MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 5th June 2025**
Time: **09:00 – 13:00**
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 **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *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 – Supporting patient flow: Fit2Sit** Richard Kemp, Divisional Director of Nursing	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 3rd April 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	**Making Tomorrow Better – Strategy Delivery Update** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 9
10.	09:55	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity and Neonatal Update** Report of the Director of Midwifery o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 10.1
11.	10:10	**Strategic Objective 3 - Improve health and wellbeing within our communities** • **Health Inequalities Annual Statement** Report of the Chief Medical Officer	Approval	Enclosure 11.1

	Time	Item	Status	Paper
12.	10:25	**Strategic Objective 5 – Sustainable use of resources and estate** • **2025/2026 Operational Plan** Report of the Chief Financial Officer • **Financial Efficiency Plan** Report of the Chief Financial Officer • **Capital Expenditure Plan** Report of the Chief Financial Officer	 Assurance Assurance Approval	 Enclosure 12.1 Enclosure 12.2 Enclosure 12.3
	BREAK (10 mins)			
	Operational			
13.	11:00	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 13
14.	11:45	**Integrated Performance Report (IPR) Annual Review** Report of the Acting Chief Operating Officer (presented by Mark Bolton, Associate Director of Operational Performance)	Approval	Enclosure 14
15.	12:00	**Post-Winter Plan de-brief** Report of the Acting Chief Operating Officer (presented by Mark Bolton, Associate Director of Operational Performance)	Assurance	Enclosure 15
	Governance			
16.	12:15	**Board Assurance Framework (BAF)** Report of the Chief Executive	Approve	Enclosure 16
17.	12:20	**Trust Seal** Report of the Director of Corporate Affairs • **Annual Summary Report 2024/2025** • **Application of the Trust Seal – April 2025**	 Assurance Assurance	 Enclosure 17.1 Enclosure 17.2
18.	12:20	**Provider Licence Self-certification declaration** Report of the Director of Corporate Affairs	Assurance	Enclosure 18
19.	12:25	**Committee Effectiveness Reviews** Report of the Director of Corporate Affairs	Assurance	Enclosure 19
20.	12:30	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) o Audit and Assurance Committee Annual Report • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • People Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance	 Enclosure 20.1 Enclosure 20.2 Enclosure 20.3 Enclosure 20.4

	Time	Item	Status	Paper
		• Partnerships & Communities Committee Report of the Committee Chair (last meeting) o Partnerships & Communities Committee Annual Report	Assurance	Enclosure 20.5
		• Charitable Funds Committee Report of the Committee Chair (last meeting) o Charitable Funds Committee Annual Report	Assurance	Enclosure 20.6
21.	12:45	**Spotlight on – Showcasing the essential work of the Orthotics Team**	Assurance	Presentation
22.	12:50	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
23.	12:55	**Any Other Business**		
24.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **7th August 2025, Boardroom, King's Mill Hospital**		
25.		**Chair Declares the Meeting Closed**		
26.		**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 10.1	• **Perinatal Safe Staffing Report**
Enc 10.2	• **Nursing Monthly Safe Staffing**
Enc 16	• **Significant Risks Report**
Enc 19	• **Committee Effectiveness Review – Audit and Assurance Committee**
Enc 19	• **Audit and Assurance Committee - TOR**
Enc 19	• **Audit and Assurance Committee – Workplan**
Enc 19	• **Committee Effectiveness Review – Finance Committee**
Enc 19	• **Finance Committee – TOR**
Enc 19	• **Finance Committee – Workplan**
Enc 19	• **Committee Effectiveness Review – Quality Committee**
Enc 19	• **Quality Committee – TOR**
Enc 19	• **Quality Committee - Workplan**
Enc 19	• **Committee Effectiveness Review – People Committee**
Enc 19	• **People Committee – TOR**
Enc 19	• **People Committee - Workplan**
Enc 19	• **Committee Effectiveness Review – Charitable Funds Committee**
Enc 19	• **Charitable Funds Committee – TOR**
Enc 19	• **Charitable Funds Committee – Workplan**
Enc 19	• **Committee Effectiveness Review – Partnerships and Communities Committee**
Enc 19	• **Partnerships and Communities Committee – TOR**
Enc 19	• **Partnerships and Communities Committee - Workplan**
Enc 20.1	• **Audit and Assurance Committee – previous minutes**
Enc 20.2	• **Finance Committee – previous minutes**
Enc 20.2	• **Cash Management**

Enc 20.3	• **Quality Committee – previous minutes**
Enc 20.4	• **People Committee – previous minutes**
Enc 20.5	• **Partnerships and Communities Committee – previous minutes**
Enc 20.6	• **Charitable Funds Committee – previous minutes**
Enc 23	• **Equality and Diversity Annual Report**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 3rd April 2025, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Chair	GW
	Steve Banks	Non-Executive Director	SB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Lisa Maclean	Non-Executive Director	LM
	Richard Cotton	Non-Executive Director	RC
	Barbara Brady	Non-Executive Director	BB
	Manjeet Gill	Non-Executive Director	MG
	Jonathan Van Tam	Associate Non-Executive Director	JVT
	Andy Haynes	Specialist Advisor to the Board	AH
	David Selwyn	Acting Chief Executive	DS
	Richard Mills	Chief Financial Officer	RM
	Simon Roe	Acting Medical Director	SR
	Rob Simcox	Director of People	RS
	Rachel Eddie	Chief Operating Officer	RE
	Phil Bolton	Chief Nurse	PB
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
In Attendance:	Georgina Goulding	Admiral Nurse, Dementia Nurse Specialist	GG
	Leanne Minett	Quality Governance Matron	LMi
	Paula Shore	Director of Midwifery	PS
	Kerry Bosworth	Freedom to Speak Up Guardian	KB
	Alison Steel	Head of Research and Innovation	AS
	Sue Bradshaw	Minutes	
	Olivia Hammond	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Dr Kerry Elgie	Patient's daughter	
	Ian Holden	Public Governor	
	Debbie Kearsley	Deputy Director of People	
	Rich Brown	Head of Communications	
	Claire Page	360 Assurance	
	3 members of the public		
Apologies:	None		

Item No.	Item	Action	Date
25/085	**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.		
25/086	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
25/087	**APOLOGIES FOR ABSENCE**		
1 min	There were no apologies for absence.		
25/088	**PATIENT STORY – BRIANS'S BRAIN**		
31 mins	GG and LM joined the meeting. GG introduced the Patient Story, which highlighted the work of the Dementia Team and some failings in the care of a patient with dementia. As a result of this patient's experience, and with fundraising from the patient's family, a campaign project has been developed to raise awareness of dementia and the work of the Dementia Team. MG felt it important to ensure the learning from this case is taken forward. PB felt the best form of learning for staff is real life situations. This is a powerful story and, with the family's permission, it will be used for staff training. JVT noted this is a distressing case, but acknowledged the good work which has been undertaken as a result. The case does highlight some fundamental issues, noting there were multiple missed opportunities on the clinical journey for someone to take ownership of the coordination of the patient's care. SR advised as part of the Trust's work in relation to 'getting the basics right', work is ongoing to make Nervecentre more visible to ward staff so it is clear what the next stage on a patient's journey is. There is more work to do to embed processes. PB advised all staff attend a fundamentals of care training day. ARB queried if there is anything further which can be done to resource the Dementia Team. PB advised the role of the Dementia Team is to get the messages out across the Trust and support complex cases. Care of patients with dementia is everyone's responsibility. SB felt there is a need to consider how the Board of Directors can be assured processes have changed and been embedded as a result of cases such as this one.		

	DS advised this is an area of focus for members of the Board of Directors when undertaking 15 Steps visits. LM advised the Dementia Team have developed an assurance data spreadsheet to capture details of every contact between the Team, wards, family, etc. MG left the meeting. NM queried if the Team feels appropriately supported from July 2024, when the Board of Directors received their training on dementia, to the present time in terms of the development of the service the Team provides and the willingness of others within the Trust to accept the responsibility as theirs, rather than solely the Dementia Team. GG advised when she took up her role in January 2024, there was a lot of stigma around the Trust in relation to dementia and this was a barrier. However, this situation has improved and people want to talk about dementia and get support. There is still work to do but the Team has been well supported by senior members of staff. BB advised she would welcome the opportunity to discuss how the dementia agenda feeds into Quality Committee. In addition, the fundamentals of care aspects need to be explored through Quality Committee. **Action** • **Chief Nurse to discuss with the Chair of the Quality Committee how the dementia agenda and fundamentals of care aspects can be fed into Quality Committee.** DS expressed the Trust's apologies to the family, acknowledging the failings in the care provided. GW asked Kerry Elgie (KE), the patient's daughter, if there were any points she wished to make to the Board of Directors. KE expressed the view the care Brian received was appalling. However, KE expressed thanks on behalf of the family to the Dementia Team for the improvements which are being taken forward. Staff on the wards need to be trained how to deal with patients with dementia and the family is willing to support this work in any way possible and appropriate. GW thanked KE for allowing the story to be shared and acknowledged the lessons which can be learnt from this case. GG and LM left the meeting.	**PB**	**05/06/25**
25/089	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 6th March 2025, the Board of Directors APPROVED the minutes as a true and accurate record.		
25/090	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/313.1, 25/018 and 25/055 were complete and could be removed from the action tracker.		

25/091	**CHAIR'S REPORT**		
5 mins	GW welcomed Jonathan Van Tam, Associate Non-Executive Director, to his first Board of Directors Meeting. GW acknowledged this was the last Board of Directors' meeting for Andy Haynes, Specialist Advisor to the Board, and expressed thanks to Andy for his work for the Trust. GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective, highlighting governor elections, work of the Trust's volunteers, Dragon's Den projects funded by money raised in the Daffodil Café and fundraising stalls, NHS Integrated Care Board (ICB) and Trust Leaders event and Board of Directors Time Out session. The Board of Directors were ASSURED by the report.		
25/092	**ACTING CHIEF EXECUTIVE'S REPORT**		
24 mins	DS presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chief Executive's perspective, highlighting the service celebrating the life of Paul Robinson, Chief Executive, pre-election period guidance, operational activity, Executive Team recruitment, Step into the NHS event, partnerships update, staff wellbeing spaces and funding for a bone density (DEXA) scanner at Newark Hospital. SB sought further details in relation to the impact of going 'two-over' on the wards. DS advised this has been utilised in a managed way, when it is recognised there is a risk to patients from overcrowding in ED, as a means of spreading the risk across the organisation. PB advised going two-over on the wards is part of a series of actions being taken as part of the Trust's Full Capacity Protocol. Going two-over has been enacted on a small number of occasions, in a controlled manner and with Executive Team oversight. This action was stepped down quickly. There is a need to balance the risk. Whenever 'two-over' was enacted, PB advised he made time to speak to patients, family and staff. Patients were happy to be moved from ED. The Trust has worked with the regulators to engage them and explain the reasoning for taking the necessary actions. SR advised taking these actions was not something the Trust wished to do but there is a need to balance the risk, including avoiding holding ambulances at the 'front door'. In the right circumstances going 'two-over' is an appropriate way of managing the risk in the organisation. SR acknowledged there is still work to do to in terms of improving ward processes and use of the Discharge Lounge. PB advised going 'two-over' has not been enacted overnight, but has been used in periods when it can be off-set against discharges which are either known or predicted. RE advised when wards do go either one or two over, the patient coming onto the ward from ED may not necessarily be the sickest person on the ward. Therefore, it is essential the situation is well managed on the ward to ensure the sickest patient is in the right space.		

	Looking ahead to next Winter, work is underway to plan how the Trust can increase bed capacity within the existing footprint. DS advised the Trust has been contacted by the Care Quality Commission (CQC). They have visited the Trust and been walked through the process. They were assured by the actions being taken. RC queried if any modelling has been undertaken on the surge of patients attending ED in terms of the reasons for them attending, noting, if this was due to flu, would that have been different with a higher vaccine uptake. DS advised with all the mitigations in the Winter Plan in place, at the peak of demand there was a gap of circa 40 beds in the modelling. This was for a finite period of time around the end of December / beginning of January. The actions taken are short and sharp to decompress ED. RE advised she is not aware of any scenario-based modelling within the system. However, there is some ongoing work at a system level looking at future demand modelling and there are some ambitious plans for demand management this year in terms of community-based actions. JVT advised there is some correlation between flu vaccine uptake in the elderly and hospitalisation, but noted of more interest is the recent reports of a reduction of 20% in hospitalisation being achieved by the new Respiratory Syncytial Virus (RSV) vaccine, which is currently available to only a limited age group. DS advised the rollout of the RSV vaccine, and eligibility for it, has been raised at a system level. The Board of Directors were ASSURED by the report.		
25/093	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
12 mins	PS joined the meeting **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting Safety Champions walkarounds, telephone triage system, NHS Resolution (NHSR) Year 6 Maternity Incentive Scheme and the launch of Year 7, workforce update, Qualified in Specialty (QIS) compliance and Safer Sleep Week. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance Model*** PB presented the report, highlighting an increase in third and fourth degree tears and still birth rate. PS advised there was also an increase in still birth rates in February 2024, noting the reasons for this are not clear. Therefore, in addition to undertaking the cluster review of 2025 cases, the governance team will look at the cases from February 2024 to identify any learning.		

	MG rejoined the meeting. BB noted the increase in third and fourth degree tears and queried if the midwives on the unit are aware the Trust has an issue with the number of tears. PS advised staff are aware the number of tears is higher than previously. This is a national change and, at a recent learning event, it was felt that due to better education and training, tears are being more readily identified. There are other elements at play also, for example, there has been an increase in interventions during birth, which increases the risk of a tear. As tears are being identified, appropriate follow up care and support is being put in place, which may not have been the case previously if tears were not identified. Thematic reviews are undertaken, which includes postcode analysis. BB noted Element 1, Smoking in pregnancy, of the Saving Babies Lives Care Bundle, is showing as 'Partially Implemented' and sought clarification regarding this. PS advised an external validation process has taken place after the report was written and elements 2, 3, 4 and 6 are now fully implemented. Smoking in pregnancy remains only partially implemented due to external factors and auditing programmes, rather than Trust practices. It is outwith the Trust's control, but it has been raised with the national team. The Board of Directors were ASSURED by the report. PS left the meeting.		
7 mins	**Learning from Deaths** SR presented the report, highlighting the Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio+ (HSMR+) rates, improvements in coding, deep dives into specific disease areas, National Audit of Care at the End of Life (NACEL), Structured Judgement Review (SJR) process, feedback and learning from serious incident investigations Coronial feedback and plans for Quarter 1 (Q1) and Q2 of 2025/2026. AH queried if there were opportunities to use AI for coding purposes and queried if internal investigations were already underway for the Coronial cases before they were raised by the Coroner. SR advised there are opportunities to increase the use of AI for coding, but more work is required to fully understand what is possible. In terms of the Coronial cases, there are things which need to be done differently in terms of more timely investigations, noting the level of medical input required for some of the recent high-profile cases. The Board of Directors were ASSURED by the report.		
25/094	**STRATEGIC OBJECTIVE 2 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE**		
20 mins	**People Strategy** RS presented the report, highlighting the delivery pillars, the Trust's vision, People Priorities, Equality, Diversity and Inclusion (EDI) agenda and achievements to date.		

	A general discussion followed, during which the following points were raised: • Good consultation in putting the strategy together. • The strategy references areas where more detail and assurance needs to be sought, but this is complimented by the assurance papers which are presented to the People Committee. • Clearer information in relation to the efficiencies, productivity and flexibility required over the next five years needs to be included. • The need to work with operational and finance teams to get the cost and productivity elements correct. • People's wellbeing is at the centre of the strategy. • Improving ways of working is included in the strategy, particularly how transformation is embraced and productivity improved. There needs to be a balance between what the Trust wants to achieve in year against delivery over the life of the strategy. • The operational delivery plans, which underpin the strategy, will be organic and flexible, depending on the needs of the organisation. • The strategy contains the right elements for the workforce. • The need to bring to life some of the ongoing detailed background work. • Clinical teams felt engaged in the development of the strategy. • Divisional Performance Reviews will provide the opportunity for triangulation of productivity, sickness rates, etc. • The need to look after the people who look after the Trust's patients. • The need to triangulate finance, quality, safety and performance and consider all those aspects, noting good colleagues are at the centre. • Strategy should include a section on the interdependency with the Finance Strategy. • This is a fundamental enabling strategy of the wider Trust Strategy. • More information to be included about different types of roles. • The productivity element will mean changes to the workforce over the next year, which will be a challenge for staff and morale. Ways to support this needs to be included. The Board of Directors were ASSURED by the report and APPROVED the delegation of authority to the People Committee to approve the final version of the People Strategy.		
21 mins	**Staff Survey** RS presented the report, advising SFHFT is the best acute trust in the East Midlands for the seventh consecutive year as a place to work and receive care. The Trust benchmarks well with the People Promise domains. The organisation remains a high performing trust, but it is important to strive to continually improve. RS highlighted the response rate, areas of focus for 2025 and next steps.		

	BB advised she was unable to identify any areas where the Trust's performance had slipped and felt there is a need to understand the areas for improvement as well as the positives. As the Staff Survey just takes place once per year, BB felt it would be useful if the results were presented in way which shows how they triangulate with other intelligence, for example, exit interviews, etc. RS advised the next version of the Cultural Heatmap is due to be presented to the People Committee in May 2025 and this will start to reinforce the triangulation. The feedback received from divisions and corporate teams, following the release of the Staff Survey results, indicates there were no surprises in the results. RC felt it would be useful to have the previous year's data on the same indicators included in the report in order to help identify any slippage. RS advised this information is included within the reports presented to the People Committee, to which members of the Board of Directors have access. AH queried if the Trust is 'hearing the voices' of colleagues who are harder to reach. AH noted that an area of slippage is staff having enough equipment to do their jobs, acknowledging capital budgets are tight. RS advised over 200 additional staff responded to this year's survey, some of whom are from areas where there has been no response previously. Provision of equipment is an area of focus and there is work to do in relation to this. NM felt managed change needs to be an area of focus for 2025. RS advised engagement is key to achieving this. RE noted there is a conflict between what the Trust wishes to do and what it can do due to financial constraints. This is the same in all NHS organisations. Therefore, benchmarking is important and it is vital to have honest conversations with teams about the financial challenges faced by the Trust. GW acknowledged 2025 is going to be challenging and noted it is important to triangulate current data and support staff through the changes over the coming year. The Board of Directors were ASSURED by the report.		
12 mins	**Freedom to Speak Up (FTSU)** SBS presented the report, highlighting the number of concerns raised, themes, investigation timescales, FTSU database and next steps. ARB noted the increase in the number of cases related to worker safety and wellbeing and queried if the reason for this increase is known. SBS advised she would query this with Kerry Bosworth, FTSU Guardian, and report to the People Committee.		

	Action • **Reason for the increase in the number of cases related to worker safety and wellbeing being reported via Freedom to Speak Up to be investigated and reported to the People Committee.** BB noted some staff who have raised concerns may be off work due to stress due to their attempts to raise issues with their line manager 'not working', which has led them to go through FTSU. There is a need to empower line managers to more effectively deal with issues. RS advised there are times when individuals do not know who their line manager's line manager is. There is a need to reinforce leadership arrangements within teams. The Board of Directors were ASSURED by the report.	**SBS**	**07/08/25**
25/095	**STRATEGIC OBJECTIVE 4 – CONTINUOUSLY LEARN AND IMPROVE**		
25 mins	**Research Annual Report** AS joined the meeting. AS presented the report, highlighting performance, recruitment, finance, patient experience feedback, impact of research, Research Strategy Update, mobile research unit, Clinical Research Facility (CRF) and next steps. JVT advised, since recently taking up post, he has had the opportunity to meet with the Research Team and he shared some of his first impressions with the Board of Directors and potential opportunities to develop research at the Trust. The Board of Directors were ASSURED by the report. AS left the meeting.		
25/096	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
21 mins	**Finance Strategy** RM presented the report, highlighting the further work required to ensure the strategy is aligned with the 2025/2026 operational plans, aims of the strategy and financial stewardship. MG queried what the strategic priorities are within the strategy and if £50m of recurrent savings is realistic. MG expressed the view the strategy needs to contain further information about workforce. RM advised the priorities feature in the aims, noting ultimately the Trust is trying to maximise income, ensuring the Trust is paid appropriately for the services it provides while managing costs. In terms of recurrent savings, this will be challenging but there is a need to find a way of living within available resources. RM acknowledged the need to include information about the links with workforce.		

	RS advised the People Strategy and Finance Strategy are enabling strategies which compliment each other. There is a need to empower people to help the Trust live within its means, while also spending wisely. SB felt it would be useful to understand what is included in the figures going forward to 2028/2029, particularly information on the cost base. SB noted pay costs have increased by circa 50% over the past 5 years and workforce numbers have increased by 20-25% in the same time period and queried if there is an understanding of all the drivers of payroll inflation and what actions can be taken to bring it back under control. RM acknowledged the need to have a longer term, more strategic view, advising this is a challenge. In terms of payroll inflation, this is partly dictated by the annual pay awards, which increases costs at a faster rate than workforce changes. Other factors include case mix, re-banding, etc. However, through the operational planning and efficiency programmes for 2025/2026, the Trust will hopefully gain a greater understanding of the drivers. JVT noted the reduced budget for 2025/2026 and queried if the financial position is being reported frankly and honestly to staff and the local population, given the nationally reported messaging about more money being made available to the NHS. RM advised this is a common issue when there are national announcements in relation to NHS budgets, as the detail often relates to the money covering overspends which have been incurred. Over the last few years, many of the income streams have been non-recurrent in nature. JVT expressed the view the Trust should be honest with the people it serves, unless prevented from doing so. RM advised internally it is a difficult balance between driving the financial messages when people are dealing with other pressures, but having frank conversations has been well received. In terms of the public arena, there is a need to home in on areas when the Trust is an outlier in terms of spend. The Board of Directors were ASSURED by the report and APPROVED the delegation of authority to the Finance Committee to approve the final version of the Finance Strategy.		
25/097	**STANDING ORDERS**		
1 min	SBS presented the report, advising the Standing Orders have been reviewed. There are some minor amendments, as highlighted in the report, which are recommended to the Board of Directors for approval by the Audit and Assurance Committee. The Board of Directors APPROVED the Standing Orders.		
25/098	**ANNUAL SIGN OFF OF DECLARATIONS OF INTEREST**		
4 mins	SBS presented the report, advising Declaration of Interests is an annual requirement and the report reflects the work done during 2024/2025.		

	The conflicts of interest register will be published on the Trust website and will include details of people who have registered an interest, people who have made nil declarations and details of people who are non-compliant. For 2024/2025, 14 people are non-compliant, of 1,235 staff who are required to declare an interest. SBS highlighted the actions being taken to improve the position. The Board of Directors APPROVED the annual Declarations of Interest report.		
25/099	**ASSURANCE FROM SUB-COMMITTEES**		
9 mins	**Audit and Assurance Committee** MG presented the report, highlighting the External Audit Plan and single tender waivers. The Board of Directors were ASSURED by the report. **Finance Committee** GW presented the report, highlighting the successful request for working capital support, Community Diagnostic Centre (CDC) overspend, financial position at the end of Month 11, financial planning for 2025/2026, PFI accounting issue and misalignment in income assumptions between the Trust and the ICB. The Finance Committee Annual Report was noted. The Board of Directors were ASSURED by the report. **Quality Committee** BB presented the report, highlighting development of the Quality Dashboard and review of Board Assurance Framework (BAF) Principal Risk 1 (PR1), Significant deterioration in standards of safety and care, PR2, Demand that overwhelms capacity, and PR5, Inability to initiate and implement evidence-based improvement and innovation. The Quality Committee Annual Report was noted. The Board of Directors were ASSURED by the report. **People Committee** SB presented the report, highlighting the impact on staff of the financial challenges for 2025/2026 and the potential knock on to patient care, review of PR3, Critical shortage of workforce capacity and capability, and partnership working with West Notts College. The People Committee Annual Report was noted. The Board of Directors were ASSURED by the report.		

25/100	**SPOTLIGHT ON – WEST NOTTS COLLEGE T- LEVELS**		
11 mins	A short video was played highlighting West Notts College T- Levels.		
25/101	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Links with West Notts College, particularly T-Levels • Patient Story and the importance of working with patients' families. • NHS pre-election guidance. • Recent executive appointments. • Trust volunteers, charity and Community Involvement Team. • People Strategy. • Staff Survey results and work required. • Promotion of research and innovation within the Trust. • Financial position.		
25/102	**ANY OTHER BUSINESS**		
1 min	No other business was raised.		
25/103	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 1st May 2025 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:45.		
25/104	**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**		

25/105	**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.		
25/106	**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.		

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PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
24/183.2	06/06/2024	Sub-committee annual reports to follow same format	Public Board of Directors	None	05/06/2025	S Brook Shanahan		**Update 29/05/2025** Reports now required to follow the format adopted by the Charitable Funds Committee. This has required an update to the annual report template (No. 9) in the Governance Framework - re-issued as version 1.3. **Complete**	Green
24/377.1	05/12/2024	Report to be presented to the Perinatal Assurance Committee (PAC) (and onwards to the Quality Committee) in relation to inequalities and equity of access issues in maternity.	Public Board of Directors	Quality Committee	~~03/04/2025~~ 05/06/2025	P Bolton		**Update 26/03/2025** Report to be presented to PAC on 28/03/2025 and Quality Committee on 02/06/2025. **Update 28/05/2025** The report was presented to PAC, as planned on 28/03/2025 and will be shared at Quality Committee on 02/06/2025. **Complete**	Green
25/054	06/03/2025	Nursing workforce numbers and spend to be a topic for a Finance Committee workshop at the end of Q1.	Public Board of Directors	Finance Committee	07/08/2025	R Mills		**Update 21/03/2025** Added to agenda for Finance Committee workshop on 29/07/2025	Grey
25/088	03/04/2025	Chief Nurse to discuss with the Chair of the Quality Committee how the dementia agenda and fundamentals of care aspects can be fed into Quality Committee.	Public Board of Directors	Quality Committee	05/06/2025	P Bolton		**Update 28/05/2025** This conversation is planned for consideration to take place at the Quality Committee meeting on 02/06/2025. **Complete**	Green
25/094	03/04/2025	Reason for the increase in the number of cases related to worker safety and wellbeing being reported via Freedom to Speak Up to be investigated and reported to the People Committee.	Public Board of Directors	People Committee	07/08/2025	S Brook Shanahan	K Bosworth		Grey

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Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:**	5th June 2025
Prepared By:	Rich Brown, Head of Communication		
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

Not applicable

Acronyms

Cllr = Councillor
CT = Computed Tomography
EMAS = East Midlands Ambulance Service
EMCCA = East Midlands Combined County Authority
ICB = Integrated Care Board
ICP = Integrated Care Partnership
ICU = Intensive Care Unit
MSK = Muscular Skeletal
NEDs = Non-Executive Directors
NUH = Nottingham University Hospitals

Executive Summary

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

Board of Directors and Council of Governors election update

Executive Team recruitment update

The Trust has been delighted to officially confirm two appointments to its Board of Directors over recent months, following a nationwide recruitment drive.

Dr Simon Roe has accepted the Trust's offer to become its Chief Medical Officer – the Trust's highest ranking medical role.

Dr Roe originally joined Sherwood Forest Hospitals as its Deputy Medical Director from Nottingham University Hospitals NHS Trust in November 2023, before he stepped-up to become its Acting Medical Director in May 2024.

He had previously worked clinically for a number of years at Sherwood, as well as having previously served as the Trust's clinical lead for its medicine division in a previous spell at Sherwood.

The role of Medical Director has also been renamed 'Chief Medical Officer' to better align the role to similar roles across the country's NHS.

Dr Roe has now taken-up his role, having completed the pre-employment checks required of all new appointments to NHS boards of directors. Dr James Thomas, who had previously been serving as Simon's acting deputy, has now been substantively appointed the Trust's Deputy Chief Medical Officer.

The Trust has also appointed Simon Illingworth as its Chief Operating Officer – a role that oversees the day-to-day running of the Trust's hospitals.

Simon's appointment follows the departure of his predecessor, Rachel Eddie, who leaves the Trust after three years in the role.

He is due to join the Trust on Monday 14th July 2025 from The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, where he has been serving as its Chief Operating Officer since August 2023.

I am delighted with each of these appointments, which I am sure will further strengthen and stabilise the Trust's leadership for the future. I cannot wait for them to get started.

The appointments follow the extension of Dr David Selwyn's tenure as the Trust's Acting Chief Executive up to the end of March 2026. Recruitment to appoint a substantive Chief Executive Officer has now also begun to bring further, long-term stability to the organisation's leadership.

Elsewhere, the Trust's Acting Executive Director of Strategy and Partnerships, Claire Hinchley, has now returned to her substantive role after acting into an executive role over the past year. We thank Claire for the difference she made during her time in this important role.

Welcome to our newly-elected Trust governors

At the May meeting of the Trust's Council of Governors on Tuesday 13 May, I was delighted to officially welcome our new intake of Trust governors – as well as to join their induction to the Trust. Their appointments follow the conclusion of April's Council of Governor elections that had filled all vacancies on the Trust's Council of Governors, prior to the subsequent resignation of one of our newly-appointed Trust governors.

Hundreds of Trust members voted in this year's Trust Council of Governor. The results for each constituency are summarised below:

- **Rest of England**
  One of our serving Trust governors, Dean Wilson, has taken-up the governor vacancy in our 'Rest of England' constituency, following a change in the Trust's constituency boundaries.

- **Mansfield, Ashfield and surrounding wards**
  Three more of the Trust's serving governors – Liz Barrett, Neal Cooper and Jane Stubbings – have all been re-elected for another term, alongside newly-elected governors Nabeel Khan and Julie Kirkby. Full election results for the Mansfield, Ashfield and surrounding wards constituency are available here.

  A sixth candidate from this year's election, Iain Peel, has taken-up a vacancy in this constituency which was created following Dean Wilson's move to the Trust's 'Rest of England' constituency.

- **Newark, Sherwood and surrounding wards**
  New governors Michael Creamer and Ann Gray have been appointed to two vacancies in this constituency. This seat was uncontested as only two candidates applied to stand for two vacancies in this constituency. Election results for the Newark, Sherwood and surrounding wards are available online here.

  Unfortunately, Michael Creamer decided to resign his position after the election results were announced. This position will remain vacant for the time being, with a plan to be communicated with Trust governors as soon as possible.

- **Staff governors**
  In addition to the seven public governors listed above, this year's election also elected two staff governors. Mitchel Speed, from the Trust's Improvement Faculty, has become our latest staff governor. He joins senior nurse, Justin Wyatt, who was elected for another term in April's election, and the Trust's Head of Therapy Services, Samantha Musson, in completing our new-look line-up of staff governors. This year's staff governor election results are available in full here.

Elsewhere, former Nottinghamshire County Councillor Bethan Eddy has now left the Trust's Council of Governors, following the latest Nottinghamshire County Council elections in May. We thank former Cllr Eddy for her work with the Trust during her time as an appointed governor. The Trust has approached Nottinghamshire County Council to appoint a new governor to its Council of Governors; I look forward to being able to update the Trust's Board as soon as an appointment has been made.

I look forward to working with our new-look Council of Governors and would also like to pay tribute to the Trust's outgoing elected governors – Ian Holden, Ruth Scott and Vikram Desai – for their contributions to the Trust during their time as governors.

Here's your new-look Board of Directors and Council of Governors:

Board of Directors

David Selwyn
Acting Chief Executive

Graham Ward
Chair

Phil Bolton
Chief Nurse

Sally Brook Shanahan
Director of Corporate Affairs

Rachel Eddie
Chief Operating Officer

Steve Banks
Non-Executive Director

Barbara Brady
Non-Executive Director

Richard Cotton
Non-Executive Director

Manjeet Gill
Non-Executive Director

Richard Mills
Chief Financial Officer

Dr Simon Roe
Chief Medical Officer

Robert Simcox
Chief People Officer

Lisa Maclean
Non-Executive Director

Neil McDonald
Non-Executive Director

Andrew Rose-Britton
Non-Executive Director

Professor Sir Jonathan Van-Tam
Associate Non-Executive Director
(Research and Innovation)

Council of Governors

Mansfield, Ashfield and surrounding wards

Liz Barrett OBE
Lead Governor

Tracy Burton

Neal Cooper

John Dove

Nabeel Khan

Pam Kirby

Julie Kirkby

Iain Peel

Jane Stubbings

Newark, Sherwood and surrounding wards

Ann Gray

Peter Gregory

Shane O'Neill

Position vacant

Rest of England

Dean Wilson

Staff governors

Samantha Musson

Mitchel Speed

Justin Wyatt

Appointed governors

Nikki Slack
West Notts College

Cllr Linda Dales
Newark and Sherwood District Council

Cllr Angie Jackson
Mansfield District Council

Kevin Stewart
Appointed Governor - Volunteers

Cllr David Walters
Ashfield District Council

Position vacant
Nottinghamshire County Council

Issued: May 2025

Recognising the difference made by our Trust Charity and Trust volunteers

April and May have been another busy period for our Trust's Community Involvement team, both in how they encouraged financial donations to be made via our Trust Charity and through the thousands of hours that continue to be committed to support the Trust by our volunteers across our hospitals.

In April alone, 380 volunteers donated over 4,500 hours across 25 services they supported during the month.

Notable developments from the Sherwood Forest Hospitals Charity and our Community Involvement team from the past three months include:

- You will remember the story of Brian Elgie from the *Patient Story* video that was shared with the Trust's Board of Directors at our April meeting.

  Since sharing his story, Brian's family have been honouring his memory by raising money to improve dementia care for patients.

The Elgie family alongside members of the Dementia team

  Since his passing, Brian's family – including his wife Mary and daughters Dr Kerry Elgie and Ffion Hawke –have raised £6,627.19 for Sherwood Forest Hospitals Charity through their fundraising initiative called Brian's Brain.

  Some of the money has been used to provide a campaign pack to promote the Dementia Specialist Team to both patients and staff; posters promoting a survey that obtains feedback from patients and carers/families living with dementia; a full-day training session for the Trust's Dementia Champions; and dementia pocketbook guides for all clinical staff.

- Patients who are recovering from a stroke are using an interactive projector as part of their rehabilitation at King's Mill Hospital. The £4,200 ultra-portable projection unit was purchased thanks to funding through Sherwood Forest Hospitals' Dragons' Den 2024, which allows teams to bid for up to £5,000 for an improvement idea that will enrich the patient and carer experience in their area of work.

- Orthoptics and Optometry patients to benefit from new equipment thanks to hospital's 'Dragon's Den' funding. The funding has provided the department with an immersive low vision simulator and a handheld photo screener after an impressive and engaging pitch from members of the team.

  The immersive low vision simulator will help patients' family and carers to understand how the patient's vison has changed and how they can support them.

