields attended and made some helpful observations on a variety of matters under review.

Items recommended for consideration by other Committees

- Workforce modelling considerations to be closely monitored by People Committee in addition to Finance Committee.

Progress with Actions

Please answer the following regarding progress on actions:

Number of actions considered at the meeting - 14
Number of actions closed at the meeting – 13
Number of actions carried forward – 1
Any concerns with progress of actions – No

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)	**Date:**	24th September 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 24th September 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• The position at Month 5 is a surplus of £0.02m, £0.57m worse than the budgeted planned surplus of £0.59m. The YTD deficit of £1.66m is also £0.98m worse than the budgeted £0.68m planned deficit. • The YTD position reflects adverse revenue and net cost effects of Industrial Action during Month 4. It also reflects a £4.14m shortfall in the financial efficiency program, and a £0.5m shortfall in planned revenue. • Whilst the FY forecast anticipates achievement of Budget, the YTD shortfall position adds further risk to challenges already embedded in the Budget, partly offset by new mitigation actions. • At M5, Cash at bank was £13.50m, due to capital and working capital timing – this positive balance is expected to unwind between now and 31 December to almost nil. • The FC noted the potential risk of removal of Deficit Support Funding as a sanction against the whole of the Nottinghamshire ICS, due to the adverse variance to plan reported for the system overall.	• Management (especially Operations, Finance, HR) are modelling workforce WTE trajectory and pay cost scenarios to target a break-even run rate at the end of March 2026, without the need for deficit support funding in 2026/27. This was developed at M4 and updated to M5. The executive team are in the process of developing organisational structures and manning to achieve this. • The Finance Committee applauded and encouraged the Executive team to keep advancing this initiative apace, and 'to put more flesh on the skeleton' of how this could be achieved operationally and financially. The core principle was reinforced of needing to design services which align with the Trust's financial constraints, as opposed to the other way around. • The Committee reinforced the need for thorough implementation planning and process mapping with regard to the transition to a new ledger, and asked for a proposal from management of key milestones to come back to the Committee for further project advancement approval.

• FC noted the £562k YTD adverse variance to plan in Women and Children Division in a presentation from the Divisional Leadership Team, and initial views on mitigation actions.	• Cash flow forecast risks and sensitivities were requested for review at the October FC meeting. • FC encouraged Management to maintain a high level of exposure of Trust remediation planning / Deficit Support avoidance actions within the ICB, Region and NHSE.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• FC received encouraging presentations on Finance and Workforce Planning (see above – 'commissioned') and on PA Consulting CIP support. On the latter, FC acknowledged the support and Operations / management engagement around PA's work in some challenging workshops and modelling exercises. • FC recognised and welcomed the recently introduced additional Grip and Control measures. • FC welcomed the embryonic planning framework changes from NHSE, moving to a multi-year exercise, potentially enabling longer range planning than currently. • Surgery DGM presented initial updates on Theatres Utilisation assessment, and the FC noted the poor historic performance, recent improvement and opportunity for further major improvements in this area, as well as current initiatives to realise these. • HR presented a paper on Band 4-9 Nursing Profiles review, and whilst welcoming the approach and potential greater alignment of banding / skills recognition for staff, FC also cautioned against opening a door for widespread salary cost creep / financial impacts on the Trust. • Recent senior Executive briefings and messaging to staff and Leadership engagement on Financial constraints vs Service delivery were positively acknowledged.	• Proposals on Radiology Insourcing and Radiology Maintenance Renewal were presented and approved. • An extension to the Pathology Managed Service contract was reviewed and approved. • The BAF was reviewed in light of the current performance and PR4 (Finance) was left unchanged at 20 (target 8) reflecting the continuing heightened state of risk in the Trust's financial operations. PR8 (Sustainability) was left unchanged at 12 (target 9), noting that a deeper review of sustainability should be made at the October or November meetings in conjunction with a future Estates update, once more immediate financial remediation planning had been addressed.

Comments on effectiveness of the meeting

- Papers were of a high quality, though unusually circulated in a somewhat rolling timeframe, partly due to staff holidays, sickness and staff changes. Papers were well presented, and there was a good quality of debate and scrutiny.
- The agenda was very full (as ever), and FC Chair and CFO will work together even more closely to ensure that FC reviews 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

- Workforce modelling considerations to be closely monitored by People Committee in addition to Finance Committee.
- Audit Committee to note / be kept abreast of SBS Ledgers migration plan and risk to Accounting.
- Audit Committee to note the move to regular 'Day 1' reporting, and the associated increase in the use of estimates / increased need for year-end true-up of Management Accounts to Financial Accounts.

Progress with Actions

Number of actions considered at the meeting - 4
Number of actions closed at the meeting – 1
Number of actions carried forward – 3

Post meeting note: one action has since been closed.