  The handheld photo screener will be used in the department to estimate whether there is a need for glasses. The device is particularly useful for patients with additional needs as it is quick and non-invasive and supports their individual care plan.

I thank all those who have made donations and who have given their time to support our hospitals over the past three months.

Other notable engagements from over the past two months:

- I joined my regular one-to-one meeting with Dr Kathy McLean, OBE – the Chair of the Integrated Care Board (ICB) and the Nottingham and Nottinghamshire Integrated Care Partnership (ICP), who is also Chair of Derby and Derbyshire ICB.

- I joined the NHS Confederation all members' chairs meeting on Monday 12th May 2025.

- I joined the regular meeting of local Chairs alongside the Chairs of East Midlands Ambulance Service (EMAS), Nottinghamshire Healthcare and Nottingham University Hospitals (NUH).

- I joined the Trust's Acting Chief Executive in meeting the Regional Director of NHS England (Midlands), Dale Bywater, to discuss future model options for the Trust.

- I conducted a '15 Steps' visit to the Trust's Stroke Unit to learn about their work.

- I joined the regular monthly Midlands Region Chairs Meeting led by Dale Bywater, which included a useful session with the Chair of NHS England, Penny Dash.

- I joined a meeting of the chairs and Chief Executive Officers from East Midlands Ambulance Service (EMAS) and the Integrated Care Board (ICB) which Sherwood hosted.

- I joined a Derby, Derbyshire, Nottingham and Nottinghamshire health system leaders' meeting, which was hosted by the East Midlands Combined County Authority (EMCCA).

- I joined the Nottingham and Nottinghamshire Non-Executive Directors (NEDs) network meeting during the month.

- I participated in the monthly Nottingham and Nottinghamshire chairs and elected members meeting.

- I joined the Midlands NHS leadership meeting in Leicester with the Trust's Acting Chief Executive.

- I met with the Trust's Lead Governor, Liz Barrett, in one of our regular one-to-ones.

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Council of Governors - Chair's Highlight Report to the Board

Subject:	Council of Governors (CoG) Highlight Report	**Date:**	13th May 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 13th May 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Some concerns expressed about the governor election process conducted by UK Engage including emails from UK Engage ending up in junk, the complexity of the voting process, some members not receiving the emails from UK Engage at all (corrected prior to the close of voting) and problems encountered when applying to become a Trust Member. All are being followed up by the Director of Corporate Affairs with UK Engage and the Head of Communications. Peter Gregory raised concerns about the cancellation of lesion removals at Newark Hospital without prior notification to the patients and of patients incorrectly being told about services not being available at Newark Hospital. The Acting Chief Executive is investigating.	
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Election of new governors and those re-elected, who were all welcomed to the meeting. Acknowledgment by the Acting Chief Executive of the failings in patient care experience by the subject of the Patient story. Positive assurance about the learning that ensued, and with the support of fundraising by the patient's family, the campaign project that has followed, with the improvements implemented being highlighted in the Patient Story. Acting Chief Executive's, Chair's and Lead Governor's reports.	

Feedback from 15 Steps visits. Improvement Faculty Update, including confirmation that where financial improvements contemplated a Quality Impact Assessment is always completed prior to any change being transacted. Quadrant reports received from the Audit and Assurance, Quality, Finance and People Committees. Membership and Engagement Group feedback from the Lead Governor. The work of the Teledermatology Clinic was highlighted in the "Spotlight on" video.	
Comments on effectiveness of the meeting	
A well-attended meeting with positive discussion and feedback from governors, new and established.	
Items recommended for consideration by other Committees	
None.	

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NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	5th June 2025
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Dave Selwyn, Acting Chief Executive		
Presented By:	Dave 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

Not applicable

Acronyms

BAF = Board Assurance Framework
CDC = Community Diagnostic Centre
CT = Computed Tomography
ED = Emergency Department
IAOCR = International Accrediting Organisation for Clinical Research
NIHR = National Institute for Health and Care Research
NHS = National Health Service
MBE = Member of the Most Excellent Order of the British Empire
MCISS = Macmillan Cancer Information and Support Service
MRI = Magnetic Resonance Imaging
MRU = Mobile research unit
NUH = Nottingham University Hospitals
RDN = Research Delivery Network
R&I = Research and Innovation

Executive Summary

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

Operational updates

Overview of operational activity

Pressures have remained high across our hospitals over recent months, resulting in our 'Full Capacity Protocols' being enacted on a number of occasions – including close to each of the four bank holidays since our last Public Board meeting.

On each occasion, we have worked with NHS providers across the Nottingham and Nottinghamshire system to offer advice and guidance to the public to ensure they are continuing to access the most appropriate NHS services to meet their needs – including over bank holidays.

In March 2025, Emergency Department (ED) attendance demand was at the highest monthly level we have seen to date. Despite managing high attendance demand across our King's Mill and Newark sites, we have been able to deliver significantly better performance across several urgent and emergency care metrics. The headline four-hour emergency access performance metric was above plan in April 2025 and was our second-best monthly performance since August 2022.

We also saw recovery in our ambulance handover position and our Emergency Department (ED) 12-hour length of stay performance. Recovery in these metrics as we exited the winter period was driven by improved hospital flow which enabled patients to be admitted to our hospitals in a timely manner, preventing extended waits and overcrowding in our ED.

The improved hospital flow was due to reduced length of stay for patients aged 65 and over, predominantly due to reduced discharge delays where patients spent less time in our hospitals once they have been deemed medically safe to leave our hospitals once they have received the acute care they need from the Trust.

The recovery we have delivered in recent months is greater than many other Trusts across the country and we have seen our benchmarked position regionally and nationally improve.

Sustaining flow out of our Emergency Department and into our hospital bed base remains a priority to minimise delay-related patient harm and provide high quality patient care.

In terms of planned care, we have continued to reduce the number of long wait patients, although we have further work to do to treat all patients waiting over 65 weeks – something that remains a key priority for us.

We have also made significant progress improving our diagnostic DM01 performance to be above our planned position.

Our cancer performance generally remains strong for the 28-day faster diagnostic standard together with the 31-day cancer treatment standard. Our main area of focus for cancer is the 62-day treatment standard which has mainly been impacted by histopathology capacity issues that we have been working to resolve.

I remain grateful to colleagues who have helped to maintain this strong performance despite the operational pressures they have faced over recent months.

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

Sherwood becomes first in the East Midlands to offer revolutionary CT scanning for cardiac patients

Sherwood has become the first NHS trust in the East Midlands to install the GE HealthCare Revolution™ Apex Elite Cardiac CT Scanner, with the new scanner being unveiled by three-time Paralympic gold medallist, Charlotte Henshaw MBE, at a launch event at King's Mill recently.

Patient care will be considerably improved by the introduction of this advanced Cardiac CT scanner which will allow cardiac scans to be offered to patients without the requirement slow the patient's heart first.

It is a hugely positive development that will significantly transform CT services in our Radiology department, increasing our capacity to offer this vital test and reducing our waiting lists considerably.

A CT scan is a diagnostic imaging procedure that combines X-rays and computer technology to produce images of the inside of the body and can show detailed images of the body including bones, muscles and organs. They are more detailed than a standard X-ray and the beam used moves in a circle around the body. They are used to diagnose tumours, investigate internal bleeding or check for other internal damage.

Patients need to keep completely still during a scan. This makes scanning the heart a more complicated procedure and the heart usually has to be slowed down for images to be successfully captured.

The new GE HealthCare Revolution Apex Elite Cardiac CT scanner can scan the patient's heart in one revolution and in less than a second, fast enough to capture images without blurring, while keeping the heart still beating normally.

This CT scanner produces very clear images while using lower radiation levels, enabling more patients to be scanned safely and efficiently without compromising the quality of results. Additionally, as technology continues the scanner will be automatically updated with the latest software and advancements, so that patients at Sherwood Forest Hospitals always benefit from cutting-edge imaging technology for the best possible care.

The one-beat cardiac CT, which is already operational, will mean that the most delicate and often challenging procedures can now be done quicker and with greater ease and comfort for the patient.

Funding for the new CT Scanner was received from NHS England.

Work starts on new MRI scanner building at Sherwood Forest Hospitals

Work has started on a project that will transform care for patients needing MRI scans in the Nottinghamshire area.

Members of the project team joined contractors at an event in early May to mark the 'first spade in the ground' for a new Magnetic Resonance Imaging (MRI) building at King's Mill Hospital.

The project, which is being funded by NHS England and has been in the pipeline for several years, will house two state-of-the-art MRI scanners. It will replace the hospital's existing one that is more than 12 years old and nearing the end of its working life, as well as another permanent scanner to replace a temporary mobile.

The Trust's current scanners are regularly in operation for more than 12 hours per day, seven days a week and the building will have space for a third scanner to accommodate future demand and growth for this vital diagnostic procedure.

This vital development will significantly improve efficiency and resilience, strengthening capacity both for inpatients and outpatients; the project will ensure patients are seen more quickly and receive their diagnosis sooner.

Rapid diagnosis of conditions such as cancer means patients can access the treatment they need more quickly, which is key to improving outcomes and quality of life for those suffering from chronic diseases.

Bringing all the Trust's MRI scanners under one roof in a purpose-built space will improve patient experience by providing a more comfortable environment for both patients and staff.

The building will have a separate covered entrance, while still being connected to the existing hospital through a new link corridor, providing better access for patients and staff.

With all patient facilities located on the ground floor, it will be easily accessible for patients and will have dementia-friendly signage.

The new build, designed by international architects CPMG, will be built by Kier Construction, and is expected to open in 2026.

Final steel beam marks major milestone in Mansfield Community Diagnostic Centre build

We have been celebrating another major milestone in the development of the new Community Diagnostic Centre (CDC) at Mansfield Community Hospital, as construction reached its “topping out” stage.

Following the demolition of the former Victoria Hospital last summer, construction has progressed and the project has now reached a key moment, the completion of the building’s steel frame.

This milestone was marked with a traditional topping-out ceremony on site, where colleagues, contractors and partners came together to sign the final beam and tighten the last bolt in celebration of the progress made so far.

With 760 individual steel pieces weighing a combined 160 tonnes - the equivalent of around 32 ambulances - the structure is now fully in place and the project is officially “out of the ground”.

The next phase of construction will see work begin on the building’s exterior to make the site weather-tight, paving the way for internal trades to begin fitting out the state-of-the-art facility.

Designed with both community benefit and sustainability at its heart, the project has already achieved impressive green credentials. It has scored 43 out of 45 on the Considerate Constructors Scheme, earned an A-rating for its environmental performance, and has successfully diverted 95% of its waste from landfill.

The average distance travelled by supply chain partners to site is just 28 miles, supporting local employment and reducing environmental impact. The project has also been 12 months accident-free and recently received an annual safety award for the Nottingham region

Once complete, Mansfield CDC will be Nottinghamshire’s first dedicated Community Diagnostic Centre, providing a one-stop location for patients to access the tests and investigations they need, helping to speed up diagnoses and improve health outcomes. The centre will also create hundreds of new jobs, further supporting the local community.

Other Trust updates

Nominations for Trust *Excellence Awards* flood-in

Nominations for this year's Trust *Excellence Awards* have now closed and judging of the over 300 nominations we received has now begun – including dozens of nominations received from members of the public for our prestigious *People's Award*.

The Trust *Excellence Awards* are single greatest opportunity to celebrate the achievements of our colleagues who have gone over-and-above to provide great patient care over the past year.

The Awards celebrate the incredible dedication and hard work of our colleagues, teams, and volunteers who make a difference in the lives of patients, visitors and their colleagues.

I look forward to celebrating our colleagues' successes at this year's Awards, which are due to take place in September.

Mobile unit takes clinical research to local communities

A state-of-the-art mobile research unit is taking to the roads of and Derbyshire, making it easier for people to take part in research opportunities and clinical trials.

Members of the SFH Research team with members of the Trust's Board of Directors

The Trust has teamed up with the National Institute for Health and Care Research (NIHR) Research Delivery Network (RDN) East Midlands and Chesterfield Royal Hospital NHS Foundation Trust to provide a mobile research unit (MRU) to take research out into local communities.

The van, which is fully accessible and equipped with patient treatment and waiting areas, will attend events to promote health and research and give patients the opportunity to take part in relevant studies.

It will be easier for patients to sign up to and remain on research trials as they won't need to travel to dedicated research facilities at King's Mill Hospital or a local GP practice.

The mobile research unit will help us to make research more visible and accessible to everyone, particularly those who might have difficulty accessing healthcare.

Research is vital to improving healthcare because it helps us to understand what treatments and interventions work and what doesn't. We look forward to meeting lots of people and sharing research opportunities as we go out and about in the local area.

The Trust undertakes a wide variety of research, for example, screening for undiagnosed liver disease and treatment for high cholesterol.

The Research and Innovation (R&I) team cares for patients taking part in research trials in more than 25 areas, including Respiratory, Oncology and Rheumatology, dementia and ageing. The Trust plans to build on this work by expanding studies into areas not previously involved in research.

In 2023, Sherwood became the first Trust in the Midlands region to achieve accreditation from IAOCR (the International Accrediting Organisation for Clinical Research). Achieving bronze standard of the globally-recognised accreditation shows that Sherwood is consistently working to industry-leading global standards of best practice.

Look out for the mobile research unit across the Trust's three hospital sites and in the local area. The R&I team is looking forward to meeting people, talking about the research SFH is doing and how you could get involved.

To learn more about how Sherwood Forest Hospitals can support clinical trials, please email sfh-tr.researchandinnovation@nhs.net

If you are a service user, you can talk to your clinical care team about the potential of getting involved in a research trial.

Trust awarded funding for new Bone Density (DEXA) scanner at Newark Hospital

A new bone density or 'DEXA' scanner that uses x-ray to assess the risk of thin bones and to diagnose osteoporosis, is due to be installed at Newark Hospital after the Trust was awarded funding by NHS England.

The number of new referrals into the Trust's DEXA service has increased, with an average of 100 per week being received – reflecting our aging population.

Between April 2023 and November 2024, the Trust received a total of 7,910 referrals for DEXA scans. This is increasing by approximately 8% year on year.

Sherwood Forest Hospitals covers a large geographical area with many patients as far afield as Lincolnshire and Leicestershire opting to choose Sherwood Forest Hospitals as their preferred healthcare provider. It was recommended by the Royal Osteoporosis Society (January 2024) that there should be one DEXA scanner per 100,000 population. Sherwood serves a population of over 350,000 and, prior to the successful funding bid, only had one scanner located at Mansfield Community Hospital.

The new scanner at Newark Hospital, which should be operational by September 2025, will significantly enhance the service we can provide to our patients, allowing them to receive their diagnostic scan at a location closer to home, reducing the need for patients to travel, as well as reducing the costs they incur.

Currently, all patients – many of whom have limited mobility – have to travel to Mansfield Community Hospital. From September, patients will be able to receive their appointment in Newark and Mansfield, whichever is nearer for them.

This project reinforces our commitment to deliver outstanding healthcare for our patients and communities and helps us to continue improving local health and care services. Osteoporosis affects over two million adults in the UK.

This new scanner will increase the capacity we can offer, allowing for an additional 360 scans per month which will help to reduce the time patients have to wait to access their diagnostic tests, increasing the speed and efficiency of the care that we provide for our patients.

New cancer information and support centre opens in Newark

A Macmillan Cancer Information and Support Centre for people affected by cancer has opened in Newark, with support from the Trust.

The Macmillan Cancer Information and Support Service (MCISS) at the YMCA Community and Activity Village on Lord Hawke Way has started welcoming service users.

The Trust is working in partnership with Macmillan Cancer Support to provide the vital service in response to feedback from patients.

The development, which is an extension of the existing service at King's Mill Hospital, is the first of its kind nationally and is likely to attract interest and help shape the future delivery of Macmillan Cancer Information and Support Services.

A Macmillan information library will remain at the Eastwood Centre in Newark Hospital and will signpost people to the MCISS at the YMCA Village, Newark.

YMCA Village is a welcoming space in Newark that already brings together people from all around the community. With an on-site café, a friendly, supportive atmosphere, and a range of health and wellbeing activities, it offers a sense of belonging.

Partnering with the Macmillan Cancer Information and Support Service, the Village provides a comfortable, accessible environment where people affected by cancer can easily access vital resources and services close to home.

According to information held by the Trust, around 250 people a year in the Newark (NG24 postcode) area are diagnosed with cancer and feedback shows that people welcome care and support closer to home.

The centre, which is open Monday to Friday 8.30am to 4pm, offers drop-in services and appointments for personalised support. Advice and signposting from a range of partners will be available to address worries and concerns that may stem from cancer - including physical, practical, emotional, social and financial issues.

The new service is designed to provide information and support in a friendly and welcoming community setting rather than a traditional hospital environment. It offers support to anyone affected by cancer – including patients, carers, family, friends, employers, and staff working with those affected by cancer.

This includes people who may be worried about cancer, waiting for or having tests, those who have recently been diagnosed, are living with cancer, receiving treatment including palliative or end-of-life care, cancer survivors and those who have finished treatment, as well as those dealing with the loss of someone to cancer.

The service is currently recruiting ambassadors who are interested in the centre and its activities. Ambassadors will help share information within their communities and contribute to the development of the new service. Anyone who is interested, should email sfh-tr.cancer.info@nhs.net to sign up to receive a regular newsletter.

Trust launches new public-facing website

In May, the Trust launched its new public website to make it even easier for patients to access the information they need online.

The new website has been created to make the site more accessible for everyone, with a particular focus on improvements that make the site easier to access and navigate for people with disabilities and impairments that impact how they access digital information.

The site features a new, clean and more modern design and has involved thousands of pieces of individual content painstakingly reviewed by experts from across the Trust to ensure that the information we provide online is credible, well-structured and easy to navigate.

The site has been designed with the highest accessibility standards built-in from the start to ensure compliance with the Public Sector Bodies Accessibility Regulations 2018, which align with European standards on web accessibility.

The Trust's compliance with those standards has increased from 57% in October 2023 to 89% today, taking Sherwood from 230th to 68th in a league table of NHS websites across the country – an improvement journey we expect to continue following the launch of our new website.

You can visit the Trust's new public-facing website for yourself by visiting www.sfh-tr.nhs.uk.

Partnership meetings continuing with key partners

Meetings have been continuing with key partners over recent months, as the Trust continues to explore strengthening its existing partnerships with key partners.

Conversations have included separate meetings with the Mayor of the East Midlands, Claire Ward, meetings with representatives from the Nottingham and Nottinghamshire Integrated Care Board, and meetings with NHS England's regional director for the Midlands, Dale Bywater.

We have also held Board-to-Board, Executive-to-Executive meetings and established a committee-in-common with our colleagues at Nottingham University Hospitals (NUH) to strengthen working relationships, improve the provision of our shared services and consider the implications and opportunities afforded by the 10-year plan 'triple-shift', with our near neighbours.

Trust risk ratings reviewed

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

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

The full and updated Board Assurance Framework (BAF) is next due to be presented at the Public Meeting of the Trust's Board of Directors in August.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors - Cover Sheet

Subject:	Making Tomorrow Better – Strategy Delivery Update Improving Lives strategy – Year 1 report	**Date:**	5th June 2025
Prepared By:	Paula Longden, Associate Director of Strategy and Partnerships		
Approved By:	Claire Hinchley, Director of Strategy and Partnerships		
Presented By:	Claire Hinchley, Director of Strategy and Partnerships		

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

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

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

Committees/groups where this item has been presented before

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

Acronyms

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

Executive Summary

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

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

- Strategic objective 1 – Provide outstanding care in the best place at the right time
- Strategic objective 2 – Empower and support our people to be the best they can be
- Strategic objective 3 – Improve health and wellbeing within our communities
- Strategic objective 4 – Continuously learn and improve

- Strategic objective 5 – Sustainable use of resources and estate
- Strategic objective 6 – Work collaboratively with partners in the community

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

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

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

The following report provides a summary of progress against each strategic objective during the first year of the strategy and performance against five strategic commitments.

Current context

Since the strategy was developed, challenges and changes across the length and breadth of the NHS have been rife, with significant and fast paced changes in policy, and increasingly challenging operational and financial climates. The NHS is often operating within a Volatile, Uncertain, Complex and Ambiguous state (VUCA) requiring rapid re-prioritisation and changes to well-intended plans at the time they were written.

The Trust strategy is no exception to these changes resulting in a slower pace of delivery in some areas as the Trust has responded to the changing landscape and re-aligned its plans accordingly. The antidote to a VUCA world is to have vision, understanding, clarity and agility to respond in an informed and timely way that still works towards delivery of the original aims and ambitions.

The awaited NHS 10 year plan is due to be released at the end of June which will go some way to providing clarity on the national direction of travel. This will be interpreted within the Trust to identify what actions the Trust needs to take itself and with health and care partners to localise those actions to meet the challenging health needs of the local population and improve health outcomes.

Summary of progress

The report outlines areas of progress, with a selected summary below. The Trust:

- Continues to see positive feedback from patients and their families and carers through the friends and family test
- Has maintained its position as best acute trust in the East Midlands, remains a high performing Trust and is incredibly proud of its overall results and how it is placed both locally, regionally and nationally against a challenging NHS landscape.
- Has made significant strategic progress with the revision of two supporting strategies Quality and People, and the introduction of the Finance strategy. In addition, the Nursing, Midwifery and Allied Health technical strategy was refreshed. All strategies have been developed through wide-scale engagement with our people and patients, have action plans and will be reported through their sub committees.
- Adopted new technologies with new digital improvements through the expansion of the

electronic patient medication administration system and implementation of a new cardiac CT scanner. It continues to progress the selection and implementation of an electronic patient record, which will provide a basis for future innovation.
- Maintains and continues to improve safe and efficient care including the introduction of a Fit2Sit area and acute frailty unit against the backdrop of increasing demand and acuity during 2024/25.

Years 2-5

The Trust strategy continues to be developed for years 2-5 through a series of Board strategy workshops. The vision to deliver outstanding care must align with three national strategic shifts that are anticipated within the new NHS 10 year plan:

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

The Trust is a local provider of healthcare for the population of Mid-Notts (Mansfield, Ashfield, Newark and Sherwood) including some of the surrounding areas, and these three strategic shifts are in the process of being formulated into the strategic plan for years 2-5 and beyond. The ambition of providing outstanding care is that local health outcomes improve over time in a way that is delivered by the Trust with other health and care partners, and within local integrated neighbourhood teams.

Recommendation

Board is asked to NOTE progress made in the first year of the five-year strategy and NOTE the plan for developing years 2-5 in line with the NHS 10 year plan.

Introduction

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

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

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

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

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

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

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

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

Summary of progress September 2024-March 2025

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

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

In our journey to be rated outstanding across all of its services, the Trust has taken steps to be at the forefront of service provision with innovative, safe and efficient healthcare. Progress has been made during a year where demand and complex health needs continue to increase.

The Quality Team consulted on a new Quality strategy for 2025-2029, aligned to the Trust's Improving Lives strategy, which was launched in April 2025.

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

- Expansion of the electronic patient medication administration system into Maternity Services and the Emergency Department, which reduces the risk of medication errors improving patient safety; supports prescribers to administer the right information in a timely way; and facilitates prompt information sharing of medication reviews with general practice improving continuity of care
- Focused improvements in cardiology with the implementation of a new cardiac CT scanner, a strengthened workforce reducing reliance on locums and short-term solutions, and the introduction of Cardiobase, a cardiology-specific solution to improve workflow and systems. These improvements have had a significant impact on access to diagnostic procedures eliminating 13 week waits for CT scans
- Introduction of a Fit2Sit area transforming it into a modern, calming and pleasant space for patients awaiting investigations and treatment, improving patient experience, flow and allowing for better utilisation of the Trust's estate
- Improvements for the Trust's frail patients with a winter trial of an acute frailty unit providing valuable learning for future strategic planning, increased focus in training and induction programmes on preventing falls and keeping patients active to improve patient outcomes and safety

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

Making the Trust a great place to work and belong is a key focus of our People Strategy, which was newly launched in April 2025.

Improvements have been made to services provided by the People Directorate, aligned to the four delivery pillars of the NHS People Plan.

Looking after our people

- Expansion of the violence prevention and reduction plan to sexual safety for colleagues to feel safer and more supported
- Development of the Trust's wellbeing offers to support teams and individuals

Belonging in the NHS

- A strong NHS staff survey response rate of 63.1%, significantly higher than the national average of 50%, reflecting strong engagement from colleagues and providing valuable feedback on staff experiences to inform future improvements
- Introduction of a new award, 'Outstanding Contribution to Equality, Diversity and Inclusion' to recognise a colleague who had made outstanding contributions towards the inclusion and belonging of colleagues within their team and/or more broadly across the Trust

Growing for the future

- Embedding the enhanced apprenticeship and work experience offers in partnership with Vision West Nottinghamshire College
- Implementation of the new coaching and mentoring network to develop the Trust's talented staff

New ways of working and delivering care

- Development of a long-term workforce model from April 2025 and supporting service lines to produce tactical plans
- Workforce plans and recruitment to the Trust's new Community Diagnostics Centre services at Mansfield Community Hospital continue to be supported

Strategic objective 3 – Improve health and wellbeing within our communities

The Trust will ensure that every contact counts and is committed to improving health and wellbeing within those people who work and live in our local population.

The Trust is taking action to address health inequalities:

- Development of an inequalities index to support service lines and specialties to identify and focus on those areas with the greatest inequalities, early work is focusing on outpatient referrals building greater understanding of did not attends and re-referral rates
- Establishment of an end of life, spiritual and pastoral care department to provide a joined-up approach for patients, their families and carers and communities
- Delivery of bespoke equality, diversity and inclusion and Allyship in Sherwood training to enhance colleagues' sense of belonging and inclusion and building knowledge and understanding in providing compassionate and inclusive healthcare
- The first steps taken into implementation of Making Every Contact Count with the identification of priority specialities and service line champions and the establishment of a community of practice
- Supporting ongoing development sessions with Place based teams to identify priority areas and how the acute sector can work with community teams to improve health outcomes

Strategic objective 4 – Continuously learn and improve

To embed a strong culture of continuous improvement the Trust has:

- Implemented "cancer huddles" in Women's and Children's Division, which have delivered strong and sustained improvements for patient care quality and experience and how the Trust uses its resources and are now being shared across the Trust
- Made it easier for patients to cancel and rearrange appointments allowing for more convenient appointment times and reducing the appointment waiting time. This has resulted in a reduction in abandoned call rates and did not attends with an associated increase in Trust productivity
- Relaunch and expansion of the Trust-led knowledge hour for general practice teams to enhance their knowledge of key subjects and processes and improve relationships across primary and secondary care

- Establishment of WAVE (working to achieve value and excellence) project in partnership with Nottingham University Hospitals to enhance care in priority specialities and share improvement knowledge and experience between the two trusts

Strategic objective 5 – sustainable use of resources and estate

To deliver the best possible care for the community we serve, and using our resources wisely the Trust has:

- Developed and launched its new five-year finance and procurement strategy, Resourcing Our Future, following development and engagement through the year
- Improved access to diagnostics with the installation and operation of a hybrid MRI and a full contrast MRI launched in Newark Hospital reducing waiting times and allowing for earlier diagnosis for our patients
- Fifty climate champions working at ward and clinical level to reduce our consumption of single use items and improve recycling and waste management.
- Rolling out the power down of computers and laptops when they are not in use to deliver significant energy savings with no impact on staff or patients.

Strategic objective 6 – Work collaboratively with partners in the community

The Trust has a long history of working in partnership, recognising delivery of the strategic objectives cannot be achieved by the Trust alone. The Trust has developed several relationships into deliverable partnerships including:

- Development and launch of the Trust's first anchor plan strengthening its intentions to be a responsible anchor organisation and credible local partner; during the year the Trust supported 172 apprenticeships and 85 work experience placements as well as two Kier apprenticeship places working on the new Community Diagnostic Centre
- Strengthened partnership working with general practice implementing a formal mechanism for resolving primary secondary care interface issues, agreeing and promoting 5 asks focused on streamlining key areas where problems can occur more frequently and implementing a twinning scheme bringing together GPs and consultants to enhance understanding and build relationships
- Existing Compact with Vision West Nottinghamshire College refreshed and strengthened confirming it as the preferred educational partner, and establishing four workstreams supporting the delivery of the new People Strategy and contributing to local employment

Commitments

The Trust made strategic commitments to its patients, people and population setting out improvements that they would experience during the period of the strategy and its supporting strategies.

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

Performance against these are shown below:

Measure	2024	2025
Be rated Outstanding by the CQC	GOOD	No change
Increase the percentage of our people who recommend Sherwood Forest Hospitals as a place to work	74.52%	70.57%
Increase the percentage of people who recommend Sherwood Forest Hospitals as a place to be cared for	95.1%[1] 93.5% [2]	95.4% [1] 93.4% [2]
Increase the percentage of our local population engaging in healthy choices and behaviours	Measure not yet established	Measure not yet established

[1] % of outpatients who had a positive experience at SFH

[2] % of inpatients who had a positive experience at SFH

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Trust Public Board of Directors - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	5 June 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		
To update the Board of Directors on our progress as Maternity and Neonatal safety champions	**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

- 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

- MNVP - Maternity and Neonatal Voice Champion
- PAC - Perinatal Assurance Committee
- LMNS - Local Maternity and Neonatal System
- NICU - Neonatal Intensive Care Unit
- MSW/MCA - Maternity Support Workers/Maternity Care Assistants
- SBLCBV3 - Saving Babies' Lives Version Three: A care bundle for reducing perinatal mortality
- TC- Transitional Care

Executive Summary

The role of the maternity and neonatal safety champions is to support the regional and national Safety Champions as local champions for delivering safer outcomes for pregnant women, birthing individuals, and their babies. At the provider level, local safety champions should:

- Build the maternity and neonatal safety movement in your service locally, working with your clinical network safety champions, continuing to build the momentum generated by the maternity transformation programme and the national ambition.
- provide visible organisational leadership and act as a change agent among health professionals and the wider perinatal team working to deliver safe, personalised care.
- act as a conduit to share learning and best practice from national and international research and local investigations and initiatives within your organisation.

This report provides highlights of our work over the last month.

Maternity and Neonatal Safety Champion (MNSC) oversight April 2025 data

Maternity

1. Staff Engagement

1.1 Safety Champion Walkaround

No Safety Champion walkaround was scheduled in April 2025 due to operational pressures. Monday to Friday, our Matrons, Deputy Head of Midwifery (DHoM), Head of Midwifery (HoM), and Director of Midwifery (DoM) take time each day to walk around clinical areas and talk with staff as a business as usual approach to leadership and visibility. We have received DATIX and email escalations from our Triage staff in April in response to an increase in acuity and its impact on their health and well-being. A maternity Matron chaired an emergency meeting with the team on 14th May 2025, and a collaborative MDT approach will be adopted to address some immediate actions.

1.2 Perinatal Services Forum

The Maternity Forum was remodelled and relaunched on 2nd April 2025 as our new Perinatal Services Forum. Chaired by Chief Nurse Phil Bolton, this meeting was attended by DoM/DDN Paula Shore, varying MDT staff, and a representative from the Staff Council. Key discussion points were the relaunch of Transitional Care, planned for 2nd June 2025 and the launch of Year 7 of the Maternity Incentive Scheme. Feedback was shared by Staff Rep Hayley Hill that overall maternity staff were feeling positive around the staffing model in the acute, and how it feels to be on busy shifts; improved support and communication, and a noticeable improvement in getting breaks. The next key area to address, however, is handovers at the start/end of each shift, as these take too long and cause staff to finish late.

1.3 NETS Survey

The National Education and Training Survey (NETS) provides us with a unique, multi-professional insight into the experience of the current and future healthcare workforce working and learning in services at SFH. Areas to celebrate within our Division are the experiences our student midwives and medical teams have during induction, but also their reported experiences of the quality of care they see provided to women and birthing individuals.

King's Mill Hospital, NG17 4JL	Midwifery	Induction	High Outlier
King's Mill Hospital, NG17 4JL	Midwifery	Quality of Care	High Outlier
King's Mill Hospital, NG17 4JL	Obstetrics And Gynaecology	Induction	High Outlier

1.4 Staff Council

Relaunched for April 2025 as the Perinatal Staff Council with additional members, including a member of Transitional Care (TC). The latest query from staff was around the role of the band 3 Maternity Support Worker (MSW) and how this impacts bank shifts and the provision of clinical care in the acute setting.
Feedback received via the Council:

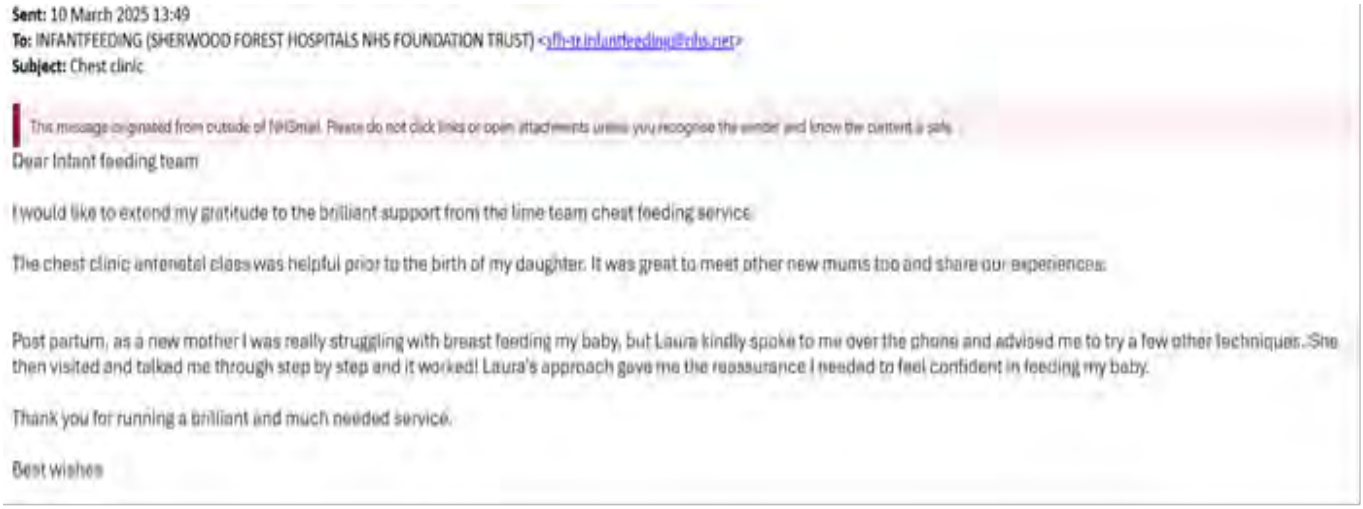
Following last Wednesdays all day ELCS list (23/04). From the LWC, midwives (especially Georgia and Ellie), surgeons, anaesthetists and theatre teams (elective and emergency) they worked together phenomenally. It was a challenging day for all involved and the pressure was on to complete all 6 ELCS (NEVER AGAIN!) But together they remained positive, communicated brilliantly and continued on despite the possibility of the 6th potentially needing to be cancelled due to SBU acuity. All ELCS were completed that day and I just want to say a huge thank you to all of them for their hard work. It has not gone unnoticed.

2. Service User Feedback

2.1 Patient Experience Committee (PEC)

Representatives from the Division attended PEC on 27th March 2025. Going forward, we will be introducing the role of our MNVP and our Lead Advocate, Sarah Seddon, formally to the committee as evidence of how we engage with service users and how the voices of our women and birthing individuals shape our quality improvements.

2.2 Compliments



Sent: 10 March 2025 13:49
To: INFANTFEEDING (SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST) <sfh-tr.infantfeeding@nhs.net>
Subject: Chest clinic

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Infant feeding team

I would like to extend my gratitude to the brilliant support from the time team chest feeding service.

The chest clinic antenatal class was helpful prior to the birth of my daughter. It was great to meet other new mums too and share our experiences.

Post partum, as a new mother I was really struggling with breast feeding my baby, but Laura kindly spoke to me over the phone and advised me to try a few other techniques. She then visited and talked me through step by step and it worked! Laura's approach gave me the reassurance I needed to feel confident in feeding my baby.

Thank you for running a brilliant and much needed service.

Best wishes

To: AYRE, Sarah (SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST); BUTLER, Lisa (SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST) Wed 30/04/2025 11:18

Some people who received this message don't often get email from maryannettaroddy@googlemail.com. Learn why this is important

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Hi Sarah & Lisa,

I got your contact details from Natalie Poismans.

I wanted to pass on some feedback about some amazing members of the team. I had a cervical stitch on Monday and have been monitored for a few weeks prior.

Lisa and Sarma from the Pre-Term team have just been fantastic.

Lisa has been supporting for the past few weeks and has gone over and above to help, support and reassure me throughout, she even called me on her day off.

Sarma really held my hand on Monday during my procedure, calmed my nerves and really distracted me through the whole process including coming to check in on me that evening and the next morning and answered all of my questions etc.

I had a traumatic labour and delivery with my little boy 3 years ago and a miscarriage last year and as a result I've been fairly anxious this time around so I'd like to thanks Lisa & Sarma for really making me feel at ease and safe throughout the process and helping to dispell some of my anxieties.

They've both really made me feel like I've been in safe hands and I know I've got a great support going forward. Please could you pass on my thanks, they're a real credit to the team.

Thank you,

2.2 Maternity and Neonatal Voices Partnership

The focus for April and May 2025 is to ensure all actions from the MNVP's 15 Steps visit in Autumn 2025 are embedded as business as usual. A follow-up visit is to be booked. MNVP have been invited to attend MNSI QRM and the MatNeo Sip Conference in May, and to be part of the Consultant Midwife stakeholder interviews planned for the end of May 2025.

2.3 Friends and Family Test

Key words from April's FFT feedback – work cloud generated by Envoy.

3. Quality Improvements

3.1 OASI bundle - full implementation

We have taken a refreshed approach to implementing the full bundle, led by Quality and Safety Lead Midwife Sarah Sarjant. Implementation Group includes MNVP support to ensure improved communication with service users, including the development of resources accessible to all service users, as an improved approach to element one of the bundle.

3.2 A new look Perinatal Services Webpage for SFH

As we look to update and improve our collaborative approach to providing care for women, birthing individuals, and their families, we will be overhauling our SFH webpage with support from the MNVP.

We will be working towards a more inclusive, multi-formatted approach to the information we can supply, with easy access and easy use formats, including sound-oriented formats in the top languages for our demographic, links to support, and better visual aids. This will be supported internally after June 2025 when the corporate team will have more capacity.

4. National Programmes

4.1 NHSE Perinatal Culture and Leadership Programme (QUAD+3)

The programme concluded on 15th March 2025, and a paper around what we have learnt and next steps will be shared at PAC in July 2025 due to the new programme of meetings. Ongoing work will now focus on relaunching the Maternity Forum as the Perinatal Services Forum, embedding open and transparent communication channel from Ward to Board and Board to Ward and leading the action plan devised from the most recent staff survey results.

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, Chief Nursing Information Officer, which will support objective 12.

4.4 NHSR

The senior team attended the national webinar on Year 7 of the Maternity Incentive Scheme (MIS) on 28th April 2025. This half-day session provided a crucial update on the scheme's changes and featured a range of expert speakers dedicated to supporting perinatal safety.

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 – Sarah Sarjant
Safety Action 2 MSDS – Lisa Butler
Safety Action 3 Transitional Care – Rachael Giles
Safety Action 4 Clinical Workforce – Samantha Barlow
Safety Action 5 Midwifery Workforce – Lisa Butler
Safety Action 6 Saving Babies Lives – Sarah Sarjant
Safety Action 7 Listening to service users – Sarah Ayre
Safety Action 8 Training – Lisa Butler
Safety Action 9 Board Assurance – Sarah Ayre
Safety Action 10 MNSI – Sarah Sarjant

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 the HoM, to be presented at PAC once completed.

4.6 National Survey - CQC

The results of the survey conducted in 2024 were published in April 2025. The Trust saw higher than average scores in most areas, coming in at number 2 out of 34 Trusts surveyed for antenatal care, and scoring highly in questions relating to mental health support. We have shared these results with our teams. The 2025 Maternity survey will be 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. The Governance Lead Midwife is currently benchmarking against the report, and her updates will be shared via PAC once completed.

5. Maternity Perinatal Quality Surveillance scorecard April 2025

5.1 Stillbirth Review 2024-2025

The Quality and Safety team have reviewed the 38 cases from February 24 to March 25, noting these cases have already been through the internal governance process, we have added additional information columns to review Saving Babies Lives indicators. A comprehensive report will be presented at PAC in July.

5.2 Current SBLCBV3 Compliance April 2025

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

Neonatal Services

5.3 Workforce - Nursing Staffing Update

NICU

- Band 5 – started 10th March 25
- Band 6 - Clinical induction date 2.6.25
- Band 6 - Clinical induction date 28.4.25

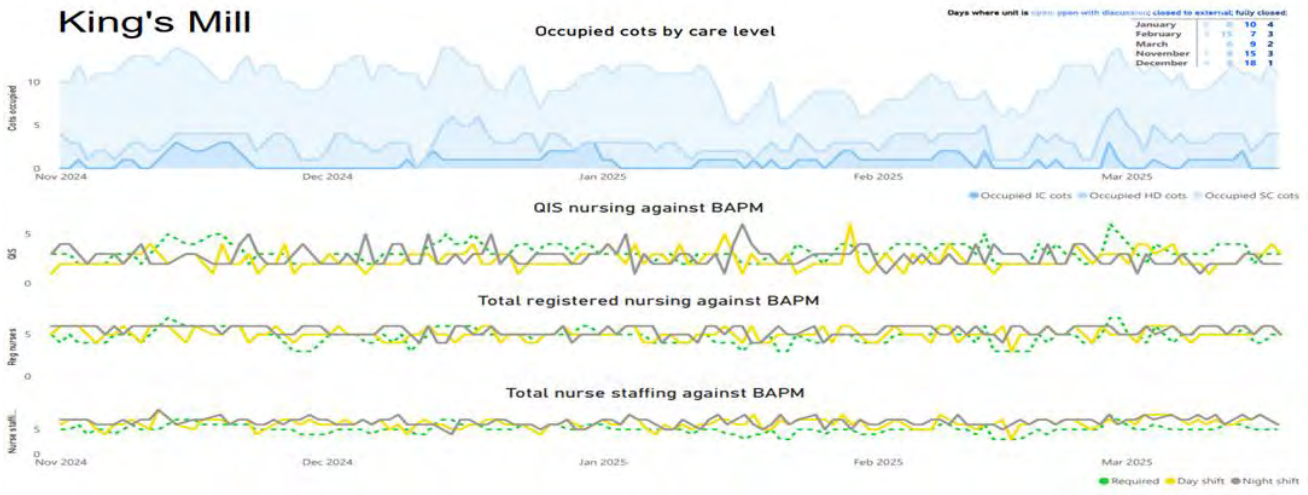
NTC

- HCSW - Clinical induction 12.5.25
- RN - Clinical induction 14.4.25
- HCSW - start date TBC internal so will only need to give 4 weeks' notice
- HCSW - start date TBC.

Interviews 16th April 25 for NTC – following this no vacancies across both teams.

Still supporting long-term sickness with 3 qualified staff and management short-term sickness.

5.4 QIS compliance



Currently 63% - BAPM requirement 70%
2 band 6 QIS staff joining NICU, going through recruitment process and when in post will make us compliant.
3 staff planned to qualify by Sept 2025- making us 74%
3 staff will complete the Sept 25-Aug 26 QIS course- resulting in a total of 82% by Sept 2026

5.5 Neonatal Transitional Care Service

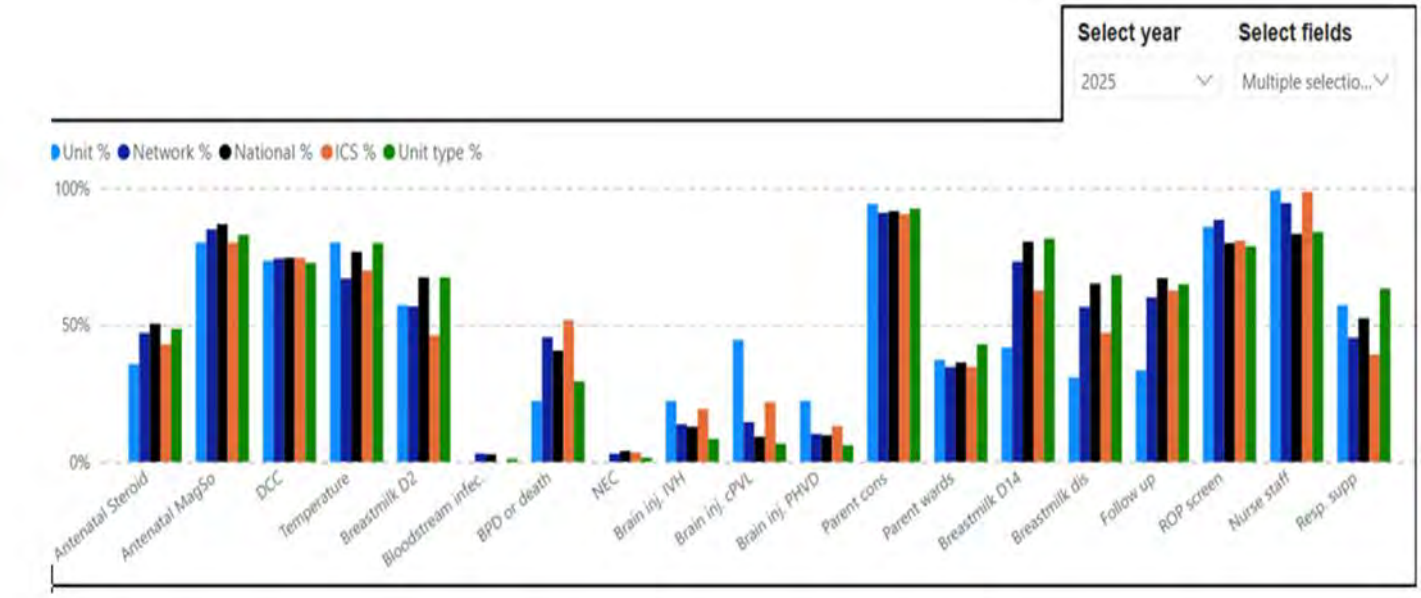
Relaunch date 2nd June 2025

- Daily huddles to discuss each TC baby to ensure the babies are in a suitable place for the care they need, using a multi-disciplinary approach.
- Recruitment of nurse to meet establishment needs.
- Recruitment of support workers to meet establishment needs.
- Training process in place to train all core midwives to complete neonatal IV antibiotics.
- Clinical office now allocated and set up.
- Excellent links and relationships the maternity staff, the Neonatal Unit and medical teams.
- Family and Friends feedback survey in place.
- Hearing screen team and NIPE team involvement to ensure efficient and timely practice.
- Homecare presence each morning at the huddle for referrals.
- Reviewing term admissions to the Neonatal Unit, for appropriateness.
- QI project in process. Measures to reduce term admissions to NICU. Themes identified from the ATTAIN data, was low saturations at birth, resulting in NICU admission, often resulting in sort term monitoring and returning the parents. Visual aids placed on all resuscitators' on SBU and theatres, identifying acceptable pre-ductal saturations at 2,5 and 10 minutes after birth, as advised by the Resuscitation Council 2017.
- Deployment of TC staff to NICU to be re-deployed back to TC in preparation for Launch.

5.6 NNAP compliance (National Neonatal Audit Program)

- Completed and submitted Midlands Regional Review of Neonatal services. Demonstrated meet requirements across most areas or are working toward.

- We have a gap on end of life and arrangements for potential organ donation. We are currently re writing our SOP around bereavement support and pathway and this is part of this review – to explore against the national guidelines.
- 1st Quarter NNAP returns have been completed 100% compliance for submission and accuracy of data. NICU leadership team have worked incredibly hard to provide the input into these audits to reflect accurately what is happening on the NICU. – below chart provides benchmarking position as to where we are in comparison to the Network, National positions.



5.7 3D Tours

The virtual tour of the Neonatal Unit is now live and it is available on our website here:

https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.emnodn.nhs.uk%2Fking-s-mill-hospital&data=05%7C02%7Csarah.ayre4%40nhs.net%7Cbc3b68a9894d42e0423f08dd865949c3%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638814440231023770%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=JLLw%2BW3yHiQl%2BCdxe%2BixJdUrhiyoEyJ53iXAUtN7H2A%3D&reserved=0

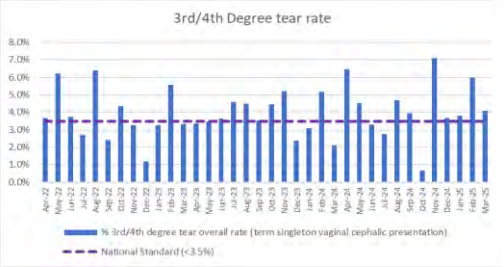
Maternity Perinatal Quality Surveillance Model for April 2025 (March 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

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

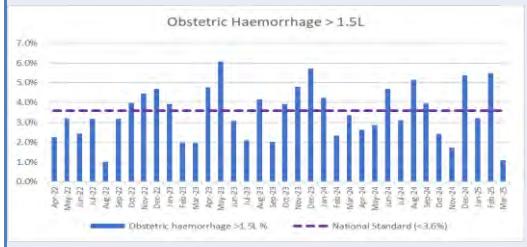
3rd/4th Degree Tear – 4.3% (YTD) (quality indicator 3.5%)

- 4.1% March 2025



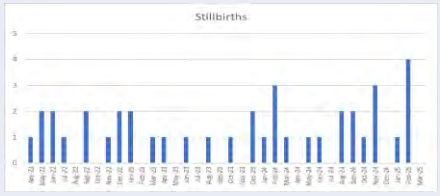
Postpartum Haemorrhage

- 1.1% March 2025



Stillbirth Rate 6.2% (YTD) (quality indicator6.2%)

- No cases in March
- Review underway – initial report to PAC 23.05.25



Patient Experience

New meeting to be chaired by Lead Advocate Sarah Seddon – to embed triangulation of investigation findings, learning, and service user voice

Service User Voice - March 2025

Engaging with MNVP on the Perinatal website redesign. Service User feedback is being collected, a range of formats is being explored – to support neurodiverse needs and improve inclusivity

Workforce

Maternity

1 Obstetric Consultant vacancy – recruitment underway.

Midwifery B6 and MSW B3 vacancy due to increased headroom from 1st April 25 - advertised. Pre-Term Birth Lead – secondment and B7 Lead for ANC/PDC – interviews 24/25 April. Consultant Midwife post out to advert

Neonatal

Significant nursing challenges due to staff absence through maternity and sickness. Local plan enacted to support.

No Neonatal Consultant vacancy.

Staffing Red Flags (March 25)

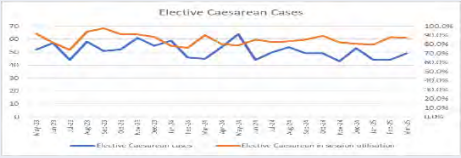
Suspension of Maternity Services

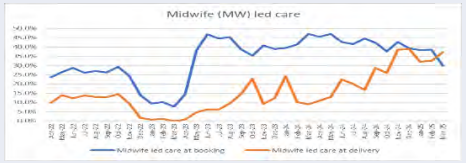
0 suspensions in March

- 18 in total year to date
- April to October – 15
- Nov – March - 3

Home Birth: 2 Homebirths in March

Discussion point: Trend in reduced midwifery-led care at booking due to maternal complexities, alongside an increase in ELCS. To be explored by the Consultant Midwifery Team.





Saving Babies Lives Care Bundle (SBLCB v3) MARCH 2025 POSITION – 100% IN 4 ELEMENTS – 91% OVERALL

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

Maternity Assurance

NHSR

- Year 6 MIS completed and achieved
- Planning for Year 7 underway – awaiting technical guidance.

National Reporting

- Ockenden - Initial 7 IEA- 100% compliant
- 3 yr. Delivery plan – system plan in development

Incidents reported Feb 2025: 107 (107 no/low harm, 0 moderate or above*)

MDT reviews	Comments
Triggers x 20	2 cases escalated to Rapid Review

- Learning identified – MDT reminded of the importance of prompt SBAR handover and improve timely communication to aid decision making
- Learning shared around prescribing aspirin when there is low PAPP-A

Maternity Perinatal Quality Surveillance scorecard March 2025

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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	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			49%	49%	48%	48%	46%	48%	46%	44%	54%	51%	52%	51%	48%	
3rd/4th degree tear overall rate	<3.5%	3.50%	2.10%	6.00%	4.50%	3.00%	2.80%	4.70%	3.90%	0.70%	7.10%	3.70%	3.80%	6.00%	4.10%	
3rd/4th degree tear overall number		79	3	11	8	4	4	7	6	1	12	6	6	6	6	
Obstetric haemorrhage >1.5L number		127	9	9	9	11	9	15	12	7	5	16	9	14	3	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	3.40%	2.60%	2.90%	4.70%	3.10%	5.10%	3.90%	2.40%	1.70%	5.40%	3.20%	5.50%	1.10%	
Term admissions to NICU	<6%	3.10%	3.80%	2.60%	4.00%	2.90%	4.70%	4.00%	3.90%	3.60%	3.30%	1.90%	1.10%	1.95%	2.32%	
Stillbirth number		10	1	0	1	1	0	2	2	1	3	0	1	4	0	
Stillbirth rate	<4.4/1000		3.100			2.300			4.400			4.500			4.300	
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		1:27	1:27	1:27	1:27	1:22	1:22	1:23	1:22.18	1.22.10	1.22.10	1.22.10	1.19.53	1.20.59	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:23	1:23	1:24	1:22.75	1:22.18	1.22.10	1.22.18	1.19.85	1.20.42	
Number of compliments (PET)		38	4	5	4	1			1	2	1	1	2	3	2	
Number of concerns (PET)		9	1	0	0	4			4	0	1	0	0	1	0	
Complaints		6	0	1	1	0			0	0	0	0	0	0	1	
FFT recommendation rate	>93%		90%	90%	91%	91%			84%	89%	84%	83%	82%	83%	89%	

External Reporting	Standard	Running Total/ average	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Maternity incidents no harm/low harm		1339	102	95	130	102	125	169	115	159	142	131	89	107	107	
Maternity incidents moderate harm & above		0	0	0	0	0	2	1	0	0	0	0	2	0	0	
MNSI/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	1	1	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	Mar-25	No cases met PMRT reportable criteria in March 25, we reviewed two cases through the MDT meeting – both are currently pending results prior to finalising reports.
Findings of review all cases eligible for referral to MNSI	Mar-25	1 case eligible for reporting to MNSI: interviews have commenced w/c 10/03/25. 1 case still awaiting outcome re whether taken on by MNSI; based on MRI results/ no consent from family.
Service user voice feedback	Mar-25	FFT RESPONSE RATE - remains poor / collaboration with MNVP to address
Staff feedback from Safety Champions and walk-abouts	Mar-25	MNSC walk arounds continue and Staff Council formed and working with Trust wide Shared Governance Council. Focus on divisional security and addressing Abduction Risk 1480

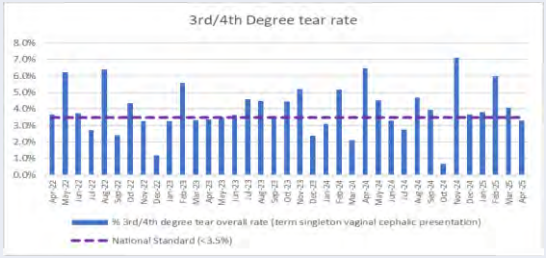
Maternity Perinatal Quality Surveillance Model for May 2025 (April 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

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

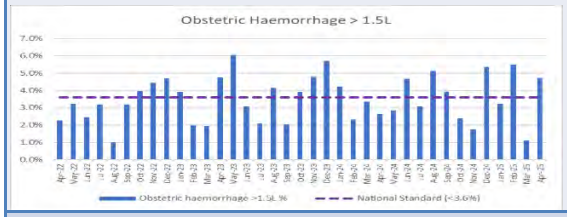
3rd/4th Degree Tear 3.3% (April 2025)

Focused relaunch of OASI bundle underway



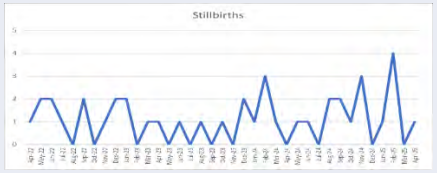
Postpartum Haemorrhage 4.7% (April 2025)

No themes identified – all cases reviewed and appropriate management noted



Stillbirth Rate 3.3% (April 2025)

Cluster review ongoing – report to PAC in July 2025

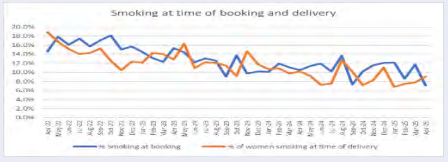


Patient Experience 94% (April 25)

Overall, remains a small response rate for the service but 94% positive with key feedback including improved communication at discharge home

Smoking Cessation

Quality improvement – Public Health



Workforce (April 2025)

Maternity

- 1 Obstetric Consultant vacancy – recruitment underway
- Midwifery B6 vacancy due to increased headroom from 1st April 25 - advertised
- Maternity Support Workers – B3 vacancy advertised
- Consultant Midwife interviews 29th May 2025

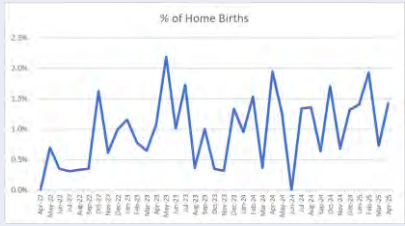
Neonatal

- Significant nursing challenges due to staff absence through parental leave and sickness absence. Local plan enacted to support.
- No Neonatal Consultant vacancy.

Staffing Red Flags (April 2025)

0 suspension of acute services in April 2025

2 Homebirths in April 2025



HB Service was suspended 4 times in April 2025 due to short-term staff sickness. Team Leads ask to look at alternative ways of working to ensure consistent service.

Red flags

8 incidents reported related to workload and staffing incidents in April 2025, no themes. Increase in incidents related to delayed obstetric reviews in Triage, impacting wait times

Saving Babies Lives Care Bundle (SBLCB v3)

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
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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

Maternity Assurance

NHSR	National Reporting
• Year 6 MIS achieved • Planning for Year 7 underway – awaiting technical guidance.	• Ockenden - Initial 7 IEA- 100% compliant • 3 yr. Delivery plan – system plan in development

Incidents reported Feb 2025: 95 (10 low harm, 2 moderate or above*)

MDT reviews	Comments
Triggers x 24	No themes identified

2 mod harm reviewed at Rapid Review

1. APH - PSIRG
2. BABY LOW TEMP AT HOME - PNRA – LEARNING/ACTIONS TO BE AGREED AND SHARED

Maternity Perinatal Quality Surveillance scorecard April 2025

Sherwood Forest Hospitals
NHS Foundation Trust

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

Maternal Perinatal Quality Surveillance Scorecard

Quality Metric	Standard	Running Total/ average	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			49%	49%	48%	48%	46%	48%	46%	44%	54%	51%	52%	51%	48%	51%	
3rd/4th degree tear overall rate	<3.5%	3.50%	2.10%	6.00%	4.50%	3.00%	2.80%	4.70%	3.90%	0.70%	7.10%	3.70%	3.80%	6.00%	4.10%	3.30%	
3rd/4th degree tear overall number		79	3	11	8	4	4	7	6	1	12	6	6	6	6	5	
Obstetric haemorrhage >1.5L number		127	9	9	9	11	9	15	12	7	5	16	9	14	3	13	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	3.40%	2.60%	2.90%	4.70%	3.10%	5.10%	3.90%	2.40%	1.70%	5.40%	3.20%	5.50%	1.10%	4.70%	
Term admissions to NICU	<6%	3.10%	3.80%	2.60%	4.00%	2.90%	4.70%	4.00%	3.90%	3.60%	3.30%	1.90%	1.10%	1.95%	2.32%		
Stillbirth number		10	1	0	1	1	0	2	2	1	3	0	1	4	0	1	
Stillbirth rate	<4.4/1000		3.100			2.300			4.400			4.500			4.300		
Rostered consultant cover on SBU - hours per week	60 hours	60	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	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:22	1:22	1:23	1:22.18	1.22.10	1.22.10	1.22.10	1.19.53		1:27	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:23	1:23	1:24	1:22.75	1:22.18	1.22.10	1.22.18	1.19.85	1.20.42	1.22.2	
Number of compliments (PET)		38	4	5	4	1			1	2	1	1	2	3	2	2	
Number of concerns (PET)		9	1	0	0	4			4	0	1	0	0	1	0	0	
Complaints		6	0	1	1	0			0	0	0	0	0	0	1	0	
FFT recommendation rate	>93%		90%	90%	91%	91%			84%	89%	84%	83%	82%	83%	89%	94%	

External Reporting	Standard	Running Total/ average	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Trend
Maternity incidents no harm/low harm		1339	102	95	130	102	125	169	115	159	142	131	89	107	107	89	
Maternity incidents moderate harm & above		0	0	0	0	0	2	1	0	0	0	0	2	0	0	0	
MNSI/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	N	N	N	N	N	1	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	1	1	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	Apr-25	0 cases reported or reviewed in April
Findings of review all cases eligible for referral to MNSI	Apr-25	1 case reported –which has subsequently now been rejected by MNSI due to MRI results and no family concerns.
Service user voice feedback	Apr-25	Service User being heard in Triage is a key focus for April and learning from this shared with the team throughout May 2025
Staff feedback from Safety Champions and walk-abouts	Apr-25	No walkaround in April due to operational pressures however staff feedback received via Perinatal Services Forum

CQC Maternity Ratings (date of inspection Nov 2022)	Overall	Well-Led	Responsive	Safe	Caring	Effective
	Good	Good	Good	Requires Improvement	outstanding	Good

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors - Cover Sheet

Subject:	Health Inequalities Annual Statement	**Date:**	5th June 2025
Prepared By:	Paula Longden, Associate Director of Strategy and Partnerships		
Approved By:	Simon Roe, Chief Medical Officer		
Presented By:	Simon Roe, Chief Medical Officer		

Purpose		
On the recommendation of the Partnerships and Communities Committee, the annual statement on health inequalities is brought to Board for approval.	**Approval**	**X**
	Assurance	
	Update	
	Consider	

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

Identify which Principal Risk this report relates to:		
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

Health Inequalities Steering Group –April 2025
Partnerships and Communities Committee – April 2025

Acronyms

CYP – children and young people
DALT - Drug and Alcohol Liaison Team
IMD – index of multiple deprivation
NHSE – NHS England
SFH – Sherwood Forest Hospitals NHS Trust

Executive Summary

Introduction

The purpose of this paper is for the Board to review and approve the Annual Statement on Health Inequalities.

Background

The Trust is required to collect, analyse and report health inequalities data to fulfil its reporting requirements for NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006).

NHS foundation trusts are required to include the statement within their annual report. The requirements are set out in the NHS Foundation Trust Annual Reporting Manual.

The indicators are mandated by NHSE guidance, and the timing of its production is in line with the annual accounts process. The criteria remain the same as 2023/24.

The following domains are relevant for Sherwood Forest Hospitals:

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

The Trust has produced its annual statement, which is appended to this cover sheet. It includes those specified indicators disaggregated by age, sex, deprivation and ethnicity, alongside actions that the Trust has taken to reduce health inequalities.

Once approved, the statement will be published within the Trust's annual report.

Recommendation

The Board is asked to consider and approve the Annual Statement of Health Inequalities.

Statement of Health Inequalities 2024-25

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

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

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

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

Population profile

SFH serves a population of approximately 350,000 people across Ashfield, Mansfield, Newark and Sherwood (Mid Nottinghamshire) and beyond. Local demographic data demonstrates a slight female majority (50.2%). The area has experienced a 9.6% population increase over the past decade. Notably, 20.6% of residents are aged 65 and over, surpassing the national average of 18.6%. This older demographic is associated with higher levels of frailty, leading to increased hospital admissions and healthcare needs1.

The population is predominantly White British (90.2%), which is higher than the national average of 74.4%. The second largest (known) ethnic group is Asian/Asian British, comprising 2.4% of the population2.

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

This socioeconomic deprivation correlates with poorer health outcomes. For instance, 78% of residents report being in good or very good health, below the England and Wales average of 80%. Additionally, 21.3% are classified as 'disabled

[1] KMH_002346_Mid_Notts_Place-Based-Partnership-Plan_2023-1
[2] KMH_002346_Mid_Notts_Place-Based-Partnership-Plan_2023-1

under the Equality Act', and 6.7% have a long-term physical or mental condition but are not classified as disabled[3].

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

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

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

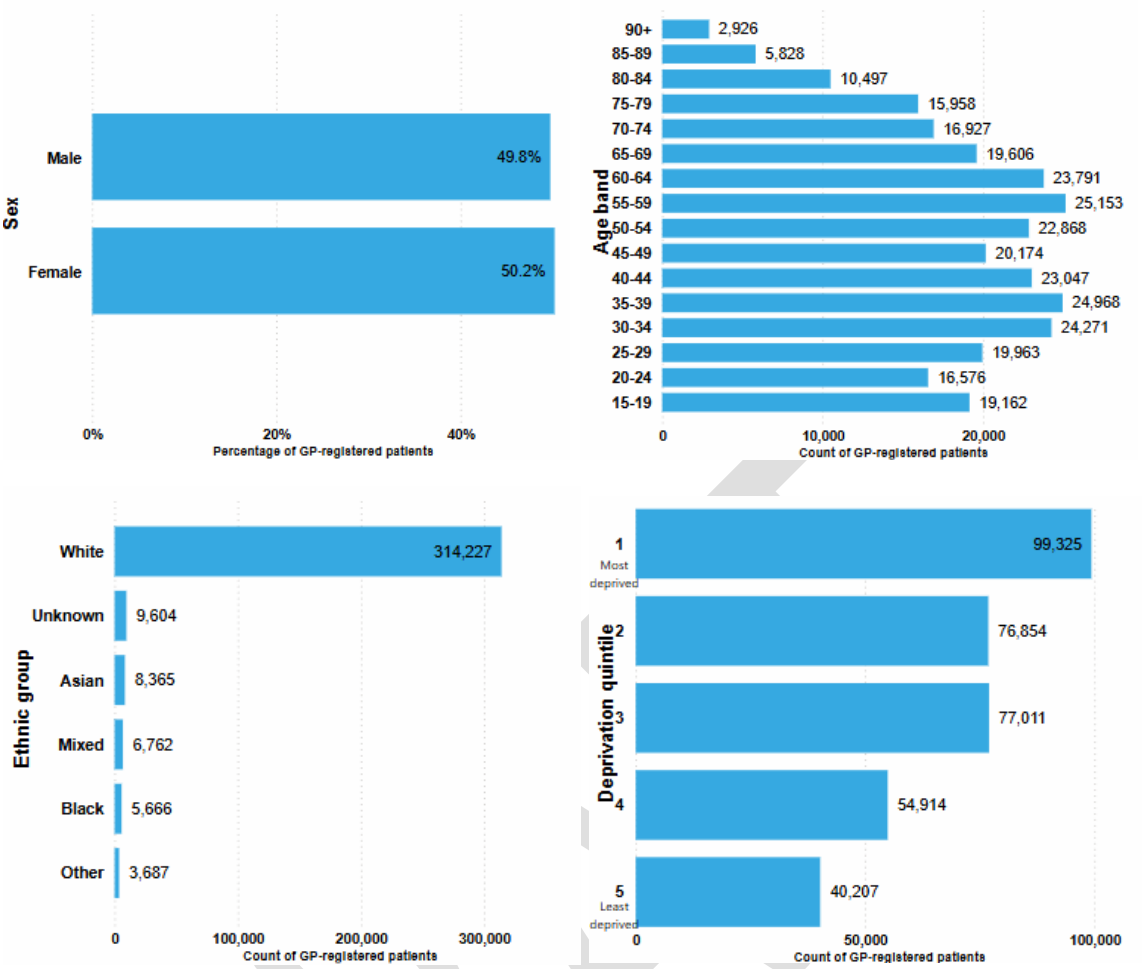
There are also disparities between men and women when looking at years spent in good health. Although women may live longer, they are living in poorer health for longer than men.

The gap between life expectancy and healthy life expectancy indicates that individuals in more deprived areas not only live shorter lives but also spend more years in poor health[4].

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

- **Smoking**: Ashfield, Mansfield, Newark and Sherwood have some of the highest smoking prevalence rates in Nottinghamshire, ranging from 16.5% to 23.1%, compared to the county average of 15.4%[5].
- **Physical Activity**: Residents of Mansfield and Ashfield are 10% below the national average in achieving recommended physical activity levels. [6]
- **Obesity**: Approximately 66.1% of adults in Nottinghamshire are classified as overweight or obese, higher than the England rate of 63.8%. For the Mid-Nottinghamshire district of Mansfield, this is even higher, at approximately 67.3%.
- **Alcohol use**: Alcohol consumption at levels posing a risk to health is high. It is estimated that 160,206 adults in Nottinghamshire drink at levels that pose a risk to their health, and 8,506 are estimated to have alcohol dependency.