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

Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	Monday 1st September 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**
- Improvement Update & Governance concerns, including the need for clearer reporting on the impact of improvement activities and the link between quality and financial efficiency. - Sentinel Stroke National Audit Plan- issues noted with scanning capabilities and disparities in commissioning, highlighting risks.	- A gap analysis will to be conducted against the Penny Dash report recommendations to assess compliance and identify areas for improvement. - Further clarification relating to change in position to 3rd and 4th degree tears to be provided via a paper to a future Quality Committee.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Positive assurance taken from the Patient Safety Committee Report. - Positive assurance taken from the Nursing, Midwifery & AHP Committee Report. - Positive assurance taken from the Dementia update and Admiral Nurse Annual Report. - Positive Assurance taken from the Governance Support Unit Annual Report. - The Trust are no longer an outlier for 3rd and 4th degree tears after the national maternity and perinatal audit recalculated birth rate figures, thus aligning the Trust with other providers.	- A verbal update is to be provided to the Quality Committee as a standing item in relation to the ongoing extreme operational pressures and the risks of patient harm as a result. This in addition to the significant impact on staff moral and the measures in place to support the organisation.

Comments on effectiveness of the meeting
Good level of papers, prompting discussion and challenge, noting significant work underway at the Trust during difficult circumstances.
Items recommended for consideration by other Committees
NA
Progress with Actions
Number of actions considered at the meeting - 3 Number of actions closed at the meeting – 3 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	Monday 29th September 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**
- Increase in medically fit patients remaining in hospital mainly due to delays in packages of care creating issues with flow and capacity. - Discussion held regarding persistent delays in accessing mental health support & MASH referrals affecting timely discharges and contributing to inappropriate stays in A&E. - Concerns raised regarding the establishment of an EPR Delivery Team due to financial climate restricting increase of headcount and risking the deployment of the EPR. A proposal is being put together for Executive consideration. - Infection Prevention & Control issues identified following a peer review, further highlighting the issues due to lack of a decant ward. - Lack of CT Scan and Angiogram overnight.	- Continued and sustained focus on quality and safety during challenges times. - Presentation to be compiled providing details against capacity and demand trends over the past 6-12 months broken down by pathway and including system and partnership influences. - Infection Prevention and Control Deep Dive to be provided to the Quality Committee for the 27th October 2025. - A standing monthly agenda item has been agreed for PSC relating to VTE following lack of assurance received.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Standing agenda item now included to allow triangulation and meaningful discussion against flow, capacity, and operational pressures. - Positive assurance and discussion in relation to the ED Recovery Plan, noting the plan to explore alternatives to ED such as direct admission areas in an aim to reduce congestion etc.	- The Committee APPROVED the IPR report for Timely Care ahead of the BOD meeting on 2nd October 2025. - The Committee APPROVED the IPR report for Quality of Care ahead of the BOD Meeting on 2nd October 2025. - The Committee APPROVED the increase of the risk score for PR1 to 20 on the BAF.

- Positive assurance in response to the Q1 Safeguarding and Vulnerability Report. - Positive discussion relating IPR Timely Care and the ongoing work to reduce cancer pathway backlogs. - Positive assurance taken from the IPR for Quality of Care and noted focus on Infection Prevention and Control. - Significant assurance provided for a 360 Assurance review into Tissue Viability- report to be provided. - Positive assurance relating to the Patient Safety Committee report. - Positive assurance taken from the PSIRF Oversight Group report and plans developed at Divisional Levels. 360 Assurance report into PSIRF delivered significant assurance. - Positive assurance in relation to the 3rd and 4th degree tears in Maternity and changes to reporting. The Trust are currently not an outlier. The newly recruited Consultant Midwife is due to start at the beginning of November 2025.	- The Committee APPROVED PR2 of the BAF with no changes to the risk score of 20. - The Committee APPROVED PR5 of the BAF with no changes to the recommended scoring.

Comments on effectiveness of the meeting

High quality of papers prompting positive discussions and challenges. Significant work underway in the Trust under extreme pressures has been acknowledged. the frequency of the Quality Committee meetings monthly remains a priority to ensure positive discussions and escalations.

Items recommended for consideration by other Committees

N/A

Progress with Actions

Number of actions considered at the meeting - 1
Number of actions closed at the meeting – 4
Number of actions carried forward - 0
Any concerns with progress of actions – No
If Yes, please describe –

Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

People Committee Chair's Highlight Report to Board

Subject:	Chair's Report	**Date:**	30th September, 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 and patient care, compounded by potential Industrial action. • Assurance on plans for Flu Campaign, but starting from a low base in 2024; Board championship requested • Ability to deliver WTE target with current activity levels and potential Industrial Action	• Engagement in National Staff Survey to maximise response from our people • No Hate Here Campaign to recognise and respond to the breadth of hate experienced by staff. Police support at a local level is waning, can we approach at a senior level to re-invigorate partnership working
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
There was much positive assurance provided including: • Approach to Employment rights bill • Engaging staff in the National Staff Survey • Actions to support Improving Resident Doctor's Working Lives • People strategy in year progress, and alignment with National 10 Year Health Plan • Some improvement in people segment of IPR • Annual Safe Staffing for Nursing, Midwifery and AHPs and the Guardian of Safe Working reports • Bi-annual Employee Relations Assurance Report	• BAF reviewed and new mitigating actions considered; risks and assurance levels remain as is.

Comments on effectiveness of the meeting
As before hot topics section working well, papers were of good quality, as was the debate; presenters summaries are more concise leading us to the right debates and having more time for debate. Overall, a positive meeting with structured discussion with appropriate challenge.
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 - 4 Number of actions closed at the meeting – 4 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

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