[3] Health Inequalities - Nottinghamshire Medicines Optimisation Team
[4] hfma.org.uk+3healthandcarenotts.co.uk+3Nottinghamshire Medicines Management+3
[5] healthandcarenotts.co.uk+1sfh-tr.nhs.uk+1
[6] healthandcarenotts.co.uk



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

SFH action in response to Health Inequalities

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

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

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

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

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

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

Elective care

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

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

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

<u>Elective Admissions</u>

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

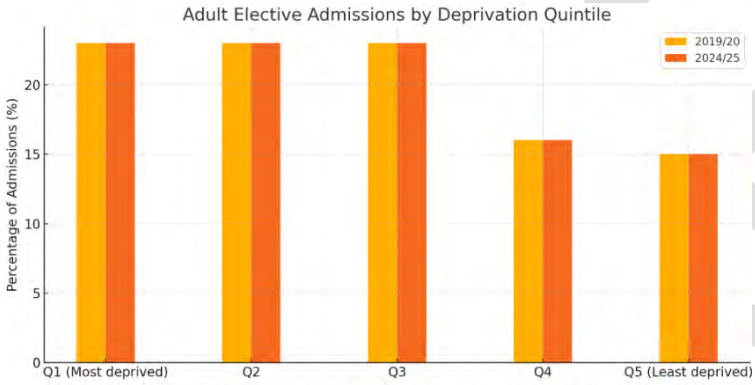
This consistent performance demonstrates SFH’s commitment to restoring services post-pandemic, while also actively addressing the backlog that disproportionately impacts those in the most deprived communities.

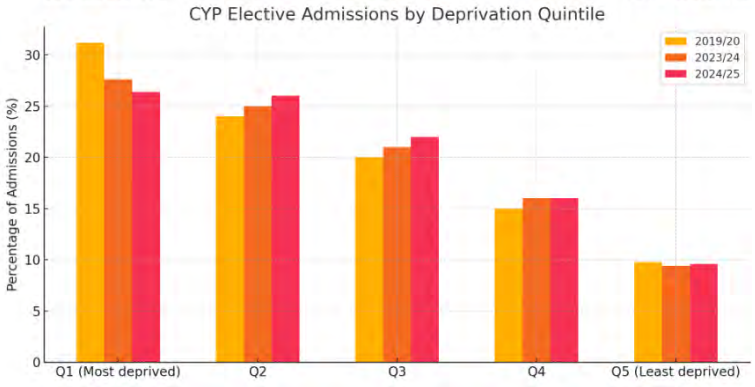
The distribution of adult elective admissions by deprivation remains broadly consistent with previous years. In line with 2019/20 and 2023/24 data, Quintiles 1, 2, and 3 continue to account for the majority of adult elective admissions, each contributing approximately 23% of total activity. The most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

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

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

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





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

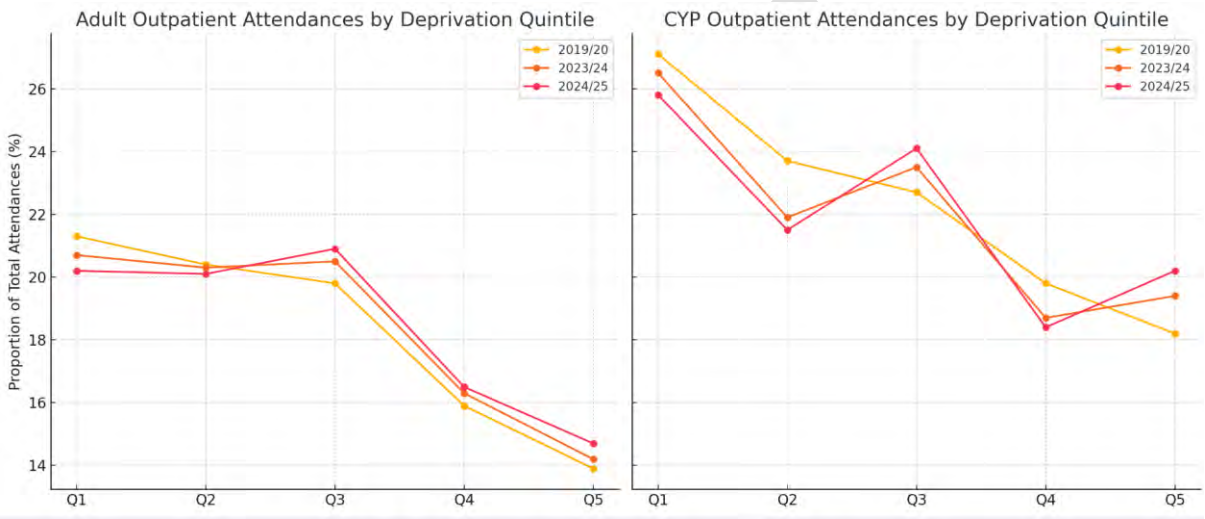
Outpatients

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

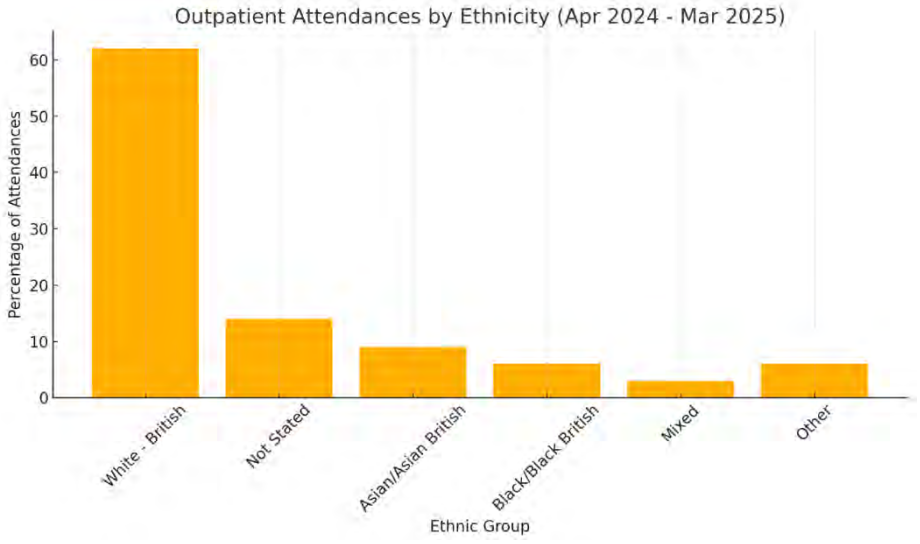
Outpatient attendances rose from 445,280 in 2019/20 to 477,665 in 2023/24 and again rose in 2024/25 to 522,864.

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

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



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



SFH Action to Respond to Health Inequalities in Elective Care.

SFH continues to make strong progress in restoring elective services, with a focus on ensuring equitable access and reducing variation in health outcomes across its patient population. SFH is currently delivering at 101% of the elective recovery fund threshold, enabling reinvestment into measures that promote access and reduce waiting times, including:

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

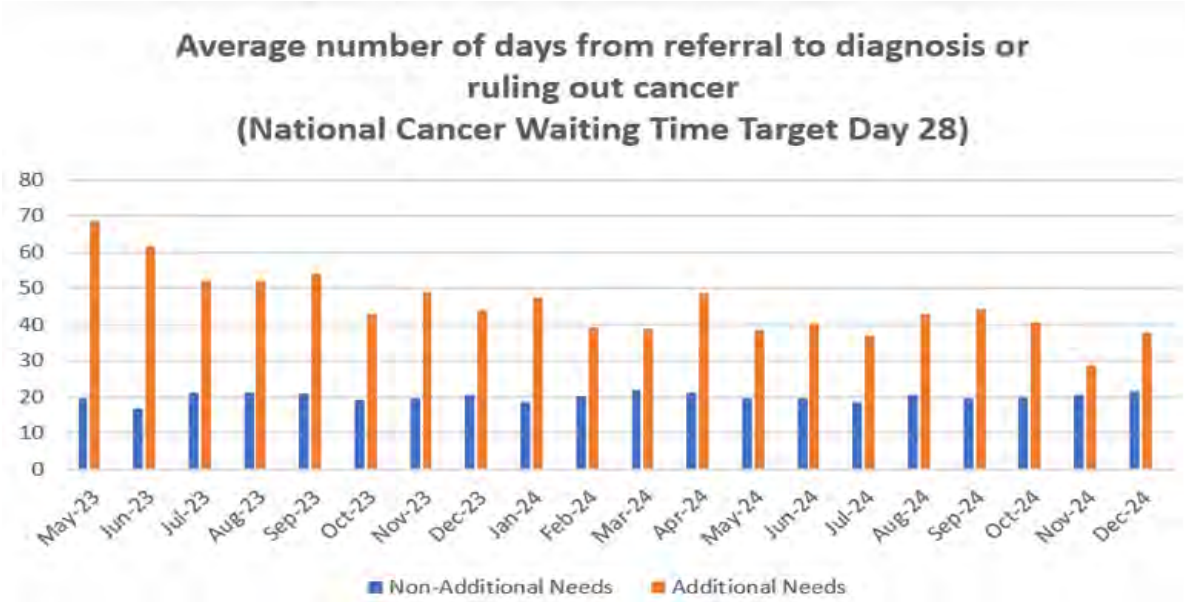
SFH continues to monitor the distribution of this activity to ensure equity of access, particularly for those in the most deprived communities and minoritised ethnic groups.

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

Patient Experience Survey Results

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

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



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

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

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

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

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

To mitigate these challenges, SFH is implementing measures to ensure that all patients, regardless of their digital literacy or access, receive equitable care. This

includes offering alternative assessment methods and providing support to those at risk of digital exclusion.

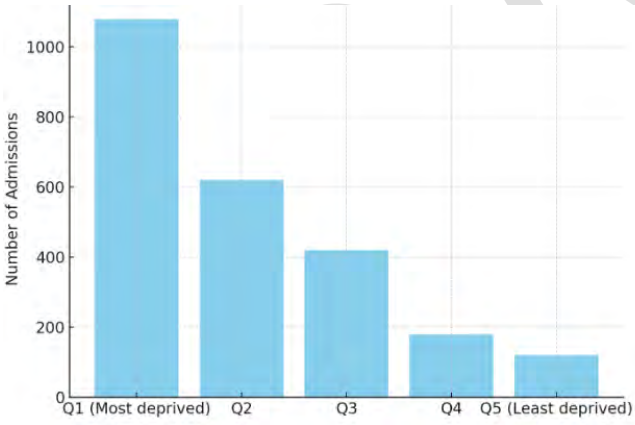
Urgent and emergency care

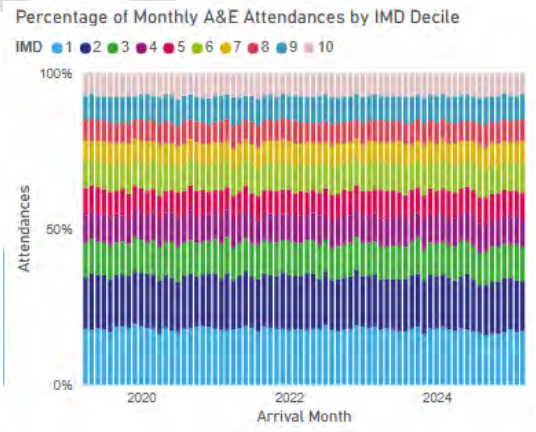
Urgent and emergency care services provide a critical role in healthcare, often treating people with serious or life-threatening injuries or illnesses who cannot be treated in primary care or in the community. National data shows that people living in the most deprived areas are 1.7 times more likely to attend an emergency department than those in the least deprived areas[7]. This statement will focus on emergency admissions for under 18's (by ethnicity and deprivation).

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

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

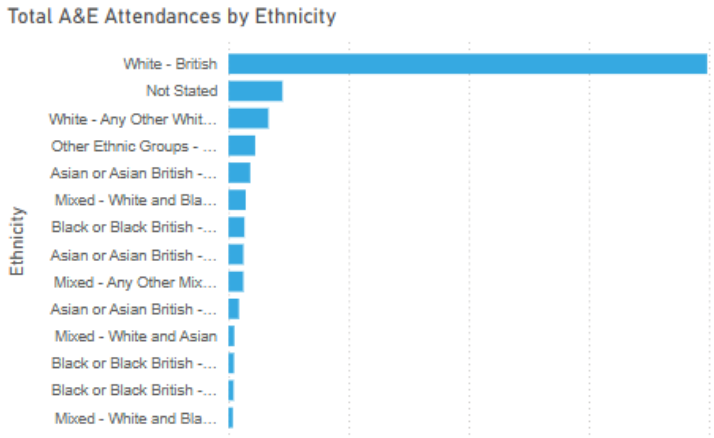
  Emergency admissions for children and young people living in the 20% most deprived populations - Q1 were more than nine times higher than those from the least deprived (Q5) .There is also a clear trend across the deprivation quintiles over the last five financial years, showing the higher the deprivation,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



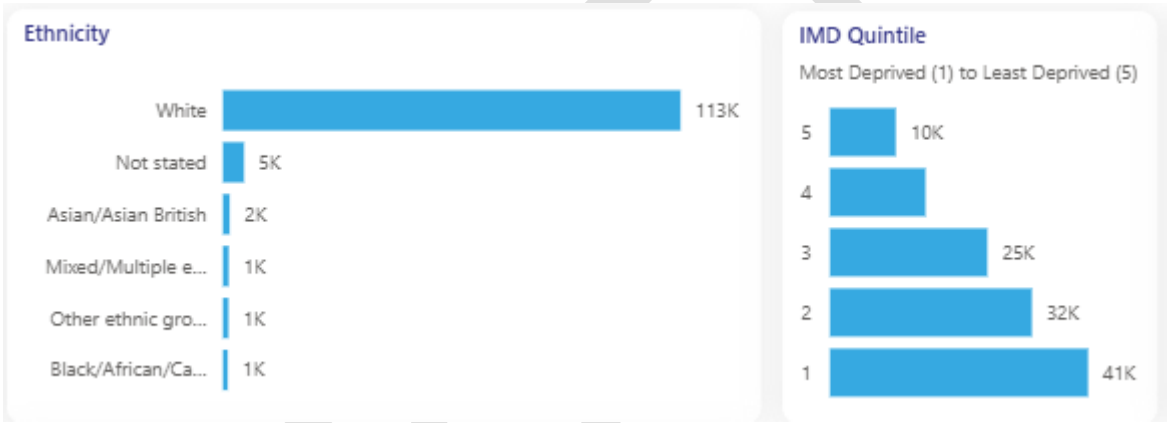


Emergency admissions in the White - British population account for over 90% of activity and this is consistent year-on-year (Figure 9). Excluding this population, the mixed and Asian groups comprise nearly 70% of the ethnic minority groups. The size order of the ethnic minority groups has remained consistent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

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



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



Actions to respond to Health Inequalities in Urgent and Emergency Care

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

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

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

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

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

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

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

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

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

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

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

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

Evidence shows that teams like DALT can:

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

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

Smoking cessation

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

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

Patient Experience

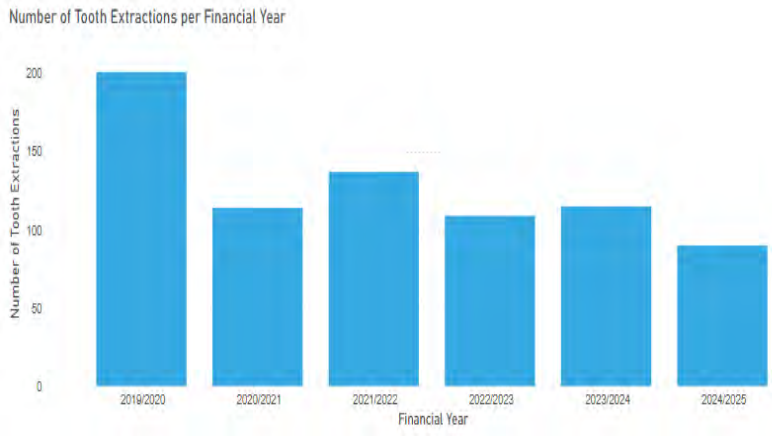
""The Phoenix Team was absolutely amazing. I felt like a friend rather than a patient. They are not here to judge and there was no pressure. I was able to try different nicotine replacement products for free and do it in my own time."

Oral health

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

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

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



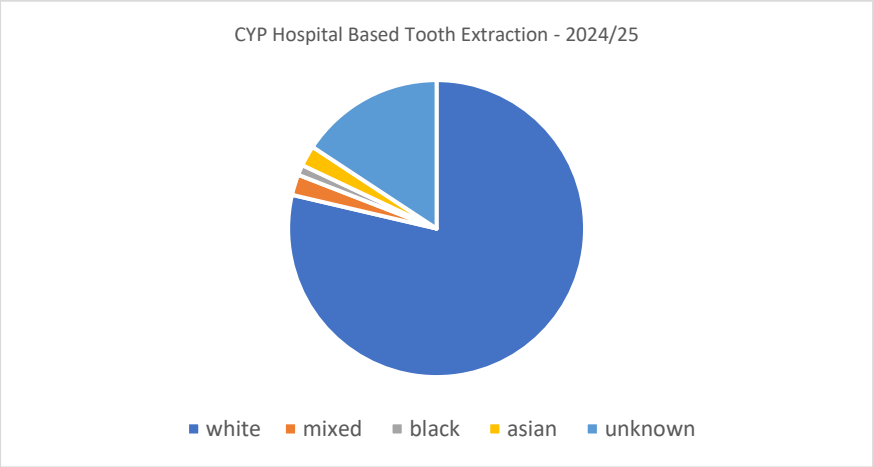
Of the 90 children and young people having a hospital tooth extraction procedure in 2024/25 41.1% were from the 20% most deprived areas in our communities.

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

Patient Experience*

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

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



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

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

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

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

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

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

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

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Trust Board - Cover Sheet

Subject:	2025/26 Annual Plan	**Date:**	05/06/2025
Prepared By:	Kevin Gallacher, Associate Director - Planning and Partnerships		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
To provide a brief overview to the trust board on the SFH component of the ICS 2025/26 operational plan submission.	**Approval**	
	Assurance	**x**
	Update	
	Consider	

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

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	Insufficient financial resources available to support the delivery of services	**X**
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
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

Trust Executive Team

Acronyms

A&E – Accident and Emergency / Emergency Department (ED) EPR – Electronic Patient Record ICB – Integrated Care Board ICS – Integrated Care System	NHSE – National Health Service England SFH – Sherwood Forest Hospitals NHS Trust WTE – Whole Time Equivalent (Normally 37.5 hours per week however this can vary across different staff groups)

Executive Summary

On the 27th March 2025 the Nottingham and Nottinghamshire ICB submitted its 2025/26 operational plan to NHS England. The plan is a consolidated position of Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham University Hospitals, and the ICB. The ICS resubmitted the plan on 30th April 2025 to include some minor technical changes with no material impact to the SFH or ICB position.

The SFH plan achieves all the relevant 2025/26 operational plan national priorities by reducing the time people wait for elective care, improving A&E waiting times, maintaining the collective focus on the overall quality and safety of our services, and by living within our budget, reducing waste and improving productivity.

The Nottingham and Nottinghamshire ICS submission stated that the 2025/26 NHS operational plan is ambitious and credible and aims to deliver all national priorities and success measures, financial balance, our local strategic priorities and the emerging national reform agenda.

The information in the main body of this paper sets out the SFH component of the 2025/26 ICS plan national priorities across the domains of operational performance, activity, workforce, finance, and capital with the headline messages shown in the table below:

Our 2025/26 plan improves our clinical and operational performance, improving lives for our people and our patients.

	5.3% increase in the number of 1st Outpatients being seen within 18 weeks *83.5% of 1st outpatient appointments will take place in 18 weeks by March 2026. This exceeds the national priority success measure of 72%.*
	5% increase in the number of patients being treated within 18 weeks *68.2% of patient treatments completed within 18 weeks by March 2026. This exceeds the national priority success measure of 65%.*
	Reducing those waiting over 52 weeks for treatment to less than 1% *by March 2026 less than 1%, 322 patients, will wait over 52 weeks for treatment. This meets the national priority success measure of 1%.*
	Earlier and faster cancer diagnosis and treatment *Improving 62-day cancer performance to 75%, from 69.7% in November 2024. This sits alongside improvements in the 28 day cancer diagnosis standard.*
	2.5% improvement in average A&E waiting times The average number of patients being seen within 4 hours will increase from 71% in 2024/25 to 73.5% in 2025/26 with 78% of patients seen within 4 hours in March 2026.
	Less people waiting 12 hours or more in the Kingsmill A&E department The percentage of attendances where the patient spends more than 12 hours in the department will reduce from an average of 5.2% in 2024/25 to 3.9% in 2025/26
	Elective and emergency activity *We will see nearly 400,000 Outpatients during 2025/26 as well as carrying out over 45,000 elective day cases and 5,000 other elective operations that require a longer stay in our hospital. We will also see over 211,000 people in our emergency department (A&E) as well as admitting nearly 47,000 people to receive emergency care.*
	Reduced reliance on high-cost temporary staffing *SFH will see a reduction in its temporary staffing WTE and expenditure, reducing agency expenditure by 37% and bank expenditure by 16% compared to 2024/25 while also reducing our expenditure on support functions to April 2022 levels.*
	£45.8 million efficiency programme to reduce the underlying deficit of the Trust *SFH has set out plans to deliver a £45.8m efficiency programme during 2025/26 after allowing for £9.8m of NHSE deficit support funding. This central deficit support has reduced from the £14m support provided in 2024/25. During 2024/25 SFH successfully delivered a £34.52m efficiency programme.*
	£38.8m capital investment in our buildings and equipment *This includes £7.4m investment in magnetic resonance imaging (MRI) Scanners, £10.7m towards our new Electronic Patient Record (EPR), and £4.2m towards the Community Diagnostic Centre as well as replacing essential medical equipment, system upgrades and cyber security, IT equipment to support our people to deliver their services and building upgrades and maintenance.*

While the plan at both ICS and SFH level is considered ambitious and credible the plan does include several inherent delivery risks.

These are:

- Reliance on the delivery of an internal programme to improve patient flow and length of stay alongside the system led urgent and emergency care (UEC) transformation programme to mitigate the demand and acuity growth experienced in our urgent care pathways.
- The delivery of the UEC target (78% of patients admitted, discharged and transferred from ED within 4 hours in Mar-26) is dependent on the ability to invest in appropriate staffing resources to reflect demand. This may be at odds with the financial efficiency requirement and/or temporary bank and agency workforce reduction plans.
- SFH has no additional physical bed capacity. As a consequence, our submitted plans show bed occupancy exceeding 96% from September 2025 and peaking at 97.5% in January 2026. This poses a risk to patient flow and admission to wards from ED.
- Delivering a significant financial efficiency while balancing the day to day operational and longer-term needs of the organisation.
- The current climate of uncertainty in the NHS, including the potential financial implications and timelines for change may inhibit the Trust's ability to deliver all our planning objectives.
- The impact of wider system commissioning discussions and decisions made during 2025/26 and savings plans of system partners which may have a detrimental impact on the demand for acute services.
- These plans also assume no further industrial action in 2025/26.

The finance, quality, and people committees of SFH board will lead on assuring themselves on behalf of the board on quality and patient safety, plan delivery, existing and emergent risks, and mitigations in place to deliver this plan during 2025/26.

The Trust Board are asked to:

Note the SFH contribution to the ICS 2025/26 operational plan submission, the planned ongoing improvements to our clinical and operational performance, improving lives for our people and our patients, and the main delivery risks.

2025/26 Operational plan submission

Introduction:

NHS England (NHSE) Priorities and Operational Planning Guidance was published on 30th January (NHS England » 2025/26 priorities and operational planning guidance).

The Nottingham and Nottinghamshire ICS was required to submit its 2025/26 operational plan to NHS England on the 27th March 2025. The ICS plan is a consolidated position of Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham University Hospitals, and the ICB and is considered both ambitious and credible by the ICS partners. The ICS resubmitted the plan on 30th April 2025 to include some minor technical changes with no material impact to the SFH or ICB position.

The information below sets out the SFH component of the 2025/26 ICS plan across the domains of operational performance, activity, workforce, finance, and capital

Operational performance 2024/25 context:

A snapshot of national provider rankings in November 2024 (the baseline for operational planning) show SFH performing above national average in all areas of planned (elective) care. This NHSE benchmarking showed SFH as 13th out of 135 providers across England.

This benchmarking also showed SFH exceeding national benchmark performance across eight of the twelve urgent and emergency care (UEC) benchmarks. SFH was below national average on the number of patients seen within 4 hours and three discharge metrics, reflecting the wider system pressures and the disproportionate levels of UEC demand and acuity seen in Mid Nottinghamshire during 2024/25 which meant as well as more patients, the patients we saw were also more ill and required more specialist care.

Between 1 October 2024 and 24 March 2025, we had:

- 4.3% more ED attends than the same period the previous year. This is 23 more patients arriving every day.
- The highest average number of ambulance arrivals we've seen over a winter period, averaging 104 per day (1.5% more than 2023/24).
- 6% (approx. 8 additional patients per day) more emergency admissions than the previous year.
- We also saw our capacity and flow affected by multiple waves of influenza and norovirus.

We are expecting so see broadly similar levels of growth in demand and acuity on our urgent care pathway during 2025/26 with only the same numbers of beds we had in 2024/25 and ongoing high levels of average monthly bed occupancy, exceeding 96% from September 2025 and peaking at 97.5% in January 2026. Further detailed operational planning to mitigate the risks associated with this will be undertaken throughout the spring and summer of 2025.

Our plan submission:

SFH seeks to continuously improve on our performance for the benefit of our patients and this ambition is reflected in the plan submission.

The SFH plan achieves all the relevant 2025/26 operational plan national priorities by reducing the time people wait for elective care, improving A&E waiting times, maintaining the collective focus on the overall quality and safety of our services, and by living within our budget, reducing waste and improving productivity.

- We have set out a 5.3% increase in the number of **1st Outpatients being seen within 18 weeks** from 78.2% in November 2024 to 83.5% by March 2026. This exceeds the national priority success measure of 72% which was set in the context of a whole of England performance of 63.1% in the baseline month of November 2024.

- We have set out a 5% increase in the number of patients being **treated within 18 weeks** from 63.2% in November 2024 to 68.2% by March 2026. This exceeds the national priority success measure of 65% which was set against a whole of England performance of 59.1%.

- We will **reduce those waiting over 52 weeks** for treatment to less than 1%, 322 patients, by March 2026. This meets the national priority success measure of 1%. SFH had 709 patients, waiting over 52 weeks in November 2024 with 221,889 patients waiting over 52 weeks across England.

- By March 2026 we will have increased the number of **cancer patients seen within 62 days** to 75%, improving this from 69.7% in November 2024.

- By March 2026 we will have increased the number of cancer patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days to 80% (known as the **28 day cancer faster diagnosis** standard), improving this from 78.4% in November 2024.

- We have set out the ambition in our plan to meet the national priority that in March 2026 **78% of patients attending A&E spend less than 4 hours** from time of arrival to admission, discharge or transfer. SFH averaged 71% during 2024/25 and has planned to increase this average by 2.5% to 73.5% during 2025/26. Delivery of this relies on wider system transformation to reduce demand and acuity that supports SFH to reduce admissions, discharge delays, and the length of stay of patients when there was no other alternative to admitting them to our hospital.

- Percentage of attendances at type 1 A&E departments where the patient **spent more than 12 hours in the department** will reduce from an average of 5.2% (an average over the year of approx. 17.5 per day) in 2024/25 to 3.9% in 2025/26 (an average of 15 per day). England performance in November 2024 was 10.7%.

Delivery of these operational performance standards requires internal change programmes alongside the system wide delivery of an ambitious urgent and emergency care (UEC) transformation programme, including financial sustainability plans, focussing on UEC length of stay and frailty/long term conditions (proactively identifying and managing individuals who are at risk) and reducing demand into our A&E.

Activity:

We have maintained the growth in planned care activity (Elective) since 2019/20 supported by the national elective recovery funding. This means we will see nearly 400,000 Outpatients during 2025/26 as well as carrying out over 45,000 elective day cases and 5,000 other operations that require a longer stay in our hospital.

We will see over 211,000 people in our ED department, an average of 23 people per day more than 2024/25, as well as admitting nearly 47,000 people to receive emergency care with 31,000 of these staying in hospital for more than one day, this is an increase of nearly 5% on 2024/25.

Workforce:

Our plan shows new recruitment of 52.9 WTE to support the development of a Hybrid MRI, Medical Growth, Nurse Establishment aligned to safer staffing assessments, digital developments associated with EPR and workforce growth to support the Community Diagnostic Centre (CDC). At the same time, we have committed to reduce our use of temporary bank and agency staff and to reduce our expenditure on support functions to April 2022 levels.

Reducing agency expenditure by 37% (circa £4.9m) and bank expenditure by 16% (Circa £3.6m) compared to 2024/25 equates to a high-cost temporary workforce reduction of 64.6 WTE while other actions will reduce our workforce by a further 68.9 WTE. Overall, this changes our workforce from 5,807 WTE in March 2025 to 5,726 in March 2026, an overall reduction of 81 WTE, with a pay bill of £338 million.

Finance:

The 2025/26 financial plan continues to tackle the underlying deficit, building on the strong progress made in 2023/24 and 2024/25 where SFH delivered a £25.7m and £34.5m efficiency programme.

SFH has a planned income of £550 million in 2025/26 and has set out a requirement to deliver an efficiency of £45.8m, after £9.8m of NHSE deficit support funding, to live within the budget we have been given. This is set against an overall efficiency requirement across the Nottingham and Nottinghamshire ICS of £231.3m after £70m of non-recurrent deficit support funding.

The SFH efficiency programme will be delivered through a combination of transformation programmes such as an estates optimisation programme alongside improvement programmes which aim to improve productivity and ‘Grip and Control’ programmes that aim to ensure that we spend the taxpayers money efficiently.

Capital:

The ICS continues to invest in its buildings, equipment, and information technology (IT), planning to spend £219m capital in 2025/26 with a further £36.3m of bids submitted to support diagnostics, elective, and UEC constitutional standards capital requirements.

£38.8m of this will be spent by SFH in 2025/26 with around £7.4m of this going towards magnetic resonance imaging (MRI), £10.7m towards our new Electronic Patient Record (EPR), and £4.2m to wards the Community Diagnostic Centre. Other capital expenditure includes replacement of essential medical equipment, system upgrades and cyber security, IT equipment to support our people to deliver their services, and wider building upgrades and maintenance.

Compliance:

The submitted plan shows the ambition to achieve all national priorities as set out in the operational planning guidance, with full compliance against the success measures.

Conclusion:

The finance, quality, and people committees of SFH board will lead on assuring themselves on behalf of the board on quality and patient safety, plan delivery, existing and emergent risks, and mitigations in place to deliver this plan during 2025/26.

The Trust Board are asked to:

Note the SFH contribution to the ICS 2025/26 operational plan submission, the planned improvements to our clinical and operational performance that contribute to improving lives for our people and our patients, and the main delivery risks.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet

Subject:	2025/26 Financial Efficiency Programme	**Date:**	5th June 2025
Prepared By:	Jo Lancaster, Associate Director – Financial Recovery & Sustainability Jim Millns, Associate Director of Transformation		
Approved By:	Andrew Graham, Deputy Chief Financial Officer		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
To provide the Board of Directors with an overview of the Financial Efficiency 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		**X**	**X**	**X**
Indicate which strategic objective(s) the report support					

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

Committees/groups where this item has been presented before

Updates on the Trust's Financial Efficiency Programme are routinely reported through the Finance Committee.

Acronyms

- FRC – Financial Recovery Cabinet
- FEDS – Financial Efficiency Delivery and Sustainability Team
- SRO – Senior Responsible Owner
- QIA – Quality Impact Assessment

Executive Summary

The Trust's 2025/26 Financial Efficiency Programme is targeting £45.8m of savings, which represents 8.1% of planned operating expenditure.

The attached report provides an overview of the programme and approach to delivery, as well as a status update on the maturity of plans.

The programme incorporates key planning requirements, including targeted reductions in variable pay and corporate growth.

The attached report provides an overview of the programme and approach to delivery, as well as a status update on the maturity of plans.

At Month 1, the Trust has reported delivery of £1.4m against a risk-adjusted target of £1.3m, representing a positive start. However, a shortfall of (£0.8m) against the full unweighted plan highlights the need for increased pace and grip.

The Financial Efficiency Delivery and Sustainability (FEDS) team has now been established to accelerate delivery. Its focus is on de-risking existing schemes, mobilising pipeline opportunities, and driving organisational ownership of new ideas.

A restructured programme framework and revised governance model will provide clearer oversight and support delivery at scale. The Financial Recovery Cabinet oversee all programmes from June 2025 and the Finance Committee provides Board oversight on delivery of the programme.

The Trust's QIA process has been reviewed to support the delivery of financial efficiencies whilst ensuring that the potential impact of projects are appropriately understood and managed.

The Board of Directors are asked to consider the contents of the report, recognising the requirement for the Trust to deliver the financial plan for 2025/26.

1. Introduction

1.1. This paper provides an update on:

- Month 1 performance against plan
- Proposed restructure of programme oversight
- The establishment of a new delivery unit (FEDS) to drive transformation and savings

2. Month 1 Performance and Programme Overview

2.1. The Trust's Financial Efficiency Programme for 2025/26 is targeting savings of £45.8m, this total has been profiled across the year. When risk-adjusted using national methodologies, the weighted delivery plan equates to £21.1m.

2.2. The table below outlines the planned monthly savings (unweighted and risk-adjusted), actual Month 1 delivery, and the year-to-date variance:

Table 1:

Reporting Period	Plan - Unweighted (100%)	Plan - Weighted (risk adjusted)	Actual	Variance to Plan (Adv)/Fav
Apr-25	2,231	1,288	1,417	(814)
May-25	3,207	1,910		
Jun-25	3,419	1,746		
Jul-25	3,620	1,452		
Aug-25	4,520	2,052		
Sep-25	4,019	1,719		
Oct-25	4,520	2,071		
Nov-25	4,020	1,738		
Dec-25	3,819	1,605		
Jan-26	4,020	1,738		
Feb-26	4,221	1,872		
Mar-26	4,212	1,872		
Total 2025/26	45,828	21,063	1,417	(814)

2.3. At Month 1, £1.4m has been delivered against a risk-adjusted target of £1.3m, however, the Trust remains behind profile against the full-year unweighted plan by £(814)k.

2.4. As at month 1 the efficiency status of schemes status;

- £6.1m of schemes are fully developed – in delivery
- £6.5m of schemes are fully developed – delivery not yet started
- £10.3m of schemes have plans in progress
- £22.9m of opportunities have been identified

2.5. The bridge chart below visualises the stages of development across the programme pipeline.

Graph 1: Financial Improvement Target v Plans

3. **Proposed Programme Restructure**

3.1. The current Financial Efficiency Programme spans across 16 programmes, these vary in nature, some of which have a direct route to cash, whilst some don't. At the April Financial Recovery Cabinet workshop, members reaffirmed the necessity of all 16 programme areas within the £45.8m Financial Efficiency Programme. However, it was recognised that existing structures lacked consistent oversight across all major areas of income and expenditure. It was agreed that a new approach was needed to improve focus, clarity and grip.

3.2. To ensure full oversight of all key expenditure areas and opportunities, the Trust proposes to restructure the programme portfolio under clearer thematic headings, with defined SROs and governance routes. The new structure, to which existing programmes of work are being realigned, are:

- Clinical Pay
- Clinical Goods and services
- Divisional Management and Admin
- Corporate
- Non-operating Expenditure
- Income

3.3. The updated structure will ensure:

- Comprehensive coverage of pay, non-pay, and income opportunities
- Elimination of duplication and increased divisional ownership
- Clearer governance, tracking and intervention capability

3.4. Each programme will report monthly to the newly established Financial Sustainability Board (FSB), with standardised governance, milestones, and QIA requirements.

4. Financial Efficiency Delivery and Sustainability (FEDS) Team

4.1. The Financial Efficiency & Sustainability Delivery Unit (FEDS) has been established to secure, accelerate, and safeguard the delivery of Financial Efficiency Programme for 2025/26. In recognition of the ongoing financial pressures across the NHS, this focused approach will operate for a minimum of 12 months, ensuring the Trust maintains financial discipline and resilience during this period.

4.2. The team will focus on three core areas:

- De-risking existing schemes - providing grip, troubleshooting barriers, and improving delivery confidence.
- Mobilising opportunities in the pipeline - accelerating implementation of schemes not yet in delivery.
- Generating new ideas and organisational ownership - creating a culture of efficiency through local innovation, engagement and accountability.

4.3. The FEDS team reports to the Deputy CFO with oversight from the Executive Team. Its outputs and performance will be routinely reported to the FRC and Trust Management Team.

5. Recommendations

5.1. The Financial Committee is asked to:

- Note the Month 1 performance position and key themes from the highlight reports
- Endorse the proposed restructuring of programmes
- Note the mobilisation and role of the FEDS team

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2025/26 Financial Efficiency Prgramme

Board of Directors
5th June 2025

2025/26 Financial Efficiency Programme - Overview

2025/26 present the biggest challenge to NHS finances in recent history, with stretching savings targets across all sectors and all organisations.

- The Trust's 2025/26 Financial Efficiency Programme is targeting £45.8m of savings, with this target profiled across the year.

Q1	Q2	Q3	Q4	Total
£8.9m	£12.2m	£12.3m	£12.4m	£45.8m
19%	27%	27%	27%	100%

- The £45.8m target represents 8.1% of planned operating expenditure and is the equivalent to the costs of running our hospitals for one month.

- The Financial Efficiency Programme includes more than 50 projects and targets all areas of influenceable expenditure. It incorporates the key expectations on NHS organisations for 2025/26, which include:

    - Reducing agency pay expenditure by 40% year-on-year
    - Reducing Bank pay expenditure by 15% year-on-year
    - Reducing Corporate cost growth by 50% by Quarter 3

- In meeting these expectations, the programme supports the Trust to live within our means and to deliver the agreed break-even financial position.

2025/26 Financial Efficiency Programme – Approach (1)

- Financial efficiency plans were initially spanned across 16 programmes. To ensure full oversight of all key expenditure areas and opportunities, the Trust is in the process of restructuring the programme portfolio under clearer thematic headings, with defined SROs and governance routes.

- The new structure, to which existing programmes of work are being realigned, are:

Income (Plan £550m) Projects focussed on securing and maximising income into the Trust in line with the £550m income plan
Clinical Pay (planned expenditure £273m – 50% of Trust total) Projects focussed on maximising clinical output within a reduced cost envelope, including delivery of the planned 40%/15% Agency/Bank reductions.
Clinical Goods & Services (planned expenditure £92m – 17% of Trust total) Projects focused on non-pay spend within clinical divisions, such as clinical supplies, drugs, devices and outsourcing, with an aim to minimise waste (units) and maximise value (price per unit).
Divisional Running Costs (planned expenditure £28m – 5% of Trust total) Projects focussed on ensuring consistent support and management of clinical services, whilst minimising costs where possible.
Corporate Support (planned expenditure £113m – 21% of Trust total) Projects focussed on reducing the corporate overhead and delivering the NHSE target on Corporate Growth reductions.
Financing & Non-Operating Costs (planned expenditure £44m – 7% of Trust total) Projects focussed on minimising financing and other non-operating costs.

- The updated structure will ensure a comprehensive coverage of pay, non-pay, and income opportunities, elimination of duplication and increased ownership, and clearer governance, tracking and intervention capability

2025/26 Financial Efficiency Programme – Approach (2)

Financial Efficiency & Sustainability Unit (FEDS):

- The Financial Efficiency & Sustainability Delivery Unit (FEDS) has been established to secure, accelerate, and safeguard the delivery of Financial Efficiency Programme for 2025/26.

- In recognition of the ongoing financial pressures across the NHS, this focused approach will operate for a minimum of 12 months, ensuring the Trust maintains financial discipline and resilience during this period.

- The team will focus on three core areas:

    1. De-risking existing schemes - providing grip, troubleshooting barriers, and improving delivery confidence.

    2. Mobilising opportunities in the pipeline - accelerating implementation of schemes not yet in delivery.

    3. Generating new ideas and organisational ownership - creating a culture of efficiency through local innovation, engagement and accountability.

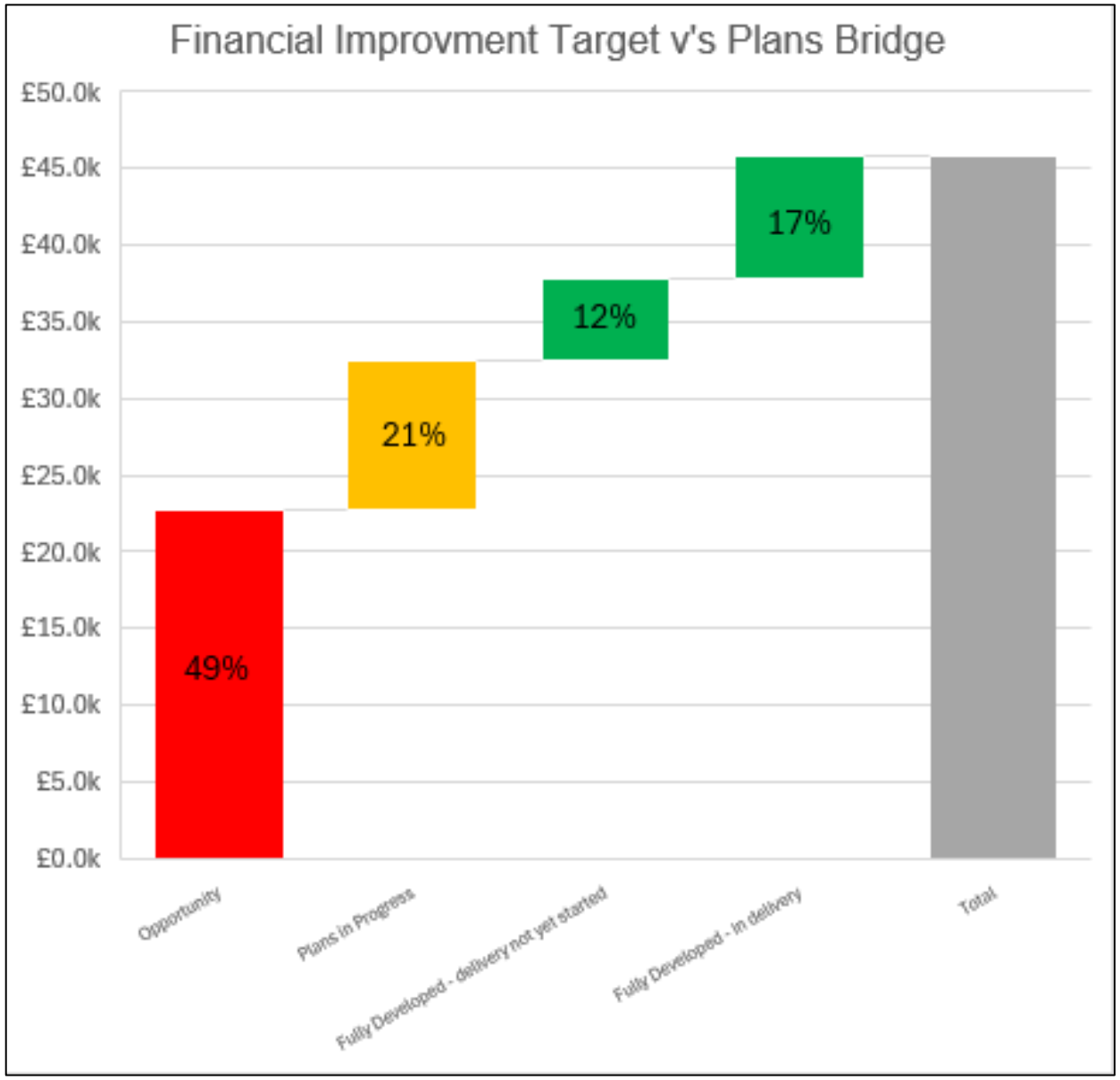
- The team will have apply a forensic and relentless focus on the ‘route to cash’ to support the Trust in meeting our financial commitments.

- The FEDS team reports to the Deputy Chief Financial Officer, with oversight from the Executive Team. Outputs and performance will be routinely reported to the Finacial Recovery Cabinet, Trust Management Team and Finance Committee.

2025/26 Financial Efficiency Programme – Status (as at 26th May)

Scheme Status	Reported WC 26/05/2025 £'m	Reported WC 19/05/2025 £'m
Fully Developed - in delivery	8.0	6.7
Fully Developed - delivery not yet started	5.4	6.5
Fully Developed	**13.4**	**13.2**
Plans in Progress	9.8	10.0
Opportunity	22.7	22.7
Unidentified		
Total Efficiencies	**45.8**	**45.8**

- As at week commencing 26th May 2025 the status of the efficiency schemes is as follows:
  - £8.0m of schemes are fully developed – in delivery
  - £5.4m of schemes are fully developed – delivery not yet started
  - £9.8m of schemes have plans in progress
  - £22.7m of opportunities have been identified
- Plans fully developed – in delivery have increased by £1.3m over the past week.



Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting held in Public

Subject:	2025/26 Capital Expenditure Plan	**Date:**	5th June 2025
Prepared By:	Thomas Palmer, Financial Controller		
Approved By:	SFH Finance Committee		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
To update the Board of Directors on the progress to develop the 2024/25 capital programme, agree the commencement of schemes and to ask the Board of Directors to formally approve the 2024/25 Capital Plan.	**Approval**	**X**
	Assurance	
	Update	
	Consider	

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

Capital Resources Oversight Group (CROG)
Trust Management Team (TMT)
Finance Committee

Acronyms

- SFH – Sherwood Forest Hospitals NHSFT
- ICB – Integrated Care Board
- NHSE - NHS England
- NHIS – Nottinghamshire Health Informatics Service
- MEMD – Medical Equipment Management Department
- CDC - Community Diagnostic Centre (Hub)
- CDEL – Capital Departmental Expenditure Limit
- CROG - Capital Resources Oversight Group
- CI - Critical Infrastructure
- CS - Constitutional Standards
- DHSC - Department of Health and Social Care

Executive Summary

The 2025/26 Capital Expenditure Plan for Sherwood Forest Hospitals NHS Foundation Trust (SFH) has been developed in accordance with NHS planning requirements. The 2025/26 Capital Expenditure Plan was discussed and approved at the Finance Committee meeting of 27th May 2025.

The Trust's capital resources come from two main sources:

- A share of the Nottingham & Nottinghamshire ICB (the ICB) capital envelope, which predominantly funds 'business as usual' capital requirements such as equipment replacement and backlog maintenance.

- Specific targeted allocations for NHS England (NHSE) priorities, such as for Digital improvements and the development of capacity to support improved operational performance.

The final 2024/25 Capital Expenditure Plan value, as submitted to NHSE, is £39.1m. This includes a provisional share of nationally targeted care funding in relation to Critical Infrastructure Risks (CI) and Return to Constitutional Standards (CS), worth £7.0m (this allocation is subject to the satisfactory completion of associated business cases).

Progress in the delivery of the Capital Expenditure Plan is managed through the Trust's Capital Resources Oversight Group (CROG), which is chaired by the Chief Financial Officer and includes corporate and clinical representatives from across the Trust. The CROG reports into the Trust Management Team and provides updates through the Finance Committee.

Further details on the capital planning process and the proposed schemes for 2025/26 are included in the attached report.

The Board of Directors are requested to accept the recommendation of the Finance Committee and approve the 2025/26 Capital Expenditure Plan.

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2025/26 Capital Expenditure Plan

Board of Directors
5th June 2025

Capital Funding Sources

The 2025/26 Capital Expenditure Plan is based on the utilisation of all sources of capital funding available to the Trust

- Single-year allocations were issued to Integrated Care Boards (ICBs) by the Department of Health & Social Care (DHSC) for 2025/26. The agreed SFH share of the Nottinghamshire allocation for 2025/26 is £15.5m
- NHS England (NHSE) also hold national capital allocations for national priorities, which are deployed to individual providers and systems on a case-by-case basis. For SFH, the targeted funding for 2025/26 includes:
    - Frontline Digitisation funding of £10.7m (confirmed), to support the implementation of an Electronic Patient Record (EPR) system.
    - Return to Constitutional Standards (CS) funding of £6.1m (provisional), to support improvements in operational performance across Urgent & Emergency Care, Elective and Diagnostic pathways.
    - Critical Infrastructure (CI) funding of £0.9m (provisional), to support the delivery of urgent estates maintenance work.
- Self-Funded capital of £5.6m, arising from depreciation, covers the costs of PFI related lifecycle capital works and residual interest.
- Donated funding from the SFH Charity (£0.3m) is also able to be utilised for capital expenditure.

The combined value of these resources for 2025/26 is £39.1m

Capital Planning Process

- A draft capital plan was collated during Quarter 3 and Quarter 4 of 2024/25, informed by the capital leads from Estates, Nottinghamshire Health Informatics Service (NHIS) and the Medical Equipment Management Department (MEMD).
- This draft plan was reviewed and discussed with Divisional leads to ensure that all potential capital expenditure requirements were fully considered.
- As with previous financial years the initial long list of capital plans exceeded the available resources, with a value of £48.8m (excluding PFI Lifecycle, Residual Interest, Charitable Funds, and nationally targeted funding) against the allocation of £15.5m.
- Within this value were two pre-committed and high priority schemes, relating to the new build Magnetic Resonance Imaging (MRI) unit and the completion of the Mansfield Community Diagnostics Centre (CDC), and additional pre-commitments relating to capital salaries, general IT and medical equipment, and lease inflation costs. The total value of these commitments is £12.1m.
- This left a residual available allocation of £3.4m for ‘business as usual’ and other capital developments.
- A prioritisation process was undertaken with capital leads to risk assess plans, to ensure that the final capital plan could be funded within the Capital Departmental Expenditure Limit (CDEL) allocated to the Trust for 2025/26.
- The final prioritised plan for the use of this funding is shared later in this report.

2025/26 Capital Expenditure Plan

Estates	**£12.54m**
Breast Screening Expansion	£0.15m
Dr's Mess Refurbishment	£0.17m
Anaesthetic Environment	£0.08m
Professional Fees	£0.30m
Car Parking	£0.20m
Feasibility Studies	£0.05m
New Build MRI Unit	£7.36m
Mansfield CDC	£4.23m

Information Technology	**£1.15m**
Laptop & PC Replacements	£0.26m
Cybersecurity	£0.30m
Device Refresh (WOWs)	£0.25m
Patient Facing Digital Services	£0.20m
Viewpoint 6	£0.04m
Grouped IT Assets	£0.10m

Provisional (Subject to Business Case)	
Return to Constitutional Standards	*£6.11m*
Critical Infrastructure	*£0.93m*

Equipment	**£0.90m**
Patient Handling (e.g. Hoists)	£0.05m
RF Fluoroscopy Room	£0.13m
Radiological Equipment (Sky Plates)	£0.04m
ITU Patient Monitoring Systems	£0.03m
Capital Accessories	£0.50m
Ageing Bed Fleet	£0.15m

Transformation Reserve	**£0.49m**

Pre-Commitments (Leases & Capital Salaries)	**£0.45m**

PFI Related Capital (Lifecycle)	**£5.59m**

Electronic Patient Record	**£10.66m**

Donated Assets	**£0.30m**

2024/25 Capital Expenditure Plan (Confirmed Funding)	**£32.08m**

2024/25 Capital Expenditure Plan (including Provisional)	***£39.12m***

Capital Planning Risks

Although the prioritised plan helps to address some long-standing challenges, several risks have been highlighted through the capital prioritisation process due to the limited availability of resources.

IT Infrastructure Failures:

- Data Centre Growth: Potential IT failures and disruption if required growth in the data centre cannot be accommodated.
- Cybersecurity: Failure to address risks through expansions and upgrades could expose the organisation to cyber threats, potentially compromising patient data and safety.
- Backup Expansion: Lack of funding may impact system reliability and result in significant operational disruptions due data loss.

Medical Equipment Shortages:

- Prioritisation Challenges: With limited funding, it is difficult to prioritise which medical equipment to replace or upgrade. This could lead to increased risks in patient care if critical equipment fails, such as ventilators, monitors, and diagnostic tools.
- Operational Risks: Specific service areas may face increased risks if their equipment needs are not met, potentially impacting patient safety and care quality.

Estates Projects Delays:

- Pre-commitments: Limited budget for estates projects could delay or halt necessary infrastructure improvements, such as upgrades to patient wards or emergency facilities, impacting patient care environments.
- Car Parking: Limited funding for car parking projects could affect patient and staff accessibility, leading to operational inefficiencies and delays in patient care services.

Transformation Projects:

- Funding Allocation: Holding back funds for transformation projects is necessary for long-term improvements, but it reduces the immediate budget available for critical infrastructure and equipment needs. This creates a balancing act between short-term risks and long-term benefits, potentially delaying improvements that could enhance patient care.

Capital Governance

Capital Prioritisation Group:

- The Capital Prioritisation Group is a sub-group of the CROG and assists with the delivery of the Trusts Capital Programme, providing monthly reports to the Trusts Capital Resources Oversight Group (CROG).
- The role of the group is to assess risks to the delivery of the Trust's Capital programme and to provide recommendations for adaptions of the in-year Capital plan based on emerging need and risk for approval by CROG.

Capital Resources Oversight Group (CROG):

- The Capital Resources Oversight Group provides oversight on the planning and management of the Trust's capital programme.
- Chaired by the Chief Financial Officer, with corporate and clinical representatives from across the Trust.
- Escalations and decisions are reported through to the Trust Management Team, and any emerging or increasing risks are highlighted to the Risk Committee to ensure that they are adequately and reported via the Trust's risk framework.

Finance Committee:

- Reviews the annual Capital Expenditure Plan and recommends approval to the Trust Board.
- Receives updates on the progress of the Capital Expenditure Plan, including any risks of slippage or overspends.
- Considers capital business cases, with decision making power as per the Scheme of Delegation limits.

Board of Directors:

- Responsible for the approval of the annual Capital Expenditure Plan and providing Board Assurance Statements on delivery as required by NHS England.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – To April 2025	**Date:**	5th June 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

The Quality of Care and Timely Care domain reports were considered by the Quality Committee in June 2025.

Acronyms

All acronyms are defined within the paper.

Executive Summary

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

This report covers performance to April 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. Appendix B contains benchmarking data for the timely

care domain to show our performance relative to other Trusts in England.

Maintaining good performance against some of the key indicators contained in the report has been challenging for the Trust during winter 2024/25 due to patient demand and acuity pressures and a seasonal increase in staff absence due to sickness. The sustained pressure for many months has resulted in patient demand often exceeding the capacity of our hospitals and being above planned, and funded levels. To support patient care we enacted escalation actions including our full capacity protocol; these actions place pressure on our people and the financial position of the Trust.

As we transitioned out of the winter period, significant improvements were observed in several Urgent and Emergency Care (UEC) metrics, particularly in March and April 2025. Improved hospital flow, driven by reduced length of stay for patients aged 65 and over, played a crucial role in this recovery.

Over the course of 2024/25 we have delivered improvements that we should celebrate and be proud of including increased compliance with mandatory and statutory training, reduced bank and agency usage and spend, reduced numbers of long wait elective patients and significantly improved diagnostic DM01 performance.

We also ended the 2024/25 financial year with strong appraisal compliance, much improved four-hour emergency access performance, low levels of medically safe patients in our hospitals, strong cancer 31-day treatment performance and delivery against our year-end financial plan (after deficit support funding).

As we look ahead to 2025/26, we are refreshing our IPR indicators (see annual review paper). We recognise we have multiple priorities to deliver across the reported care domains. The IPR from August 2025 will reflect Board approved changes to the reported indicators and set out the ambitions we have against these metrics to March 2026.

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 April 2025

Balanced Scorecard

Sherwood Forest Hospitals NHS Foundation Trust

Category	At a Glance	Indicator	2024/25 Standard	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	Jan-25	Feb-25	Mar-25	2024/25 Qtr 4	Apr-25	2024/25 Final
Quality of Care	Safe	Falls with lapse in care	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1
		Falls per 1000 occupied bed days	≤6.63	✓ 6.2	✓ 5.8	✗ 6.7	✓ 6.3	✗ 6.7	✓ 5.9	✓ 6.2	✓ 6.3	✓ 6.0	✗ 7.4	✗ 7.3	✗ 6.9	✗ 7.9	✗ 7.2	✓ 5.3	✗ 6.8	-	✓ 6.6
		Never events	0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2
		MRSA reported in month	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1
		Cdifficile reported in month	≤13 qtr	4	4	5	✓ 13	4	3	4	✓ 11	7	4	6	✗ 17	4	5	5	✗ 14	7	✗ 55
		Ecoli blood stream infections (BSI) reported in month	≤22 qtr	5	1	4	✓ 10	3	5	2	✓ 10	4	6	0	✓ 10	4	1	3	✓ 8	4	✓ 38
		Klebsiella BSI reported in month	≤1 qtr	0	1	2	✗ 3	1	1	0	✗ 2	1	1	0	✗ 2	1	0	2	✗ 3	2	✗ 10
		Pseudomonas BSI reported in month	≤3 qtr	0	0	1	✓ 1	0	0	0	✓ 0	0	1	0	✓ 1	0	0	0	✓ 0	0	✓ 2
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care		0	0	0.1	0.1	0	0	0	0	0.2	0.1	0	0.1	0.1	0.2	0	0.1	0	0.1
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	✓ 0	✗ 1	✗ 1	✗ 2	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 2	✗ 2	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✗ 6
		Patient Safety Incident Investigations (PSII)		3	4	0	7	0	2	2	4	1	0	2	3	2	1	0	3	0	17
	Caring	Complaints per 1000 occupied bed days	≤1.9	✓ 0.7	✓ 1.5	✓ 0.9	✓ 1.0	✓ 1.5	✓ 0.8	✓ 0.8	✓ 1.0	✓ 0.8	✓ 0.8	✓ 0.4	✓ 0.7	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.0	✓ 1.3	✓ 0.9
		Compliments received in month		161	138	151	450	155	120	119	394	204	160	147	511	140	152	184	476	155	1831
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	✗ 104	✗ 103	✗ 102	✗ 102	✗ 102	✗ 102	✗ 103	✗ 103	✗ 103	✗ 103	✗ 101	✗ 103	✗ 101	✗ 102	✗ 102	✗ 102	✗ 103	✗ 102
		SHMI	≤100	✗ 109	✗ 108	✗ 107	✗ 107	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 107	✗ 106	✗ 106	✗ 107
		Still birth rate	≤4.4	✓ 0	✓ 3.2	✓ 4.2	✓ 2.3	✓ 0.0	✗ 6.8	✗ 6.4	✓ 4.4	✓ 3.4	✗ 10.3	✓ 0	✗ 4.5	✓ 3.5	✗ 15.5	✓ 0.0	✗ 6.2	✓ 0	✓ 4.3
		Early neonatal deaths per 1000 live births	≤1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 3.2	✗ 1.1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0.3
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	-	-	-	✓ 6.8	-	-	-	✓ 6.8	-	-	-	✓ 7.1	-	-	-	-	-	✓ 6.9
	Growing the Future	Vacancy rate	≤8.5%	✓ 8.2%	✓ 8.0%	✓ 8.1%	✓ 8.1%	✓ 8.4%	✓ 7.7%	✓ 7.4%	✓ 7.9%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 8.3%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✓ 8.0%
		Turnover in month	≤0.9%	✓ 0.5%	✓ 0.3%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.5%	✓ 0.6%	✓ 0.7%
		Appraisals	≥90%	✗ 88.5%	✓ 90.1%	✗ 88.8%	✗ 89.1%	✓ 90.3%	✓ 90.0%	✗ 89.7%	✓ 90.0%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.2%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✗ 88.9%	✓ 90.0%	✗ 89.0%
		Mandatory & statutory training	≥90%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.4%	✓ 91.3%	✓ 90.9%	✓ 91.2%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 91.1%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.7%	✓ 92.2%	✓ 91.5%
	Looking after our People	Sickness absence	≤4.2%	✗ 4.3%	✗ 4.4%	✗ 4.7%	✗ 4.4%	✗ 4.9%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.8%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 5.1%	✗ 4.9%	✗ 5.0%
		Total workforce loss	≤7.0%	✓ 6.4%	✓ 6.4%	✓ 6.8%	✓ 6.5%	✓ 6.9%	✓ 6.3%	✓ 6.7%	✓ 6.6%	✗ 7.6%	✗ 7.8%	✗ 8.1%	✗ 7.8%	✗ 7.8%	✓ 6.9%	✓ 6.6%	✗ 7.1%	✗ 7.1%	✗ 7.01%
		Flu vaccinations uptake (front line staff)	≥75%	-	-	-	-	-	-	-	-	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	✗ 47.8%	-	✗ 47.8%
		Employee relations management	<17	✗ 20	✗ 23	✗ 15	✗ 19	✗ 20	✗ 20	✗ 21	✗ 20	✗ 19	✗ 20	✗ 18	✗ 19	✗ 20	✗ 25	✗ 31	✗ 25	✗ 23	✗ 21
	New Ways of Working	Bank usage	≤8.5%	✓ 8.3%	✗ 10.3%	✗ 9.3%	✗ 9.3%	✗ 9.8%	✗ 10.3%	✓ 8.1%	✗ 9.4%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✓ 8.0%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✗ 8.8%	✓ 6.3%	✗ 8.9%
		Agency usage	<3.2%	✗ 4.6%	✗ 4.6%	✗ 4.7%	✗ 4.6%	✗ 5.1%	✗ 4.2%	✗ 3.4%	✗ 4.2%	✗ 3.6%	✗ 3.7%	✗ 3.2%	✗ 3.5%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 3.6%	✓ 2.5%	✗ 4.0%
		Agency (off framework)	0.0%	✗ 0.1%	✓ 0%	✓ 0%	✗ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✓ 0%	✗ 0.01%
		Agency (over price cap)	≤40.0%	✗ 55.1%	✗ 55.6%	✗ 59.7%	✗ 57.1%	✗ 60.3%	✗ 53.6%	✗ 55.5%	✗ 56.4%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 45.4%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✗ 52.2%	✗ 55.3%	✗ 52.9%
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	96.6%	96.5%	95.1%	96.1%	95.6%	96.8%	93.5%	95.3%	93.7%	87.4%	80.6%	87.1%	86.3%	86.3%	89.0%	87.2%	92.1%	✗ 91.4%
		Ambulance delays >60 mins	0.0%	✗ 0.2%	✓ 0%	✓ 0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 1.1%	✗ 0.6%	✗ 0.7%
		ED 4-hour performance	≥76%	✗ 74.2%	✗ 73.4%	✗ 70.9%	✗ 72.8%	✗ 71.7%	✓ 82.0%	✗ 73.6%	✗ 75.6%	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.8%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✗ 69.8%	✓ 77.3%	✗ 71.0%
		ED 12-hour length of stay performance	≤2%	✗ 3.1%	✗ 2.2%	✗ 2.3%	✗ 2.5%	✗ 2.9%	✓ 0.9%	✗ 3.0%	✗ 2.3%	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.0%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✗ 3.7%	✗ 2.1%	✗ 3.4%
		SDEC rate	≥33%	✓ 38.2%	✓ 37.7%	✓ 38.6%	✓ 38.2%	✓ 38.1%	✓ 41.3%	✓ 39.0%	✓ 39.4%	✓ 40.1%	✓ 39.4%	✓ 36.7%	✓ 38.7%	✓ 37.8%	✓ 40.1%	✓ 39.3%	✓ 39.0%	✓ 38.9%	✓ 38.8%
		Adult G&A bed occupancy	≤92%	✗ 93.6%	✗ 94.8%	✗ 94.7%	✗ 94.4%	✗ 95.5%	✗ 92.2%	✗ 93.8%	✗ 93.9%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 94.9%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.9%	✗ 94.6%	✗ 94.5%
		Long length of stay (21+) occupied beds	≤Plan	✗ 124	✓ 96	✓ 91	✓ 110	✓ 102	✓ 105	✓ 103	✓ 104	✓ 96	✓ 97	✓ 106	✓ 100	✓ 115	✓ 106	✓ 97	✓ 106	✓ 99	✓ 103
		Inpatients medically safe for transfer for greater than 24 hours	≤40	✗ 91	✗ 64	✗ 71	✗ 75	✗ 84	✗ 65	✗ 57	✗ 69	✗ 57	✗ 56	✗ 59	✗ 57	✗ 65	✗ 48	✗ 50	✗ 54	✗ 53	✗ 64
	Electives	Advice & guidance	≥16%	✓ 24.5%	✓ 25.8%	✓ 22.0%	✓ 24.1%	✓ 25.2%	✓ 24.6%	✓ 22.3%	✓ 24.0%	✓ 24.7%	✓ 23.9%	✓ 24.2%	✓ 24.2%	✓ 23.5%	✓ 23.1%	✓ 25.5%	✓ 24.0%	✓ 26.3%	✓ 24.1%
		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	✓ 6.0%	✓ 5.9%	✓ 5.9%	✓ 5.9%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.2%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 6.1%	✓ 6.2%	✓ 5.8%	✓ 6.6%	✓ 6.0%
		Outpatient attends that are first or follow up with a procedure	≥Plan	✗ 43.3%	✗ 40.7%	✗ 43.9%	✗ 42.6%	✗ 42.2%	✗ 42.9%	✓ 43.1%	✗ 42.7%	✗ 41.5%	✗ 41.7%	✗ 41.7%	✗ 41.6%	✗ 41.4%	✗ 40.7%	✗ 40.9%	✗ 41.0%	-	✗ 42.0%
		Incomplete RTT waiting list	≤Plan	✗ 36,584	✗ 35,858	✗ 35,720	✗ 35,720	✗ 35,251	✗ 35,165	✗ 35,507	✗ 35,507	✗ 35,440	✗ 34,538	✗ 34,147	✗ 34,538	✗ 33,876	✗ 34,438	✗ 35,324	✗ 35,324	✗ 35,319	✗ 35324
		Incomplete RTT pathways +52 weeks	≤Plan	✓ 1,312	✓ 1,162	✓ 1,177	✓ 1,177	✓ 1,080	✗ 1,019	✗ 870	✗ 870	✗ 786	✗ 709	✗ 569	✗ 569	✗ 609	✗ 553	✗ 469	✗ 469	✓ 453	✗ 469
		Incomplete RTT pathways +65 weeks	≤Plan	✓ 140	✓ 129	✓ 109	✓ 109	✓ 77	✗ 105	✗ 50	✗ 50	✗ 44	✗ 36	✗ 40	✗ 40	✗ 28	✗ 32	✗ 22	✗ 22	✗ 32	✗ 22
		Incomplete RTT pathways +78 weeks	0	✗ 2	✗ 1	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Diagnostics	Diagnostic DM01 backlog		3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	1,427	989	940	940	920	499	642	642	978	642
		Diagnostic DM01 performance under 6-weeks	≥Plan	✓ 71.6%	✓ 72.7%	✗ 70.5%	✗ 70.5%	✗ 69.5%	✗ 70.2%	✗ 76.3%	✗ 76.3%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 89.4%	✓ 88.7%	94.4%	93.1%	94.4%	✗ 88.9%	✓ 93.1%
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	✓ 75.3%	✓ 79.8%	✓ 79.2%	✓ 78.2%	✓ 81.6%	✓ 81.6%	✓ 78.2%	✓ 80.5%	✓ 79.9%	✓ 78.4%	✓ 76.1%	✓ 78.2%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 76.4%	-	✓ 78.3%
		Cancer 31-day treatment performance	≥Plan	✓ 89.8%	✓ 87.5%	✓ 88.3%	✓ 88.6%	✓ 95.0%	✓ 91.1%	✓ 95.0%	✓ 93.8%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 92.0%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 93.1%	-	✓ 91.9%
		Cancer 62-day treatment performance	≥Plan	✓ 71.8%	✗ 56.3%	✓ 70.3%	✗ 66.1%	✗ 71.4%	✓ 67.9%	✗ 61.2%	✗ 67.0%	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 65.8%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✗ 59.2%	-	✗ 64.4%
		Suspected cancer patients waiting over 62-days		100	80	81	81	75	99	95	95	98	86	92	92	107	100	86	86	87	86
Best Value Care	Finance	Income & expenditure against plan	≥£0.00m	✗ -£0.02	✓ £0.02	✗ -£0.61	✗ -£0.61	✗ -£0.33	✗ -£0.31	✓ £0.44	✗ -£0.20	✗ -£0.17	✗ -£0.79	✗ -£0.10	✗ -£1.06	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £1.87	✓ £0.00	✓ £0.01
		Financial Improvement Programme (FIP) against plan	≥£0.00m	✗ -£0.54	✓ £1.48	✓ £0.66	✓ £1.60	✗ -£1.61	✗ -£1.40	✗ -£1.43	✗ -£4.44	✓ £4.70	✗ -£1.97	✗ -£0.20	✓ £2.53	✓ £0.26	✗ -£0.04	✓ £0.15	✓ £0.37	✗ -£0.81	✓ £0.08
		Capital expenditure against plan	≤£33.61m	✓ -£0.52	✗ £2.26	✗ £1.27	✗ £3.01	✗ £1.10	✗ £1.38	✗ £1.26	✗ £3.74	✗ £1.41	✗ £1.01	✗ £1.92	✗ £4.34	✗ £2.43	✗ £1.62	✗ £18.40	✗ £22.45	✗ £0.35	✓ £33.58
		Cash balance	≥£1.45m	✗ £1.34	✓ £1.73	✓ £1.50	✓ £1.50	✗ £0.32	✗ -£0.15	✗ £0.05	✗ £0.05	✓ £9.46	✓ £4.17	✗ £1.28	✗ £1.28	✗ -£0.53	✓ £13.00	✓ £24.72	✓ £13.00	✓ £24.72	✓ £26.53
		Implied Productivity 2023/24 v 2024/25	3.1%	-	-	-	-	✓ 6.7%	✓ 5.2%	✓ 6.1%	✓ 6.1%	✓ 6.9%	✓ 5.4%	✓ 4.6%	✓ 4.6%	✓ 4.6%	✓ 4.4%	-	-	-	✓ 4.6%
		Value weighted elective activity	105%	✗ 103.5%	✓ 110.9%	✓ 112.0%	✓ 108.8%	✓ 108.8%	✓ 118.7%	✓ 118.5%	✓ 115.3%	✓ 119.1%	✓ 113.6%	✓ 114.4%	✓ 115.7%	✓ 123.1%	✓ 125.5%	✓ 124.3%	✓ 124.3%	-	✓ 119.1%
		Agency expenditure against plan	≥£0.00m	✗ -£0.19	✗ -£0.29	✗ -£0.29	✗ -£0.77	✗ -£0.39	✗ -£0.24	✓ £0.01	✗ -£0.62	✗ -£0.17	✗ -£0.09	✓ £0.14	✗ -£0.12	✗ -£0.03	✗ -£0.15	✗ -£0.20	✗ -£0.38	✗ -£0.44	✗ -£1.89
		Reported agency spend		£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£1.18	£1.14	£0.90	£3.22	£1.03	£1.05	£1.00	£3.08	£0.75	£13.70
		Reported bank spend		£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£2.36	£2.41	£2.61	£7.38	£2.81	£2.22	£2.51	£7.54	£1.88	£30.55
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan	✗ 111.5%	✗ 106.8%	✗ 104.1%	✗ 107.3%	✗ 106.5%	✓ 96.7%	✗ 102.0%	✗ 101.7%	✗ 105.9%	✗ 107.4%	✗ 107.7%	✗ 107.0%	✓ 99.5%	✓ 99.2%	✗ 110.3%	✗ 103.1%	✓ 95.2%	✗ 104.8%
		Non-elective admissions	≤Plan	✗ 111.3%	✗ 110.4%	✗ 103.3%	✗ 108.3%	✗ 105.5%	✗ 102.1%	✓ 99.1%	✗ 102.2%	✓ 98.1%	✓ 96.1%	✗ 101.2%	✓ 98.4%	✗ 103.0%	✓ 98.7%	✗ 106.2%	✗ 102.6%	✓ 87.6%	✗ 102.8%
	Electives	Average daily elective referrals		343	340	325	336	348	320	347	338	374	350	304	342	346	362	330	346	-	341
		Outpatients - first appointment	≥Plan	✗ 99.3%	✗ 84.0%	✗ 94.0%	✗ 92.3%	✗ 90.5%	✗ 87.5%	✗ 96.0%	✗ 91.3%	✗ 82.9%	✗ 83.4%	✗ 78.8%	✗ 81.8%	✗ 78.3%	✗ 81.0%	✗ 82.2%	✗ 80.4%	✗ 89.0%	✗ 86.4%
		Outpatients - follow up	≤Plan	✓ 100.0%	✗ 102.4%	✓ 94.1%	✓ 98.9%	✓ 99.1%	✓ 92.2%	✓ 97.2%	✓ 96.2%	✓ 97.2%	✓ 92.6%	✓ 92.7%	✓ 94.2%	✓ 95.7%	✓ 99.8%	✓ 97.7%	✓ 97.6%	✗ 102.3%	✓ 96.7%
		Outpatients - procedures	≥Plan	✓ 133.0%	✓ 129.3%	✓ 114.4%	✓ 125.3%	✓ 122.7%	✓ 118.7%	✓ 139.0%	✓ 126.1%	✓ 139.9%	✓ 126.9%	✓ 148.9%	✓ 137.8%	✓ 147.3%	✓ 137.1%	✓ 121.1%	✓ 134.7%	✗ 94.3%	✓ 130.8%
		Day case	≥Plan	✗ 96.3%	✗ 96.1%	✗ 96.0%	✗ 96.1%	✓ 102.7%	✓ 101.3%	✓ 100.0%	✓ 101.3%	✗ 95.8%	✓ 101.4%	✗ 97.3%	✗ 98.1%	✗ 99.7%	✗ 94.9%	✗ 90.6%	✗ 95.0%	✗ 92.0%	✗ 97.7%
		Elective inpatient	≥Plan	✗ 92.5%	✗ 94.6%	✗ 90.0%	✗ 92.4%	✗ 84.0%	✗ 99.8%	✗ 96.7%	✗ 93.3%	✓ 108.0%	✓ 109.9%	✗ 98.5%	✓ 105.7%	✗ 87.7%	✗ 89.2%	✗ 93.6%	✗ 90.2%	✗ 90.8%	✗ 95.4%
	Diagnostics	Diagnostics	≥Plan	✓ 102.6%	✓ 109.2%	✗ 98.1%	✓ 103.2%	✓ 104.9%	✓ 111.4%	✓ 112.5%	✓ 109.5%	✓ 120.5%	✓ 114.9%	✓ 114.6%	✓ 116.7%	✓ 115.9%	✓ 108.8%	✓ 115.7%	✓ 113.4%	✓ 105.9%	✓ 110.7%

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Quality of Care

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Domain Summary: Quality of Care

Overview	Lead: Chief Nurse/Chief Medical Officer

In 2024/25 quarter four, there was a continued high volume of people consistently accessing urgent care, with the Trust often in escalation and using surge capacity. This prolonged, unrelenting period of operational pressure impacts on our ability to provide good, safe patient care. At the start of 2025, we continued to see long waits for admission beds and over-crowding within our Emergency Department (ED) with associated impacts on patients and staff.

During the months of Jan-25 to Mar-25 the Patient Experience Team received a total of 76 formal complaints, 516 compliments and 445 concerns. In Apr-25 we received a total of 25 formal complaints, 160 compliments and 175 concerns. We continue to identify actions and themes that are tracked through the Patient Experience Committee.

Following discussion with NHS England about the requirement to carry out a Patient Safety Incident Investigations (PSII) on all C-Diff deaths if on part one of the death certificate, they have confirmed that this is no longer required, and they are comfortable with such cases following the Trusts Patient Safety Incident Response Framework (PSIRF) process.

During 2024/25 quarter four and Apr-25, we met several of our Infection Prevention and Control (IPC) targets. However, in 2024/25 we breached our C-Diff, MRSA and Klebsiella targets. This is following the national pattern; we are not an outlier with our case numbers. Over the year we have conducted investigations into all hospital acquired infections, completing 303 in total. This enables us to carry out thematic reviews on a more regular basis to identify any areas of improvement required. We have achieved our Ecoli and Pseudomonas target. With Pseudomonas, we have had a 64% reduction in cases compared with the previous year.

Three PSII were commissioned by the Patient Safety Incident Response Group (PSIRG) in 2024/25 quarter four. This followed an in-depth discussion during which representatives from the Integrated Care Board (ICB) were present. During Apr-25 the PSIRG panel commissioned one after-action review and commissioned an external review following identification of a possible theme with adverse outcomes following squint surgery.

Three PSII's were signed off in 2024/25 quarter four, and one in Apr-25. The key learning points were identified (shared on later slide).

There are five off-track metrics during 2024/25 quarter four and Apr-25:

- Falls per 1000 occupied bed days: Falls rate for Jan-25 (7.9) and Feb-25 (7.2) exceeded the national average of 6.63 per thousand occupied bed days and put us of track for the quarter.
- Category 3/4 Hospital Acquired Pressure Ulcers (HAPU) and ungradable pressure ulcers with lapses in care: SFH reported one avoidable category three pressure ulcer.
- Hospital Standardised Mortality Ratio (HSMR): Latest 12-monthly rolling = 102.2 (Jan-24 to Dec-24); (quarter three report HSMR+ 101.4). As expect.
- Summary Hospital-level Mortality Indicator (SHMI): Latest reporting = 106.06 (Nov-23 to Oct-24); (quarter three report 106.05). Remains as expected.
- Stillbirths: Five (one in Jan-25 and four in Feb-25). Each case received an individual review as outlined on a later slide and has been reported through the Perinatal Mortality Review Tool (PMRT) process.

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

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Scorecard: Quality of Care

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

At a Glance	Indicator	2024/25 Standard	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	Jan-25	Feb-25	Mar-25	2024/25 Qtr 4	Apr-25	2024/25 Final
Safe	Falls with lapse in care	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1
	Falls per 1000 occupied bed days	≤6.63	✓ 6.2	✓ 5.8	✗ 6.7	✓ 6.3	✗ 6.7	✓ 5.9	✓ 6.2	✓ 6.3	✓ 6.0	✗ 7.4	✗ 7.3	✗ 6.9	✗ 7.9	✗ 7.2	✓ 5.3	✗ 6.8	-	✓ 6.6
	Never events	0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2
	MRSA reported in month	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1
	Cdifficile reported in month	≤13 qtr	4	4	5	✓ 13	4	3	4	✓ 11	7	4	6	✗ 17	4	5	5	✗ 14	7	✗ 55
	Ecoli blood stream infections (BSI) reported in month	≤22 qtr	5	1	4	✓ 10	3	5	2	✓ 10	4	6	0	✓ 10	4	1	3	✓ 8	4	✓ 38
	Klebsiella BSI reported in month	≤1 qtr	0	1	2	✗ 3	1	1	0	✗ 2	1	1	0	✗ 2	1	0	2	✗ 3	2	✗ 10
	Pseudomonas BSI reported in month	≤3 qtr	0	0	1	✓ 1	0	0	0	✓ 0	0	1	0	✓ 1	0	0	0	✓ 0	0	✓ 2
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care		0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.2	0.1	0.0	0.1	0.1	0.2	0.0	0.1	0.0	0.1
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	✓ 0	✗ 1	✗ 1	✗ 2	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 2	✗ 2	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✗ 6
	Patient Safety Incident Investigations (PSII)		3	4	0	7	0	2	2	4	1	0	2	3	2	1	0	3	0	17
Caring	Complaints per 1000 occupied bed days	≤1.9	✓ 0.7	✓ 1.5	✓ 0.9	✓ 1.0	✓ 1.5	✓ 0.8	✓ 0.8	✓ 1.0	✓ 0.8	✓ 0.8	✓ 0.4	✓ 0.7	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.0	✓ 1.3	✓ 0.9
	Compliments received in month		161	138	151	450	155	120	119	394	204	160	147	511	140	152	184	476	155	1831
Effective	HSMR (basket of 56 diagnosis groups)	≤100	✗ 104	✗ 103	✗ 102	✗ 102	✗ 102	✗ 102	✗ 103	✗ 103	✗ 103	✗ 103	✗ 101	✗ 103	✗ 101	✗ 102	✗ 102	✗ 102	✗ 103	✗ 102
	SHMI	≤100	✗ 109	✗ 108	✗ 107	✗ 107	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 107	✗ 106	✗ 106	✗ 107
	Still birth rate	≤4.4	✓ 0.0	✓ 3.2	✓ 4.2	✓ 2.3	✓ 0.0	✗ 6.8	✗ 6.4	✓ 4.4	✓ 3.4	✗ 10.3	✓ 0.0	✗ 4.5	✓ 3.5	✗ 15.5	✓ 0.0	✗ 6.2	✓ 0.0	✓ 4.3
	Early neonatal deaths per 1000 live births	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✗ 3.2	✗ 1.1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3

Indicator in Focus: Falls per 1000 occupied bed days

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

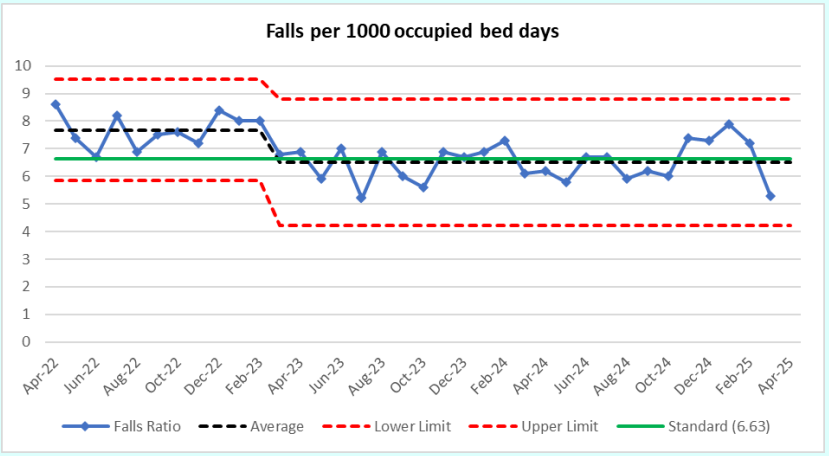
Jan-25 (7.9) and Feb-25 (7.2) exceeded the national average of 6.63 per thousand occupied bed days, putting us off track for 2024/25 quarter four. This position recovered in Mar-25 (5.3). The deviation in Jan-25 and Feb-25 may partially result from the ongoing high demand for urgent care, with the Trust operating in surge capacity and occasionally implementing the Full Capacity Protocol (FCP). The meeting with the East Midlands Falls group also highlighted broader concerns about the rise in falls, as other Trusts were experiencing similar trends.

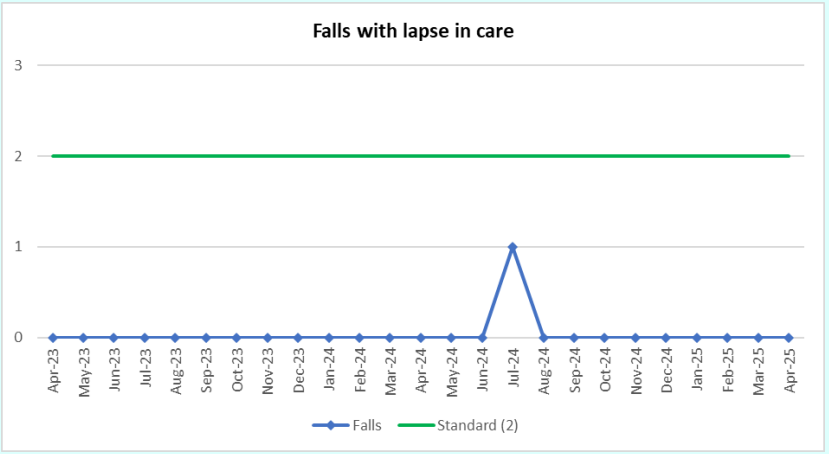
Comprehensive falls reviews revealed that no incidents were linked to lapses in care. The actions and lessons identified from these investigations are outlined below.

Jan-25 saw a rise in repeat falls, prompting the team to prioritise reviews of these patients and those with moderate or higher harm. This has reduced in Feb-25. The figures are as follows:

- Jan-25: 40 repeat falls (29 patients)
- Feb-25: 26 repeat falls (16 patients)
- Mar-25: 14 repeat falls (10 patients)
- Apr-25: 18 repeat falls (16 patients)

Data





Root causes	Actions and timescale	Impact
Increased falls due to our hospitals running in high level of escalation with implementation of FCP actions.	• Training on focus days for preceptorship nurses.	• Staff up to date with falls information.
	• Focused support for wards that request additional training.	• To share relevant information for that area regarding recent incidents and how they can learn from them.
	• Reviewing patients on pathway two to look at themes and trends.	• This allows the falls team to identify patterns or underlying reasons behind patient falls, facilitating the development of targeted training or mitigation strategies to prevent future incidents.
Increase in repeat falls in Jan-25.	• Supporting wards with identifying repeat falls and providing education to patients to reduce risk of falling again. Ensure a falls review is completed on these patients.	• To reduce risk of repeat falls.

Indicator in Focus: Hospital Acquired Pressure Ulcers (HAPU)

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 Jan-25, SFH reported one avoidable category three pressure ulcer for a patient that attended ED and was transferred to EAU with a history of confusion and reduced mobility.

We remain on track for Hospital Acquired (category 2) per 1,000 occupied bed days with lapses in care.

Root causes

PURPOSE-T in ED was inaccurate as recorded that patient was mobilising independently.

Lack of skin checks in ED.

Lack of documentation regarding equipment and care plan.

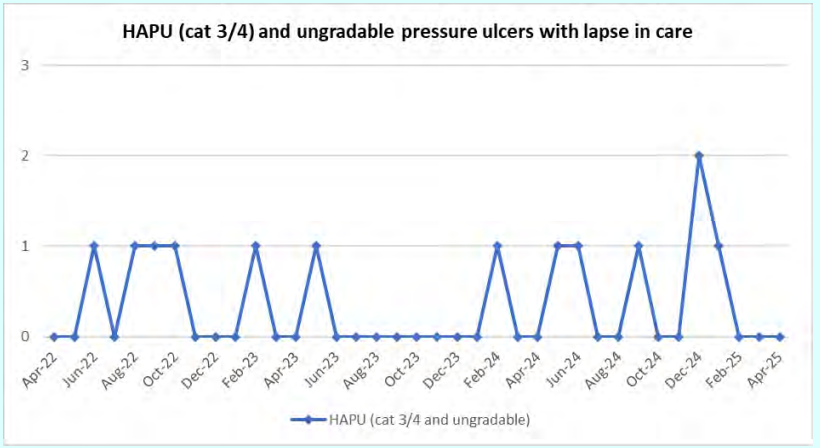
Actions and timescale

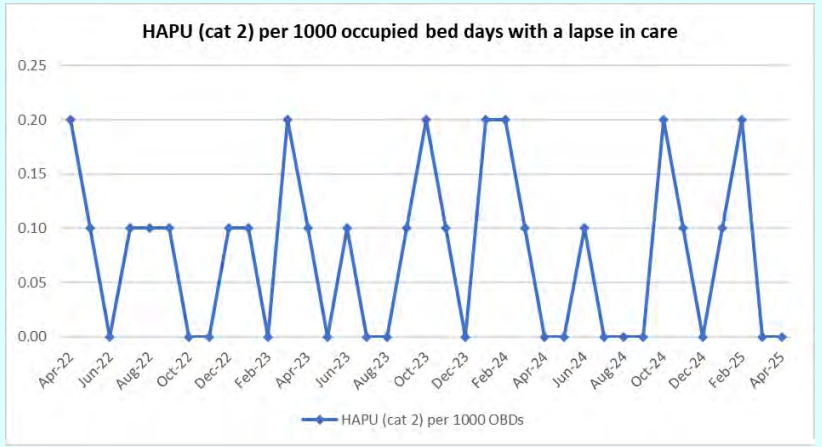
- Learning from this incident shared at team brief to highlight the importance of early and ongoing skin checks in deteriorating patients.
- Training planned for new ED carers to incorporate learning from this incident.
- Plans in place for the Tissue Viability team to present as a case study to facilitate learning Trust-wide.

Impact

- Reduce likelihood for similar incidents.

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 2024/25 quarter four, three PSII's were commissioned by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the ICB were present.

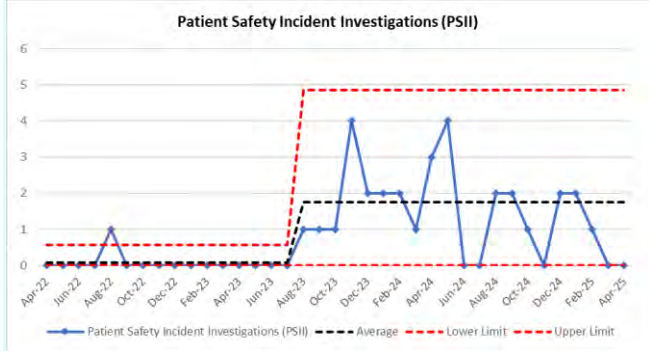
PSII with potential coronial interest	MSNI investigation	Never Events
One of the patients has died, the case has not been taken by the coroner.	One commenced.	None reported in 2024/25 quarter four.

During Jan-25 three PSII's was signed off and the key learning points were identified as follows:

1) Following concerns with the management of an unrecognised obstruction, a PSII was completed which identified multiple actions including, a review of the standard operating procedure (SOP) for internal professional standards to ensure clearer protocol for referral pathways which will then be communicated to all divisions and a review of where cases of pseudo-obstruction and severe constipation should be managed, particularly with reference to clinical ownership and with consideration of shared care pathways, should be considered.
2) PSII was completed and presented to the coroner in Mar-25 in relation to a delay in the transfer of a paediatric patient from ED to QMC, learning identified: consider mandating a single drug chart for paediatric patients, continue progress towards electronic prescribing in all areas of the department (currently being rolled out in adult areas), review functioning of overdue observations on electronic system, continue with the business case to expand paediatric nursing staff provision and local transfer arrangements to be included in the paediatric surgical assessment pathway and covered in induction or mandatory training.
3) A PSII commissioned to understand the reasons behind Ophthalmology patients experiencing delays in care identified that a clear process for risk stratifying cancelled patients is required, clear timeframes to be specified in letters, development of a risk stratification tool for senior Glaucoma clinical and admin team to use to support admin Glaucoma SOP and development of agreed community referral pathways with HealthHarmonie for Glaucoma pathways was required.

In Apr-25 one PSII was signed off: Mortuary incident in relation to the transfer and release of patients and specimens into the mortuary. An extensive action plan was produced with many actions completed. Final report has been shared with the Human Tissue Authority (HTA) ahead of the agreed date.

Data



Root causes	Actions and timescale	Impact
Maternity and newborn safety investigation (MNSI) commissioned for a maternity case where there were concerns following an emergency caesarean section under GA and cord prolapse.	It was agreed by the division that no immediate actions were required; await the MNSI investigation. Issues around documentation have been acknowledged and addressed. A reflective discussion has taken place with the staff involved. MNSI liaises with families to ensure they are involved throughout the investigation.	MNSI/PSII ongoing.
PSII commissioned following a C-Diff death.	PSII commissioned, Community onset hospital acquired C-Diff.	PSII ongoing.
HTA reportable incident involving transfer the transfer of products of conception and non-viable foetuses.	Commissioned as a PSII with an external investigator. Peer reviews to be completed whilst awaiting completed report to provide assurance around immediate actions taken.	PSII ongoing.

Indicator in Focus: Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indictor (SHMI)

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

HSMR+ (Plus): Latest 12-monthly rolling = 102.2 (Jan-24 to Dec-24); (2024/25 quarter three report HSMR+ 101.4). As expected.
HSMR+ (Plus) methodology in place since Nov-24
SHMI: Latest reporting = 106.06 (Nov-23 to Oct-24); (2024/25 quarter three report 106.05). Remains as expected.

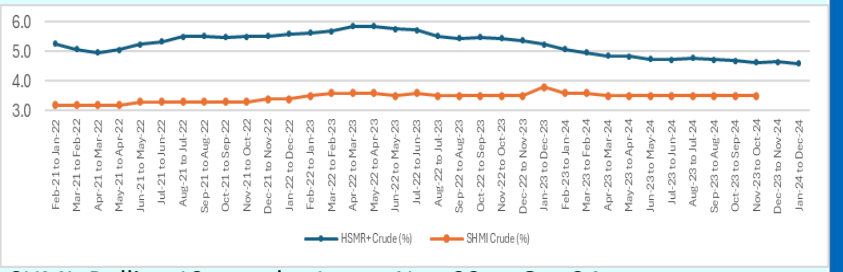
Root causes	Actions and timescale	Impact
Data Quality including timely diagnosis, documentation, coding, co-morbidity capture	• Close working between coding team, business intelligence / analytics and, through Learning from Deaths, departmental morbidity/mortality meetings and other channels, an emphasis on communication with clinical teams to support (and promote) timely and accurate documentation, effective decision-making and an understanding as to how this relates to coding and reflection of activity being undertaken.	HSMR (+) figure will not, necessarily, reflect until 12 months after action commenced.
Patient management and flow including clinical pathways, management bundles and effective signposting.	• Targeted reviews, as part of the wider Learning from Deaths (LfD) process, to investigate / understand outlier areas and identify Trust opportunities for improvement. • Divisional review for specific areas undertaken, including Anaemia (deficiency) and Intestinal Infection; these are being fed into Learning from Deaths to support assurance. • Targeted review initiated for new mortality outlier, identified as “superficial injury, contusion”.	Reporting aids discussion, learning and helps provide quality assurance with route for escalation / further action.
Palliative care coding (remains low, nationally)	• Although HSMR+ does not account for Specialist Palliative Care coding, a separate focus remains, and Specialist Palliative Care continues to be monitored. • SFHT has been noted as an outlier for End-of-Life Care initiation in early stage of admission- review includes how/why decisions and advanced care planning (including ReSPECT forms) are undertaken prior to acute admission, alongside the decision to initiate EOL care in-hospital.	Requires strategic understanding and development on ICB footprint with local input as to resource / investment.
Learning from Deaths (LfD)	• Discussion and review of trends and outliers, from Trust and Specialty-specific perspective • Improved attendance, representation and engagement (including divisional / speciality) • Close working and monthly intelligence meeting with Telstra (data analytics / HSMR+), for benchmarking analysis, triangulation and learning / action.	Greater divisional ownership and reporting assurance.
Data intelligence and benchmarking	• HSMR+ and SHMI continue to be reported as expected. • Crude Rate: The Trust has seen a continued reducing HSMR+ Crude Rate (thought in part to be aligned to increasing spell activity). In contrast, SHMI data appears to show a relatively stable picture but continues to be monitored.	Greater focus (Trust and specialty) on outlier areas.
	• The urgency has been raised for Trust and wider (ICS) “benchmarking tool” procurement discussion (and action) to take place, due to current end-of-contract timelines. • Use of internal dashboard and analytics to support and triangulate external information. • Continued development of quality dashboard, including patient safety metrics.	Internal / external analytics, assurance and understanding.
External peer review, wider accountability and collaboration	• Involvement of ICS colleagues within LfD for reporting and assurance, alongside wider learning • “Interface Workstream” includes Primary, Secondary Care and with involvement from Local Medical Council (LMC) to improve working and consider system wide understanding.	Whole pathway approach and system understanding.

Data

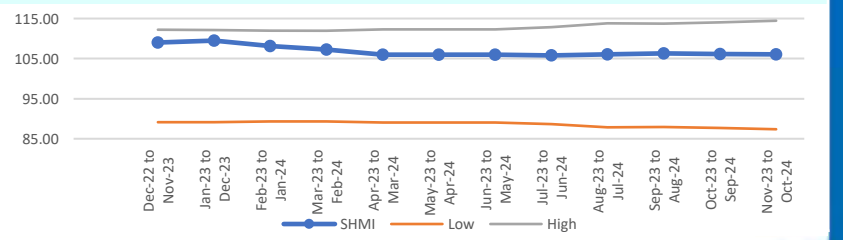
HSMR+ 3 yearly (12-month rolling) trend: Jan-22 to Dec-24 (36m)

HSMR Single-Month Trend: Jan-24 to Dec-24

Crude Rate: HSMR+ (Blue) and SHMI (Red): Jan-22 to Dec-24 (36m)



SHMI: Rolling 12 months: Latest Nov-23 to Oct-24



Indicator in Focus: Still Birth Rate

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

In 2024/25 quarter four, there was five stillbirths (one in Jan-25 and four in Feb-25). Each case received an individual review as outlined below and has been reported through the Perinatal Mortality Review Tool (PMRT) process where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

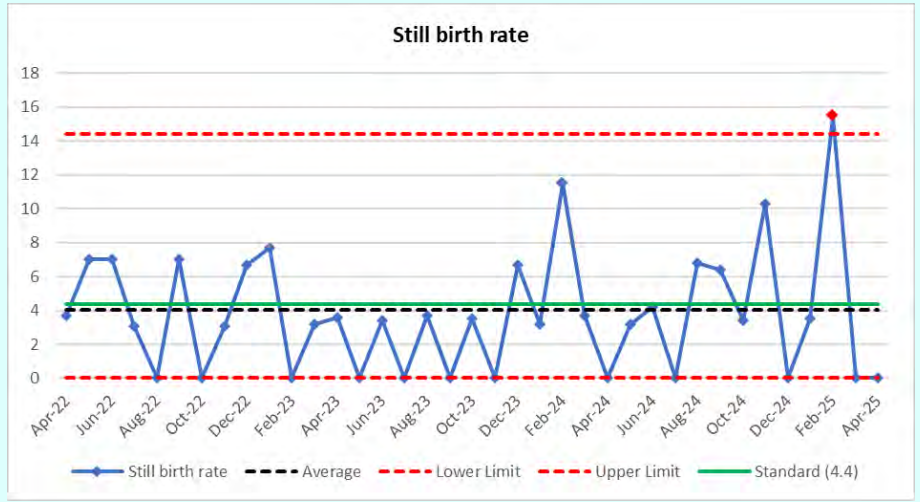
Jan-25

- Attended Community Midwife appointment at 25 weeks and four days gestation, no fetal heart present, confirmed by ultrasound scan. Reviewed through PMRT process, no family concerns raised to date and awaiting final report with results from tests.

Feb-25

- Attended triage at 36 weeks and one day gestation with altered fetal movements, no fetal heart present when assessed. Reviewed through PMRT process, awaiting final report with results from tests. No initial concerns raised.
- Attended triage with altered fetal movements at 36 weeks and six days gestation and no fetal heart rate present when assessed. No initial concerns raised, awaiting final report when results from tests and investigations are available.
- Attended at 24 weeks and one day gestation, known fetal abnormalities from antenatal scan, no fetal heart present. No concerns identified. Reviewed through PMRT process.
- Attended at 31 weeks and five days gestation with altered fetal movements, known Diabetic, and no fetal heart present upon arrival. No initial concerns raised, reviewed through PMRT process, awaiting final report.

Data



Root causes	Early/ urgent learning identified	Impact
No early themes/ concerns.	• As the Stillbirth rate has reached the upper limit, we have a local and system action plan in place to perform a cluster review. • Initial local data has provided no themes, graded A or B through PMRT (low risk) but review to be shared within system partners for peer scrutiny.	Low

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People and Culture

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Domain Summary: People and Culture

Overview	Lead: Chief People Officer

Our hospitals and Nottingham and Nottinghamshire Integrated Care System (ICS) have experienced a busy period, with additional controls and governance swiftly mobilised to support delivery of our financial position for 2024/25. Notably, during 2024/25 quarter four, we have observed positive performance across several People and Culture metrics and a promising start to month one of 2025/26.

The month one position is commendable, with six out of eleven indicators meeting or exceeding the standard, as detailed in the scorecard on the next page.

The appraisal compliance level has fluctuated, prompting significant efforts to promote the benefits and ensure the quality of appraisals. Divisions and services, along with colleagues attending our Divisional Performance Reviews (DPRs), have reviewed and challenged the position, resulting in a compliance level equivalent to the 90% standard over recent months.

Turnover has remained strong, staying below the standard, with Apr-25 reporting at 0.6%. Our Mandatory and Statutory Training (MaST) compliance level has consistently surpassed targets across 2024/25 and continues to do so in Apr-25.

Apr-25 also saw improvements in our bank usage and agency usage, aligned with ongoing efforts to meet NHS planning expectations of a 40% reduction in agency and a 15% reduction in bank usage. Since Apr-24, there has been zero use of ‘off framework’ agency. Against the proposed month one targets, bank usage shows a strong position of 6.3% against a proposed new standard of 7.8%. Agency usage is above position reported at 2.5% against a proposed new standard of 1.9%.

Sickness absence levels for Apr-25 were reported at 4.9%, higher than our standard of 4.2%, but still within the upper and lower statistical process control limits. This matter was discussed in the People Committee, leading to a deep dive in quarter four, and subsequent actions are being implemented. We are noting high levels of staff reporting absences related to Cold, Cough, Influenza and in Chest and Respiratory problems.

Overall staff influenza vaccination uptake was reported at 47.8%, reflecting a decrease from previous years (55.9% in Dec-23). Nevertheless, this figure compares favourably with national NHS statistics, where 38.8% of eligible healthcare workers received the influenza vaccine. Research by the Health Foundation indicates a declining trend in vaccine uptake among Healthcare Workers nationally since 2020/21, with the national average for 2024/25 reported at 38%. A post-vaccination review is underway to assess our approach for 2025/26.

Employee relations cases over the quarter have remained high in 2024/25 quarter four, with a monthly average of 25, an increase from quarter three (19).

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

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Scorecard: People and Culture

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

At a Glance	Indicator	2024/25 Standard	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	2024/25 Final
Belonging in the NHS	Engagement score	≥6.8%	-	-	✓ 6.8	-	-	✓ 6.8	-	-	✓ 7.1	-	-	-	-	✓ 6.9
Growing the Future	Vacancy rate	≤8.5%	✓ 8.2%	✓ 8.0%	✓ 8.1%	✓ 8.4%	✓ 7.7%	✓ 7.4%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✓ 8.0%
	Turnover in month	≤0.9%	✓ 0.5%	✓ 0.3%	✓ 0.6%	✓ 0.5%	✓ 0.6%	✓ 0.5%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.7%
	Appraisals	≥90%	✗ 88.5%	✓ 90.1%	✗ 88.8%	✓ 90.3%	✓ 90.0%	✗ 89.7%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 89.0%
	Mandatory & statutory training	≥90%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.4%	✓ 91.3%	✓ 90.9%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 91.5%
Looking after our People	Sickness absence	≤4.2%	✗ 4.3%	✗ 4.4%	✗ 4.7%	✗ 4.9%	✗ 4.2%	✗ 4.7%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 5.0%
	Total workforce loss	≤7.0%	✓ 6.4%	✓ 6.4%	✓ 6.8%	✓ 6.9%	✓ 6.3%	✓ 6.7%	✗ 7.6%	✗ 7.8%	✗ 8.1%	✗ 7.8%	✓ 6.9%	✓ 6.6%	✗ 7.1%	✗ 7.01%
	Flu vaccinations uptake (front line staff)	≥75%	-	-	-	-	-	-	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	✗ 47.8%
	Employee relations management	<17	✗ 20	✗ 23	✓ 15	✗ 20	✗ 20	✗ 21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✗ 21
New Ways of Working	Bank usage	≤8.5%	✓ 8.3%	✗ 10.3%	✗ 9.3%	✗ 9.8%	✗ 10.3%	✓ 8.1%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✗ 8.9%
	Agency usage	<3.2%	✗ 4.6%	✗ 4.6%	✗ 4.7%	✗ 5.1%	✗ 4.2%	✗ 3.4%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✓ 2.5%	✗ 4.0%
	Agency (off framework)	0%	✗ 0.1%	✓ 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%
	Agency (over price cap)	≤40.0%	✗ 55.1%	✗ 55.6%	✗ 59.7%	✗ 60.3%	✗ 53.6%	✗ 55.5%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✗ 55.3%	✗ 52.9%

Indicator in Focus: Vacancy Rate

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

The 2024/25 quarter four vacancy position was reported at 7.7%. We have seen an increase in Apr-25 to 9.3%; which is an expected increase that we see at the start of each financial year due to budgets being approved and lags in recruitment. The position in Apr-25 sits above our target (8.5%). During the 2024/25 quarter four, the vacancy remained stable.

Increases in vacancies are noted within multiple areas within Medicine and within Women's & Children's. This is an expected variance as during the start of the financial year, we approve new budgets, but there are lags in recruitment, so the variance is artificially increased.

Data

Root causes	Actions and timescale	Impact
Our vacancy level is calculated from a variance between establishments and in-posts. During the start of the financial year, we approve new budgets; however, there are lags in recruitment, so the variance is artificially increased.	• Aligned to financial control, we monitor vacancies on a weekly basis via our vacancy control panels (VCPs). • We have re-set establishment levels and will continue to monitor our vacancy levels.	• We actively manage vacancies on a weekly basis via the VCP process and have strong governance processes around this.

Indicator in Focus: Sickness Absence

Sherwood Forest Hospitals NHS Foundation Trust

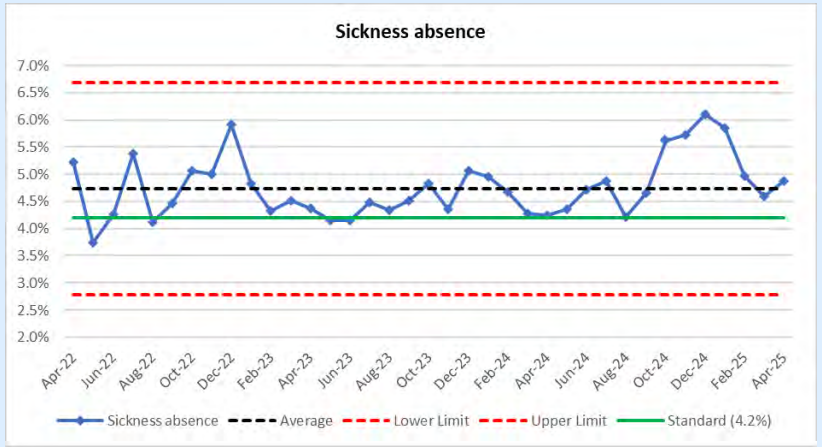
Overview and national position

The sickness position across 2024/25 is reported at 5%, with the Apr-25 position at 4.9%. This sits above our standard (4.2%), but within the upper and lower statistical process control levels. We are noting high levels of staff reporting absences related to Cold, Cough, Influenza and in Chest and Respiratory problems.

Monthly, we report and discuss the sickness absence position at a divisional and service line level and within the people directorate 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. Within these reviews we also review the root causes, that are mainly personal issues. However, we are seeing instances relating to morale. In addition to these elevated levels, we have experienced impact from frequently being on a high level of escalation due to challenging patient flow across our hospitals.

Local benchmarking shows that the Integrated Care Board (ICB) provider sickness absence level is reported at 5.3% (Mar-25).

Data



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

- All services are supported with one-to-one support from the Divisional People Lead teams with sickness absence management on a case-by-case basis and in line with policy where we will be re-focusing on fundamentals.
- A person-centred approach is taken in relation to sickness absence management.
- Sickness absence key performance indicators are monitored through People and Performance meetings, Service Line meetings and via Divisional Performance Reviews (DPRs).
- The Deputy Chief People Officer is meeting monthly with the Divisional People Leads to review all sickness cases and provide guidance and support in terms of management.
- We have completed a deep dive into sickness that has been reviewed at our People Committee. An action plan is being developed for divisions that will be monitor via Divisional Performance Reviews (DPRs) and People Cabinet.

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: Employee Relations Management

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

During 2024/25 quarter four the employee relations level has fluctuated between 20 and 31 cases, with the average of quarter four being 25 cases. The increased level of employee relations has primarily been related to formal disciplinary processes. During Apr-25 the case work level has reduced to 23 cases.

There are several other cases which have proceeded under a Some Other Substantial Reason (SOSR) process. These cases relate to safeguarding concerns, which are of a sensitive nature and/or where there has been third party involvement. This includes colleagues working under Agenda for Change and Medical and Dental terms and conditions. We continue to put training and support in place for all colleagues involved in employee relations matters.

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

Data

Root causes	Actions and timescale	Impact
The Trust has seen several formal disciplinary cases being concluded between Jan-25 and Mar-25, as a result, there has been an increase in the number of appeals. This increase in appeals was anticipated. Disciplinary investigations are the key employee relations reason within the quarter.	• All cases are managed using Just Culture Principals and take a person-centred approach with additional training taking place. • Partnership working continues with Staff Side representatives, Clinical colleagues and People Directorate colleagues in management of cases. • Enhanced wellbeing support has been developed to support colleagues who are part of any employee relations process. • Person-centred approach is in place in relation to sickness absence management. • Re-emphasis on an informal resolution to incidents, concerns and adverse events, where possible.	• The work we undertake supports our workforce as we move into 2025/26. We do not expect this to reduce immediately.

Indicator in Focus: Agency Usage (including off framework and over price cap)

Sherwood Forest Hospitals NHS Foundation Trust

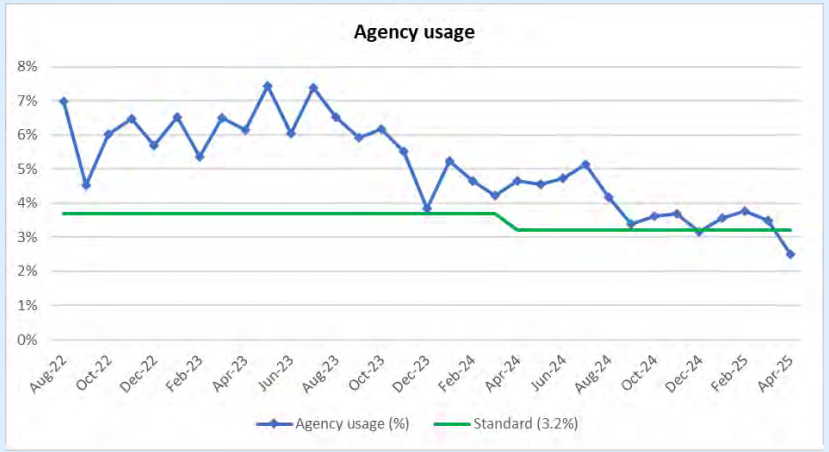
Overview and national position

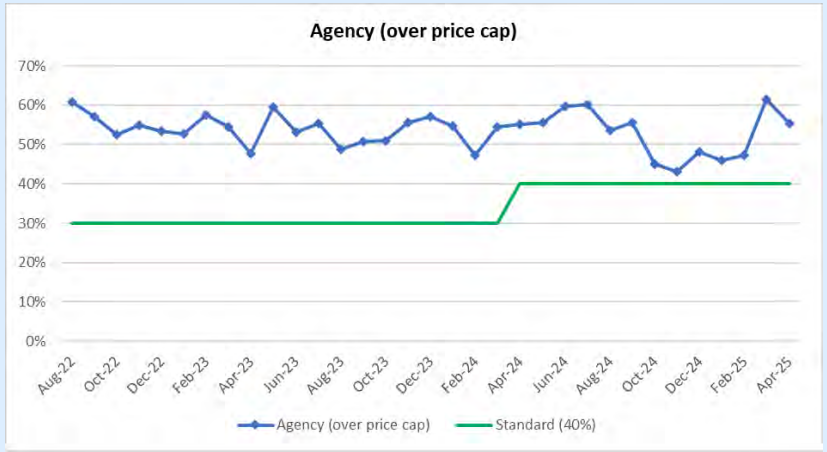
The agency position across 2024/25 is reported at 4%. This sits above our standard (3.2%) and is influenced by the hospitals OPEL position. Our current agency position for Apr-25 shows reductions to our agency usage and our 'on framework, over price cap' position.

We have modelled this with plans over the 2025/26 period to sit around the NHS planning guidance and our targets have been amended to reflect this.

The reduction to both these metrics are 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 specialty shortages.	• During 2024/25 we have continued the significant work to reduce reliance on agency usage and support the financial recovery challenge.	• We have been actively filling medical roles and have had success in some key specialities. The reductions are noted across the 2024/25 period.
	• We continue to advertise and fill medical posts, that has gradually reduced our agency level. We organise medical specialty 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, on to direct engagement contracts.	• Over the 2024/25 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.
	• A strict authorisation process for approval of shifts for high-cost agency has been implemented in Nursing. Detailed reports illustrating areas using all agency, with high-cost agency highlighted, are produced for the Deputy Chief Nurse.	

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Timely Care

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Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

As we exited winter, and particularly in Mar-25 and Apr-25, we have seen a significant improvement in several of our Urgent and Emergency Care (UEC) metrics. Many of these metrics are recovering from a yearly low in Dec-24 when winter pressures and patient acuity (evidenced by high NEWS2 scores when patients arrived) peaked. The headline 4-hour emergency access performance metric was above plan in Apr-25 and was our second-best monthly performance since Aug-22; this has moved us from the bottom 40% of Trusts nationally to middle of the national pack. We also saw recovery in our ambulance handover position and our Emergency Department (ED) 12-hour length of stay performance; both metrics continue to benchmark favourably nationally. Recovery in these metrics as we exited the winter period was primarily driven by improved hospital flow which enabled patients to be admitted to our hospitals in a timely manner, preventing extended waits and overcrowding in our ED.

The improved hospital flow was due to reduced length of stay for patients aged 65 and over, predominantly due to reduced discharge delays (patients spending less time in our hospitals when they were medically safe, or clinically ready, for transfer). The recovery in 4-hour performance we have delivered in recent months is greater than many other Trusts across the country as evidence by the increase in our benchmarked position nationally. Sustaining flow out of ED and into our hospital bed base remains a priority to minimise delay-related patient harm and provide high quality patient care. We are working to sustain the length of stay changes so we can continue to deliver more timely patient flow through our bed base and quicker access to emergency care for our patients.

In terms of planned care, we have continued to reduce the number of long wait patients, although we have further work to do to treat all patients waiting over 65 weeks; this is a key priority for us with a focus on ENT. We continue with strong performance providing advice and guidance and patient initiated follow up; both of which are consistently above target. In outpatients, first attendance activity levels have shown a reduction versus plan in recent months. This is driven by an increase in the number of one-stop clinics where patients are having a procedure during their first appointment (as seen in the over-delivery versus plan for outpatient procedures). This change is better for patients and should not be considered a concern from a performance perspective. As we transition into 2025/26, we begin to focus on the 18-week referral to treatment (RTT) metric once more where we have a 5% improvement on our Nov-24 position to deliver by Mar-26. This will be reported in the new suite of metrics, subject to Board approval. We are pleased to say that we benchmark favourably for the 18-week RTT metric.

In recent months, we have made significant progress improving our diagnostic DM01 performance to be above our planned position. We are working on sustaining this position whilst balancing activity levels considering the challenging financial position.

Our cancer performance generally remains strong for the 28-day faster diagnostic standard together with the 31-day cancer treatment standard. Our main area of focus for cancer is the 62-day treatment standard which has mainly been impacted by histopathology capacity issues that we have been working to resolve. Recovery plans are in place across several tumour sites and further details around the key root causes and actions are on the following pages.

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

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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	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	2024/25 Final	Latest Benchmark Position (Mar 25)
Urgent Care	Ambulance turnaround times <30 mins	≥95%	✓ 96.6%	✓ 96.5%	✓ 95.1%	✓ 95.6%	✓ 96.8%	✗ 93.5%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 91.4%	✓ 37 / 175
	Ambulance delays >60 mins	0.0%	✗ 0.2%	✓ 0.0%	✓ 0.0%	✗ 0.2%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.7%	✓ 29 / 175
	ED 4-hour performance	≥76%	✗ 74.2%	✗ 73.4%	✗ 70.9%	✗ 71.7%	✓ 82.0%	✗ 73.6%	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✗ 71.0%	– 61 / 140
	ED 12-hour length of stay performance	≤2%	✗ 3.1%	✗ 2.2%	✗ 2.3%	✗ 2.9%	✓ 0.9%	✗ 3.0%	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✗ 2.1%	✗ 3.4%	✓ 25 / 175
	SDEC rate	≥33%	✓ 38.2%	✓ 37.7%	✓ 38.6%	✓ 38.1%	✓ 41.3%	✓ 39.0%	✓ 40.1%	✓ 39.4%	✓ 36.7%	✓ 37.8%	✓ 40.1%	✓ 39.3%	✓ 38.9%	✓ 38.8%	– 98 / 178
	Adult G&A bed occupancy	≤92%	✗ 93.6%	✗ 94.8%	✗ 94.7%	✗ 95.5%	✗ 92.2%	✗ 93.8%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 94.5%	✓ 68 / 179
	Long length of stay (21+) occupied beds	≤Plan	✗ 124	✓ 96	✓ 91	✓ 102	✓ 105	✓ 103	✓ 96	✓ 97	✓ 106	✓ 115	✓ 106	✓ 97	99	✓ 103	
	Inpatients medically safe for transfer for greater than 24 hours	≤40	✗ 91	✗ 64	✗ 71	✗ 84	✗ 65	✗ 57	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 64	
Electives	Advice & guidance	≥16%	✓ 24.5%	✓ 25.8%	✓ 22.0%	✓ 25.2%	✓ 24.6%	✓ 22.3%	✓ 24.7%	✓ 23.9%	✓ 24.2%	✓ 23.5%	✓ 23.1%	✓ 25.5%	✓ 26.3%	✓ 24.1%	
	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	✓ 6.0%	✓ 5.9%	✓ 5.9%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 6.1%	✓ 6.2%	✓ 6.6%	✓ 6.0%	
	Outpatient attends that are first or follow up with a procedure	≥Plan	✗ 43.3%	✗ 40.7%	✗ 43.9%	✗ 42.2%	✗ 42.9%	✓ 43.1%	✗ 41.5%	✗ 41.7%	✗ 41.7%	✗ 41.4%	✗ 40.7%	✗ 40.9%	-	✗ 42.0%	
	Incomplete RTT waiting list	≤Plan	✗ 36,584	✗ 35,858	✗ 35,720	✗ 35,251	✗ 35,165	✗ 35,507	✗ 35,440	✗ 34,538	✗ 34,147	✗ 33,876	✗ 34,438	✗ 35,324	✗ 35,319	✗ 35,324	
	Incomplete RTT pathways +52 weeks	≤Plan	✓ 1,312	✓ 1,162	✓ 1,177	✓ 1,080	✗ 1,019	✗ 870	✗ 786	✗ 709	✗ 569	✗ 609	✗ 553	✗ 469	✓ 453	✗ 469	✓ 55 / 151
	Incomplete RTT pathways +65 weeks	≤Plan	✓ 140	✓ 129	✓ 109	✓ 77	✗ 105	✗ 50	✗ 44	✗ 36	✗ 40	✗ 28	✗ 32	✗ 22	✗ 32	✗ 22	✗ 93 / 151
	Incomplete RTT pathways +78 weeks	0	✗ 2	✗ 1	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1 / 152
Diagnostics	Diagnostic DM01 backlog		3,569	3,584	3,861	4,295	3,634	2,558	1,427	989	940	920	499	642	978	642	
	Diagnostic DM01 performance under 6-weeks	≥Plan	✓ 71.6%	✓ 72.7%	✗ 70.5%	✗ 69.5%	✗ 70.2%	✗ 76.3%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✓ 93.1%	✓ 35 / 135
Cancer	Cancer 28-day faster diagnosis standard	≥75%	✓ 75.3%	✓ 79.8%	✓ 79.2%	✓ 81.6%	✓ 81.6%	✓ 78.2%	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	-	✓ 78.3%	✗ 89 / 135
	Cancer 31-day treatment performance	≥Plan	✓ 89.8%	✓ 87.5%	✓ 88.3%	✓ 95.0%	✓ 91.1%	✓ 95.0%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	-	✓ 91.9%	– 66 / 135
	Cancer 62-day treatment performance	≥Plan	✓ 71.8%	✗ 56.3%	✓ 70.3%	✗ 71.4%	✓ 67.9%	✗ 61.2%	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	-	✗ 64.4%	✗ 126 / 135
	Suspected cancer patients waiting over 62-days		100	80	81	75	99	95	98	86	92	107	100	86	87	86	

Notes:

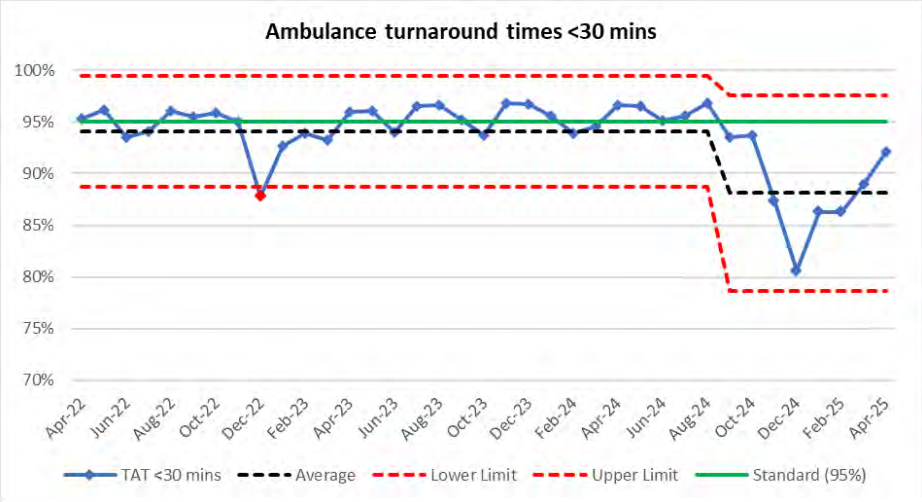
(1) Within the reported cancer treatment standards, we have aligned our reporting to match with the national cancer waiting time standards which remove auto upgrades. The reported position for the last two months for the cancer treatment standards can move as provisional cancer waiting time data is validated. We align the reported position in the Integrated Performance Report to the national reported position.

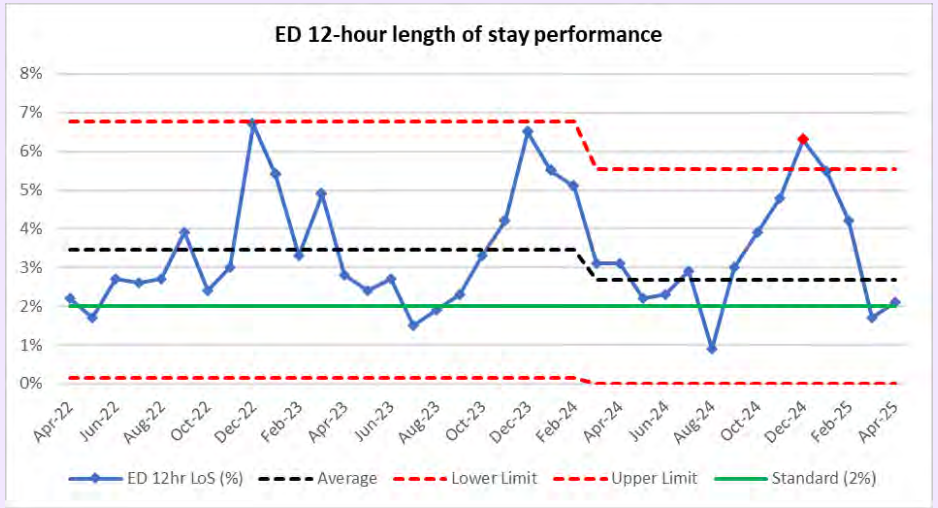
(2) As part of the IPR annual review undertaken in 2024/25 quarter one, we agreed to add benchmarking data to the timely care domain in the quarter two report. This has been added to the above scorecard and referenced as appropriate in the following pages.

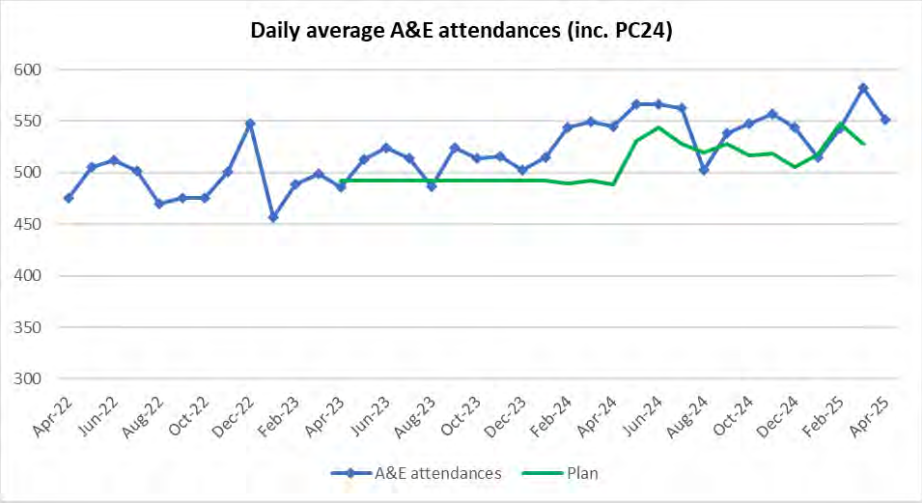
Indicators in Focus: Urgent Care – A&E (1/3)

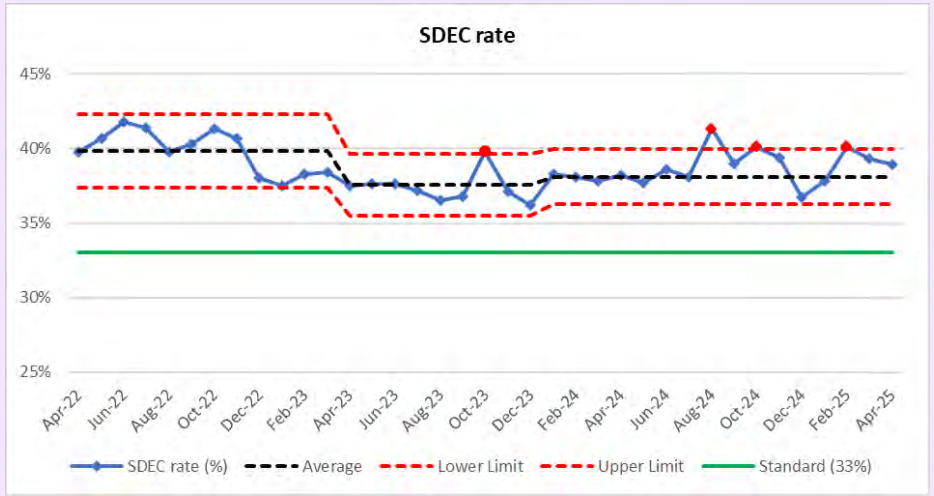
Sherwood Forest Hospitals NHS Foundation Trust

Data





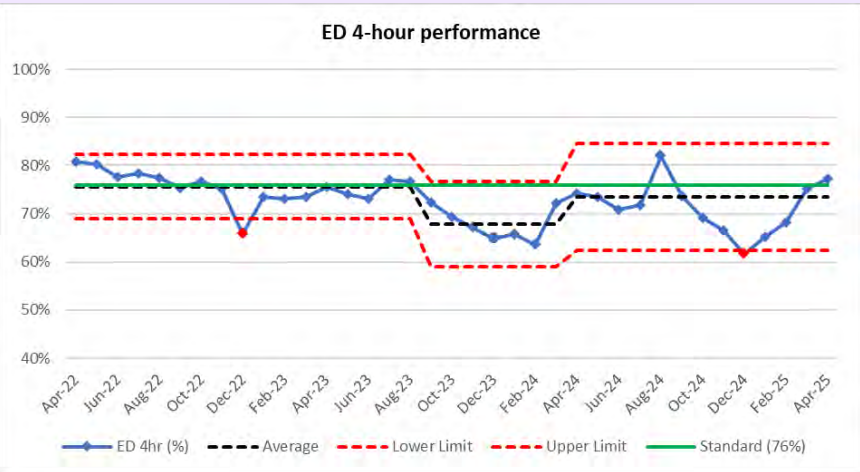




Indicators in Focus: Urgent Care – A&E (2/3)

Sherwood Forest Hospitals NHS Foundation Trust

Data

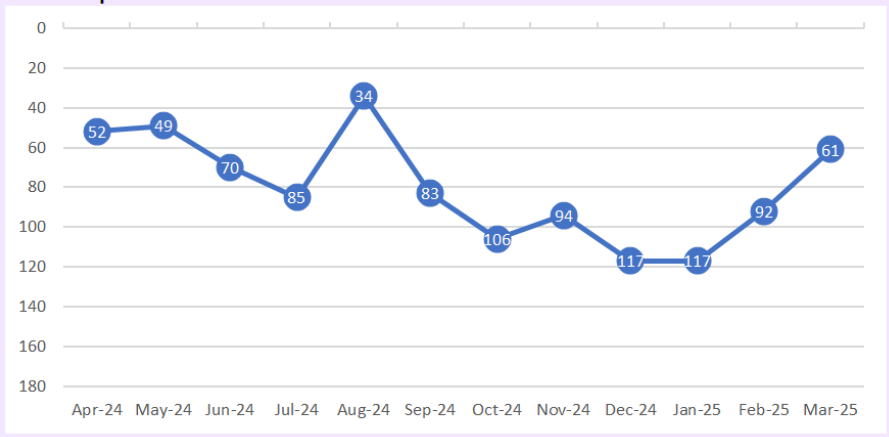


Overview and national position

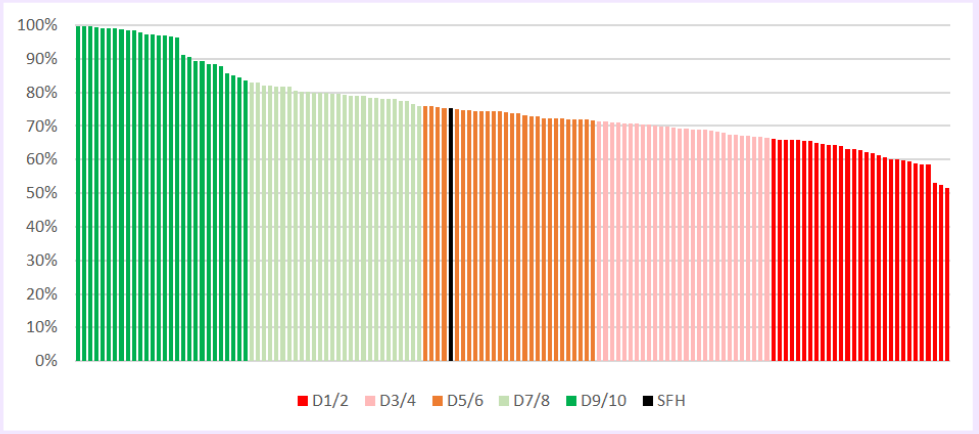
- We have seen an improvement in our ambulance handover position in recent month as new processes within STREAM are embedded and flow through and out of ED improved. We remain significantly better than the East Midlands Ambulance Service (EMAS) average. Key messages to note are:
  - We are frequently one of the best Midlands and top quartile nationally for ambulance handovers.
  - Our mean ambulance handover time in Apr-25 stands at 18 minutes, ranking us 26th out of 117 Trusts nationally. Our 30-minute ambulance turnaround performance similarly ranks us 25th out of 117 Trusts in Apr-25.
  - Type one Accident and Emergency (A&E) attendance demand growth is in the upper quartile nationally (amongst the highest in the country). Type three Newark Urgent Treatment Centre attendance levels increased following the introduction of extended opening hours in Nov-24, and the promotion of the service that came with the communication of it.
- We are currently ranked in the top quartile for the GIRFT-EM index of patient flow (GEMI) which takes into consideration 4-hour performance, 30-minute handover delays and 12-hour length of stay.
- Our 4-hour emergency access performance benchmark position has improved (see graphs below).

Benchmarking Position and Standings

ED 4-hour performance



Mar 25 Position



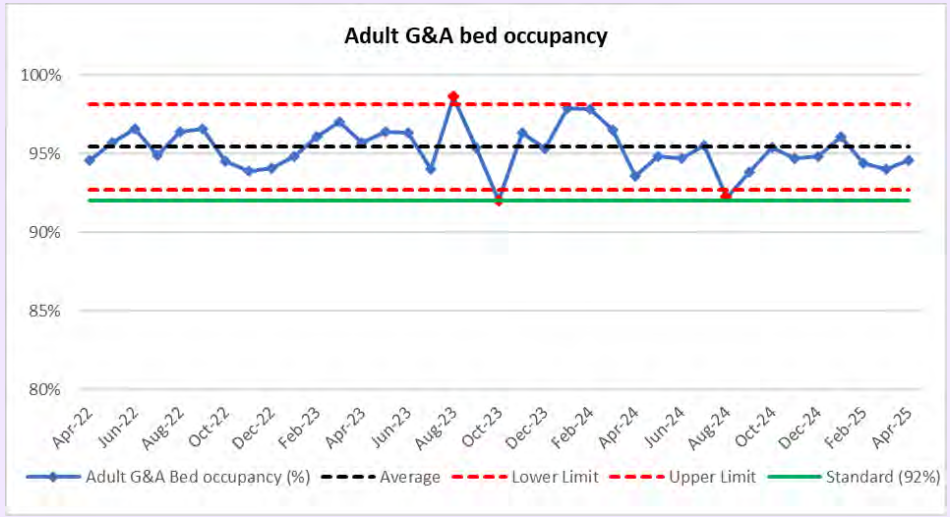
Indicators in Focus: Urgent Care – A&E (3/3)

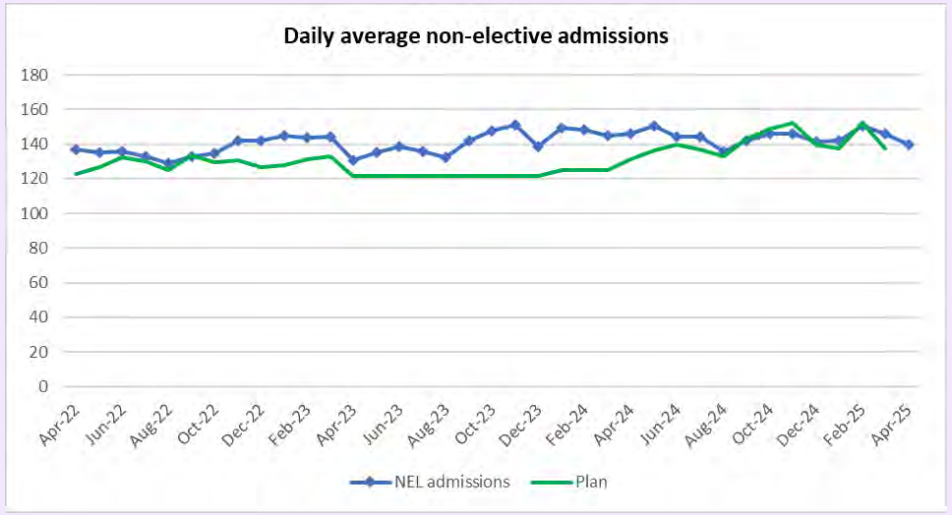
Root causes	Actions and timescale	Impact
Surges in Accident and Emergency (A&E) attendance demand.	• Admission and attendance avoidance with system partners include: – Focus on frailty attendances: Call before you convey; use of urgent care response teams. – Develop pathways out of the Urgent Care Co-ordination Hub. – Review all category 3 activity for missed opportunities. Category 3 activity is urgent patients but not life-threatening (category 1) or emergency calls (category 2). – Development of alternatives to ED workstream in line with the Emergency Care Improvement Plan.	• 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. • Reduce overnight admission conversion rate.
	• 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.	
	• Develop links with 111 and Urgent Care Coordination Hub (UCCH) for appropriate and effective patient streaming and redirection.	
	• 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 August / September.	• 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.	
	• Implement ED Nervecentre task list to improve visibility of tasks and escalations to progress patients care and journey.	
A&E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Wards have begun to go 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 12-hour LOS to less than 2%
	• New Fit to Sit area in ED opened at the end of Mar-25.	
	• Patient flow actions detailed on the following slides.	

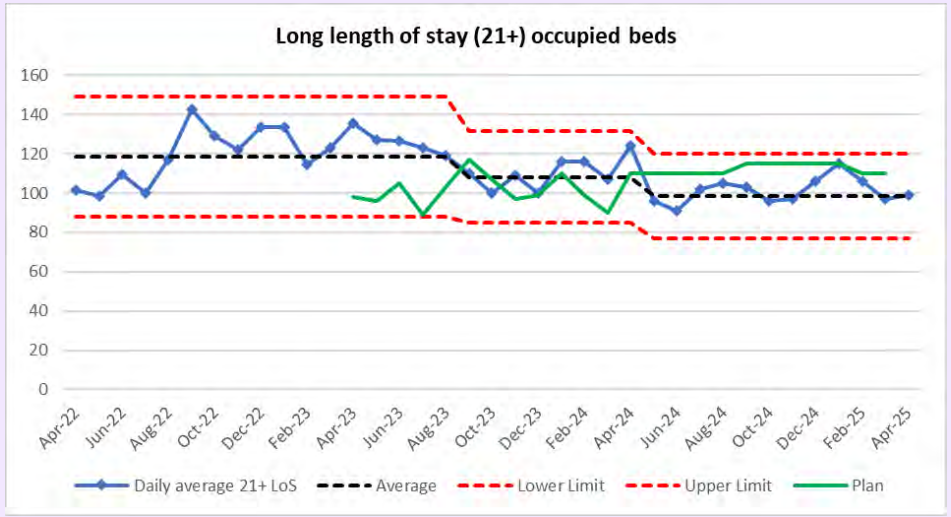
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

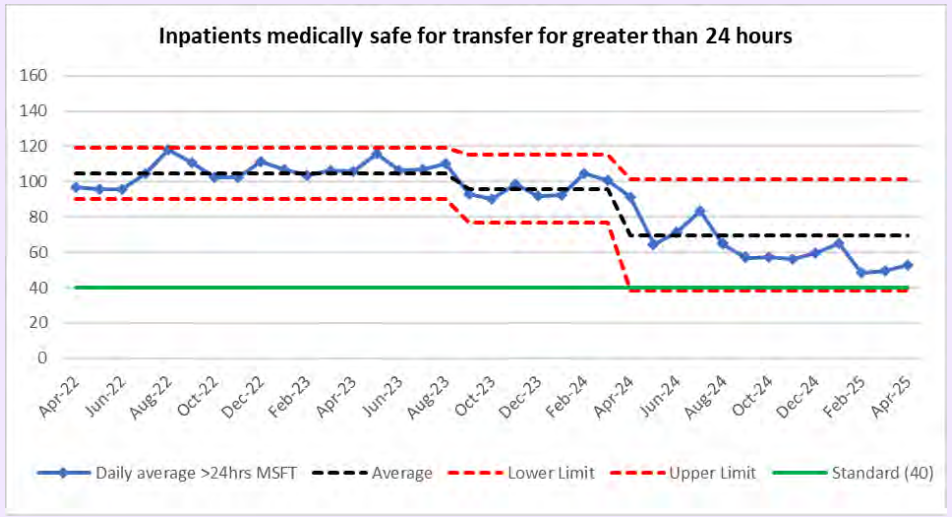
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

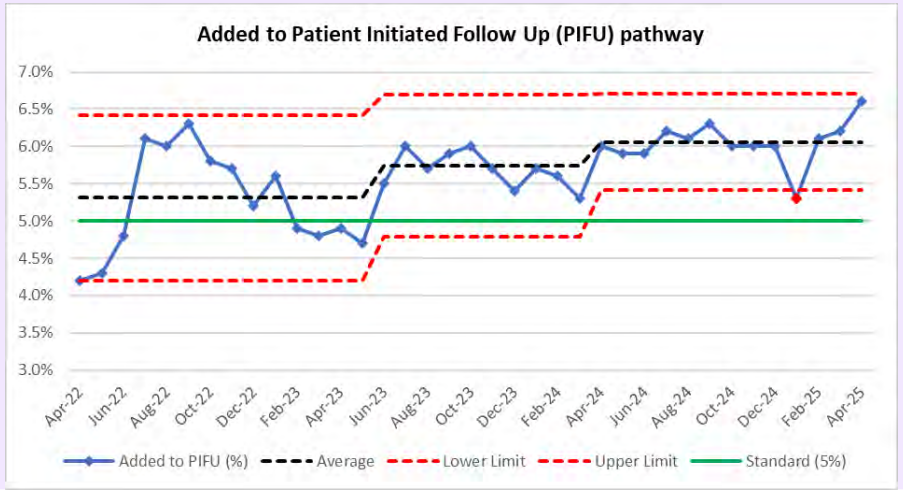
- The number of patients Medically Safe For Transfer (MSFT) for greater than 24 hours has reduced significantly during 2024/25 which drove a step change (reduction) on the statistical process control chart. This position is mirrored in the national Discharge Ready Date reporting whereby we compare very favourably for the average delay for patients to leave hospital (3.6 days at SFH, verses 6 days nationally).
- Reduced length of stay for patients aged 65 and over, predominantly due to reduced discharge delays has significantly improved patient flow supporting 4-hour emergency access performance recovery (and recovery in other associated urgent and emergency care metrics as described earlier in the report).
- The number of long stay patients has been consistently better than our plan throughout 2024/25.

Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• Long length of stay (LOS) meetings embedded for both pre and post medically safe patients.	• LOS meetings identify opportunities for alternative pathways and early engagement with partner agencies to support discharge.
	• Dedicated ward Discharge Coordinators engage early with patients and families.	• Early identification of potential barriers to discharge.
	• The 'Getting the Basics Right ' programme championed by the Chief Operating Officer and Chief Medical Officer continues to focus on board rounds and ward processes to support consistency of clinical documentation and clear recording of decisions.	• Review of ward processes especially around TTOs (To Take Out medications) will help us ensure people can be discharged in a timely way. Focus on 7-day LOS will now have a positive impact upon pre medically safe planning.
Delays to post-medically safe discharge processes.	• The discharge team undertake a daily review of all patients that have been medically safe for greater than 24 hours to identify actions to support timely discharge.	• Improve LOS for complex discharges across our hospitals.
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. Both EMED and Ambicorp conveyances now under both local and system-wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge and further reduction in (good progress already seen) the number of abandoned discharges.
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 for Ashfield and Newark residents which is delaying patient discharge. System-wide demand and capacity work underway.	• Reduce discharge delays for patients requiring mental health beds and reduce the number of medically safe patients in our hospitals.
	• Working with partners both 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.	

Indicators in Focus: Outpatients

Sherwood Forest Hospitals NHS Foundation Trust

Data

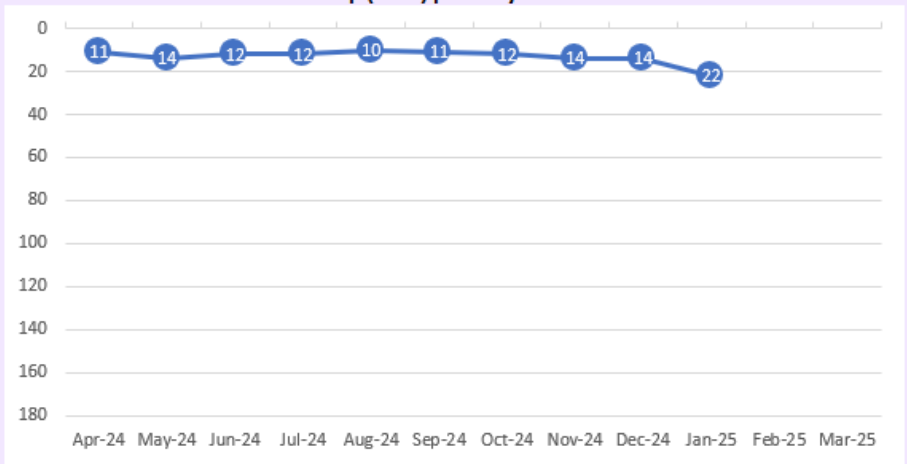


Overview and national position

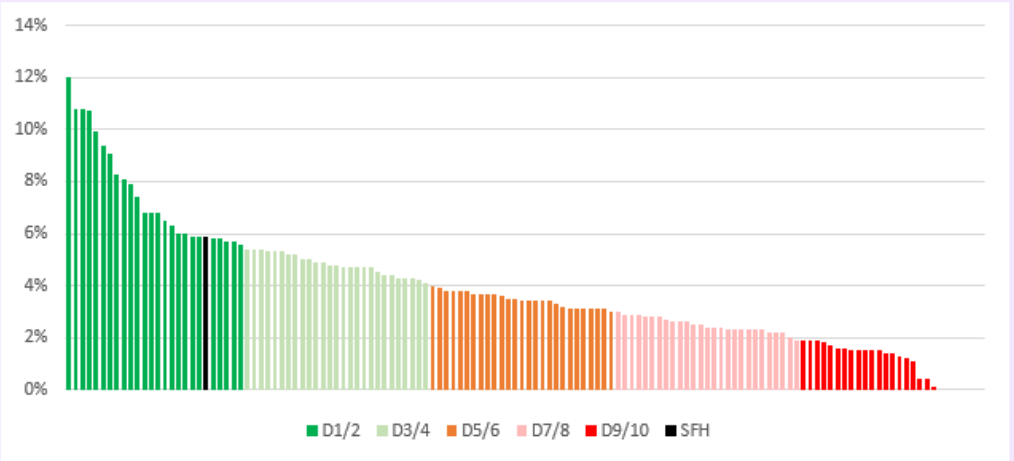
- We consistently perform above the 5% Patient Initiated Follow Up (PIFU) target with the latest position being our best performance to date. We also benchmark strongly (see below).
- Our volume of advice and guidance surpasses national targets, and in six of the last seven months, we have responded to greater than 95% of requests in less than five days.
- Trust first attendance activity levels have shown a reduction versus plan in recent months. This is driven by an increase in the number of one-stop clinics where patients are having a procedure during their first appointment (as seen in the over delivery versus plan for outpatient procedures). This change is better for patients and should not be considered a concern from a performance perceptive.
- Our outpatient follow up activity levels have been slightly below our planned levels, which is positive in the context of the national ambition to reduce the volume of patients returning for follow up outpatient appointments.
- There are no specific escalations to raise for our outpatient metrics for this report.

Benchmarking Position and Standings

Added to Patient Initiated Follow Up (PIFU) pathway



Jan 25 Position

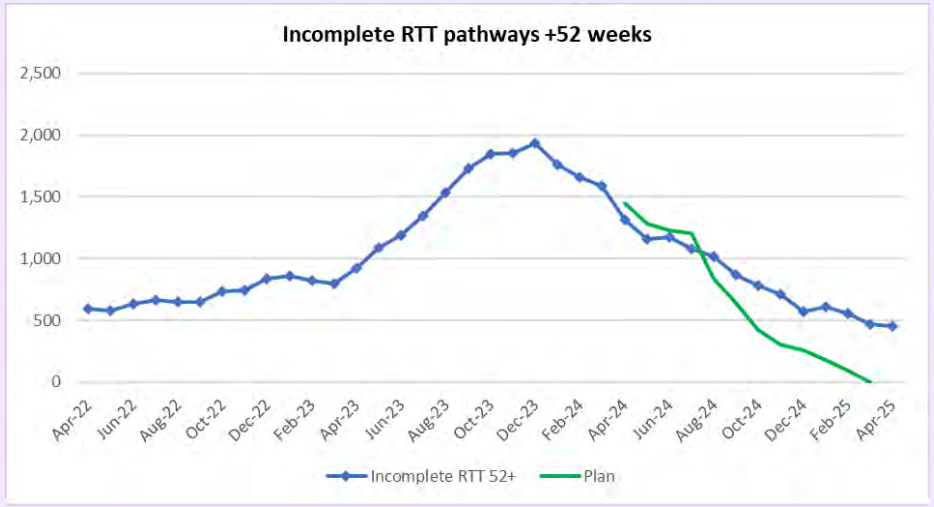


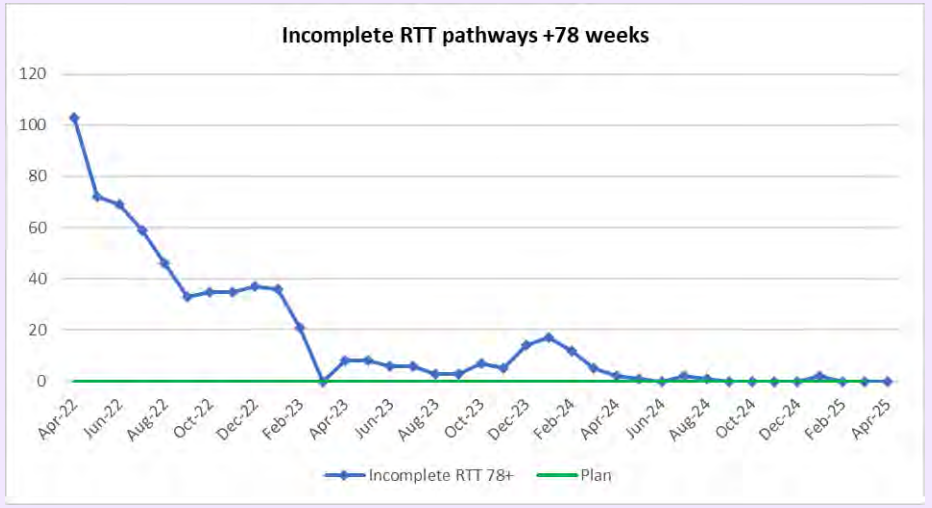
Please note: *There was an issue with PIFU data reporting that has recently been resolved which has meant that there has been a small gap in benchmark reporting with the latest position being Jan-25.*

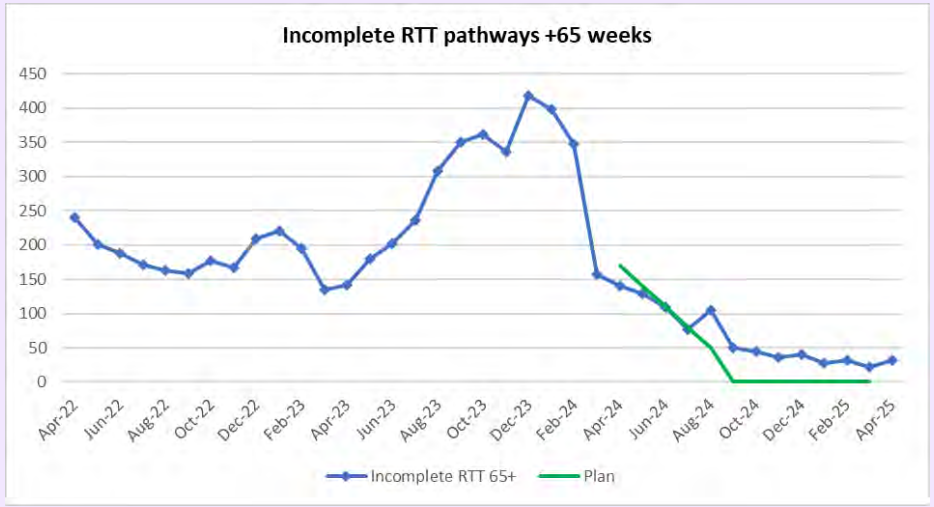
Indicators in Focus: Referral To Treatment (1/3)

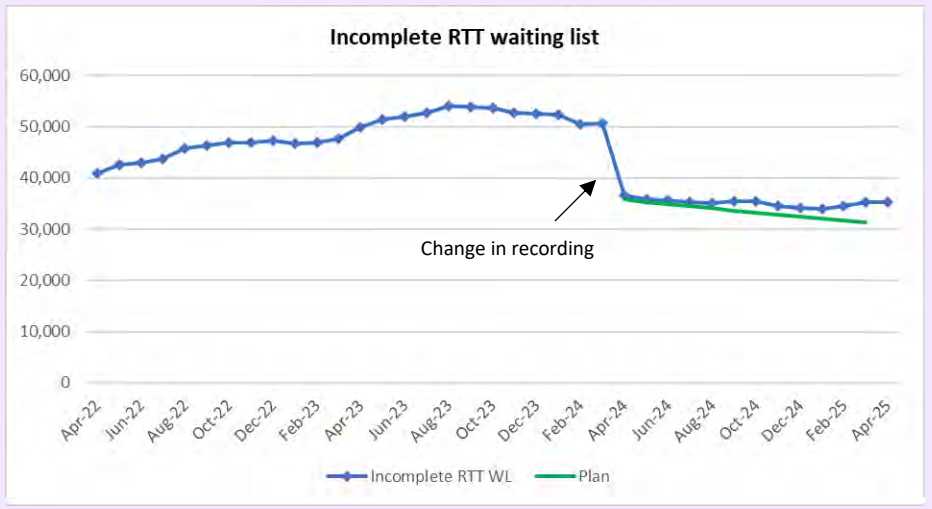
Sherwood Forest Hospitals NHS Foundation Trust

Data









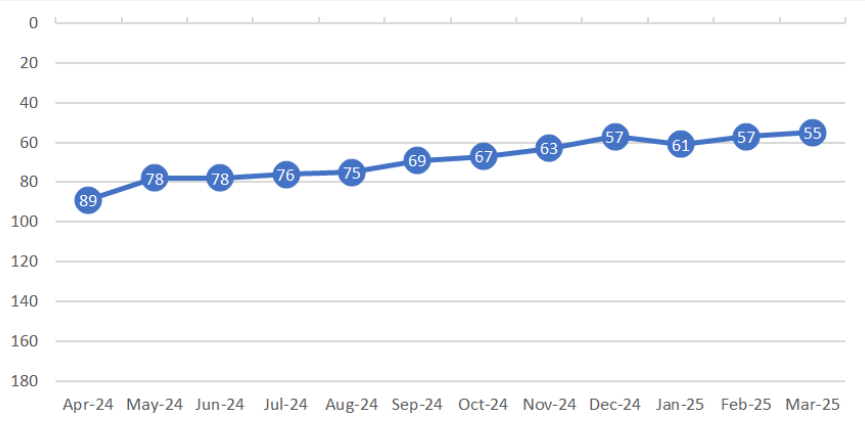
Indicators in Focus: Referral To Treatment (2/3)

Sherwood Forest Hospitals NHS Foundation Trust

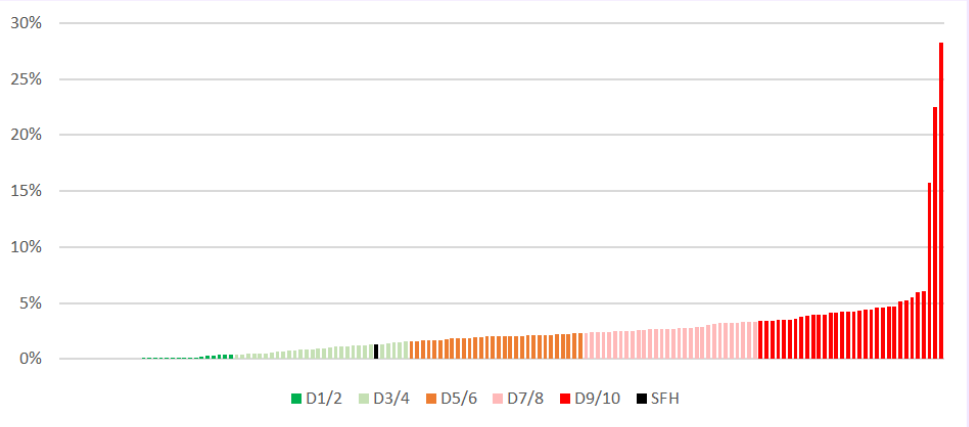
Data

Benchmarking Position and Standings

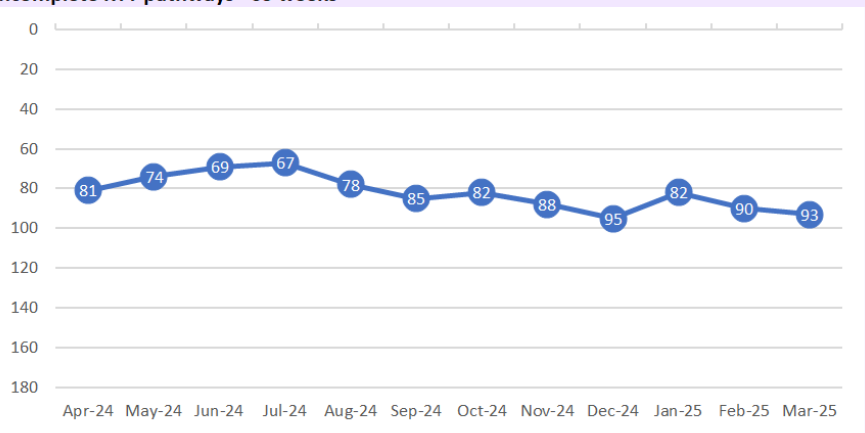
Incomplete RTT pathways +52 weeks



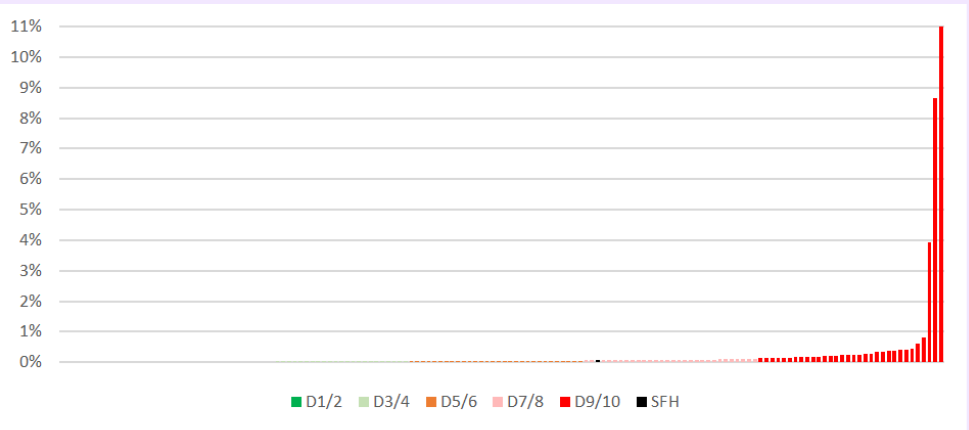
Mar 25 Position



Incomplete RTT pathways +65 weeks



Mar 25 Position



Indicators in Focus: Referral To Treatment (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

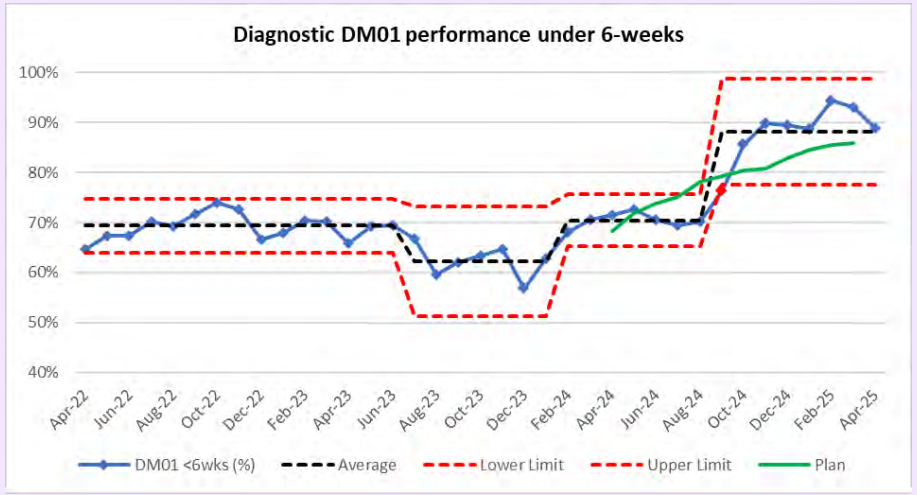
- Referral to Treatment (RTT) waiting times across England has increased to 7.4 million. National reporting of long wait patients more than 52 weeks wait has reduced to circa 180k. The emphasis within the planning guidance is to reduce the volume of long waiting pathways and for 2025/26 improve 18-week RTT performance (will be added to this report subject to the annual review being approved by Trust Board).
- Our 52-week waits position has improved throughout 2024/25; nationally we are 55th out of 151 Trusts – our best position in the last year (see previous slide).
- 65-week wait patient volumes reduced to 22 at the end of 2024/25, though it has risen to 32 in Apr-25. We continue to feel the impact of the provision of system support earlier in 2024/25 in ENT where surgical capacity continues to be an issue, mirroring the national trend. We are middle of the pack nationally when considering benchmarking data.

Root causes	Actions and timescale	Impact
Surgical capacity within specialties • ENT and General Surgery (some of which is driven by system support).	• SFH supporting NUH patients across in Urology and ENT. Cross-provider support for ENT patients (NUH supporting SFH, and SFH supporting NUH). Extraordinary meeting between NUH and SFH planned to address system issues with ENT and Cardiology to be held in Jun-25.	• Equalise waits across the system. This has impacted on reported positions for long waits at a provider level.
	• Insourcing to increase ENT capacity in place and exploring expansion of additional mid-week and dropped theatre lists, expected to be in place in Jun-25 and Jul-25. Potential for weekend working with support from NUH clinical cover.	• One list per week increase in ENT capacity to enable further reduction in long waits in a sustainable way.
	• System approach to managing ENT backlog through weekly system PTL meetings.	• Treat longest waiting patients first regardless of provider.
	• Successful bid for additional equipment to increase Functional Endoscopic Sinus Surgery (FESS) delivered Mar-25.	• Increase the volume of FESS that can be booked each week by up to two patients per week.
Lack of anaesthetic capacity. • Current deficit of 7 WTE consultant vacancies • Increasing risk of list cancellation due to insufficient staffing cover.	• Insourcing up to eight lists per week in place since quarter three.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations.
	• Robust plan to increase anaesthetic staffing levels in place, including: – Two substantive consultants recruited in Mar-25. – One locum consultant recruited in May-25. – Covering additional gaps with increased hours for part-time clinicians since Mar-25, a return from long-term sickness in May-25, and an acting up consultant from Aug-25.	
Quality of data within our PTL • Incorrect data and patients potentially no longer needing or wanting treatment remaining on our waiting list.	• Use of DrDoctor to enable mass validation programme. Pilot commenced in Nov-24. Following success of pilot, contract extended in Mar-25 for an indefinite period.	• PTL will be 'clean' and represent only those patients genuinely waiting treatment.
	• Robotic Process Automation (RPA) pilot and Federated Data Platform (FDP) project to commence in Jun-25, both supported by NHS England.	
	• Increased validation resources utilising ERF and NHS England sprint funding during quarters one and three of 2025/26.	• Reduction in overall incomplete position through validation.

Indicators in Focus: Diagnostics

Sherwood Forest Hospitals NHS Foundation Trust

Data

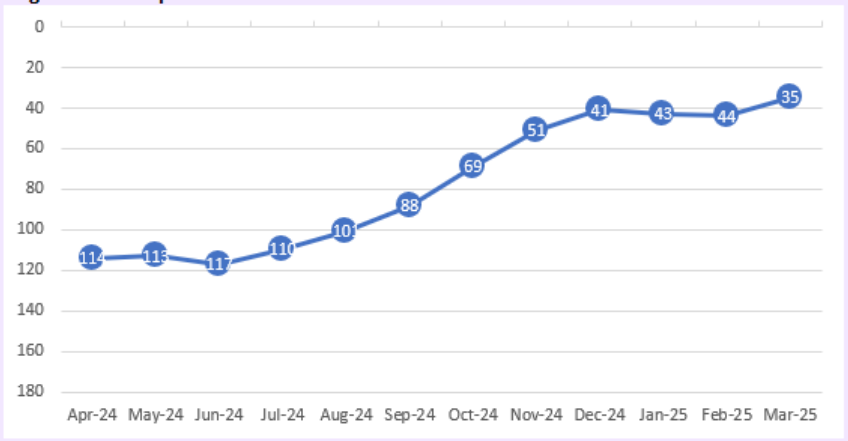


Overview and national position

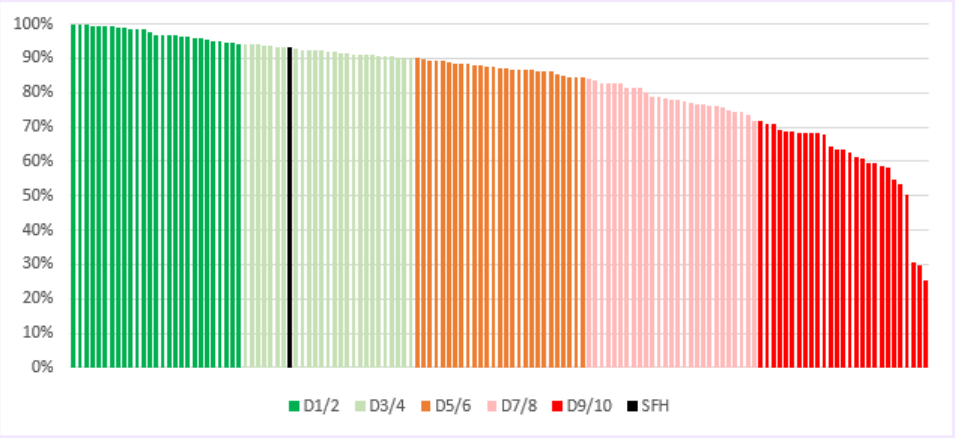
- In recent months, we have made significant progress improving our diagnostic DM01 performance to be above our planned position and the national average. This has resulted in an improvement in our benchmarking position to 35th out of 134.
- In Mar-25, 81.6% of patients nationally were seen within 6-weeks against the interim national standard of 95%.
- We have observed significant and sustained improvement in DM01 performance and in 6 and 13-week backlog levels since Jul-24. The greatest improvements have been seen in Echocardiography, Computed Tomography (CT), Urodynamics and Cystoscopy.
- This indicator has performed better than plan throughout the second half of 2024/25.

Benchmarking Position and Standings

Diagnostic DM01 performance under 6-weeks



Mar 25 Position



Indicators in Focus: Cancer (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

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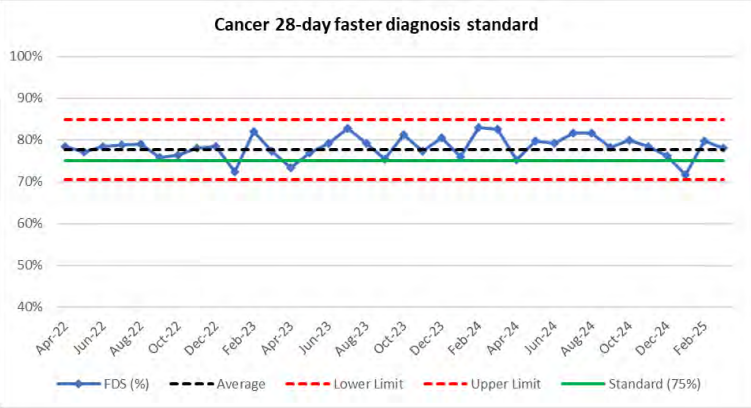

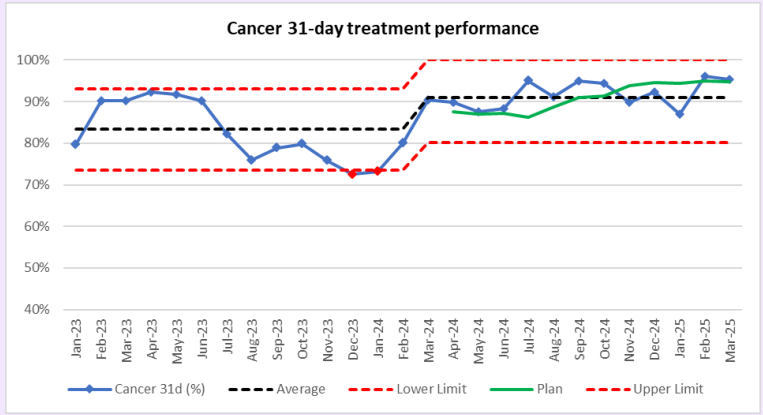

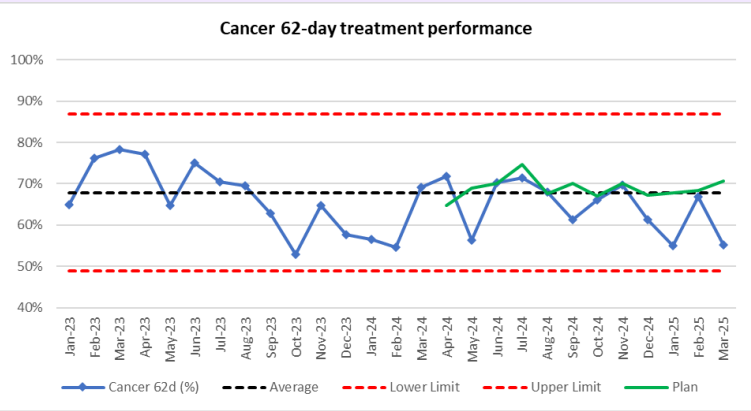

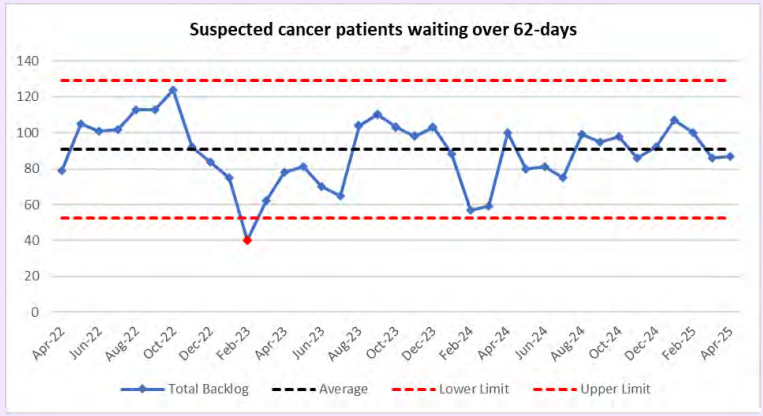

Overview and national position

Considering the latest national data (Mar-25):

- Nationally, 28-day Faster Diagnosis Standard (FDS) is 79% against the 75% standard. SFH is performing above the national standard but just below the England position. In Mar-25 we ranked 89th out of 135 providers.
- Nationally, 31-day performance (first treatment) is 91% against the 96% standard. SFH is performing above the England position and just below the national standard. In Mar-25 we ranked 66th out of 135 providers.
- Nationally, 62-day performance is 71% against the interim 70% standard. SFH is performing worse than the England position and below the interim national standard. In Mar-25 we ranked 126th out of 135 providers.

Revised national cancer waiting time standards launched in Oct-23 with the original 10 standards reduced to three. The 31-day and 62-day standards present validated month-end, published data against the new standards from Oct-23. The historical data is based on a proxy as these metrics did not exist pre-Oct-23; as such the Jan-23 to Sep-23 data should be used as a guide and does not reflect the month-end, validated and published data.

We have aligned our reporting of the 31-day and 62-day treatment standards to match with the national cancer waiting time standards which remove auto upgrades. The reported position for the last two months for the cancer treatment standards can move as provisional cancer waiting time data is validated. We align the reported position in the Integrated Performance Report to the national reported position.

Indicators in Focus: Cancer (2/2)

NHS 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 completed in May-25. Successful appointment of two substantive consultants, one of which is now in post (in addition to a locum consultant) and another substantive to start in Jul-25.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
	• Outsourcing and insourcing routine cases to increase internal reporting capacity for cancer from Feb-25.	
	• East Midlands Cancer Alliance funding to enable a move to seven day working from Mar-25. Successful recruitment to two of the three Medical Laboratory Assistant (MLA) posts.	
	• Productivity-incentivised 'Pay Per Point' scheme introduced in Oct-24 and is ongoing.	• More than 2,500 additional points reported.
	• Capital bid for 2025/26 to increase digital pathology capacity approved. Awaiting confirmation of timescales to operationalise.	• 10% productivity improvement through more efficient digital processes.
Insufficient specialist Head and Neck ultrasound radiology workforce capacity.	• Recruited an additional Consultant to increase capacity and reporting turnaround. Commenced independent lists Apr-25. One-stop capacity review commenced in May-25 to agree clinical model and identify a start date.	• Reduced wait for test from six to two weeks.
Insufficient clinical triage and decision-making workforce capacity in Upper Gastrointestinal (UGI).	• East Midlands Cancer Alliance funding bid submitted to increase clinically-led triage capacity to streamline the front end of the pathway and to implement a navigator to support with patient engagement and the timely management of clinical decisions. Funding usually confirmed in quarter one; timescales for completion dependant on approval.	• Improvement in first seen within seven days, reducing the time on the overall pathway.
Insufficient capacity to meet demand in Lower Gastrointestinal (LGI).	• Introduction of nurse-led clinics and results reviews and consultant snippet letters for faster diagnosis in place from Mar-25. Planning to commence consultant daily hot clinics in 2025/26 quarter two is underway.	• Improved FDS performance. FDS increased from 40% in Jan-25, to 60% in Mar-25.
	• Updated standard operating procedure in Mar-25 for appropriate management of urgent suspected cancer referrals. This supports the redirection of non-cancer patients to the appropriate urgent or routine pathway.	• Reduced referral demand. 7-day referral to triage best practice standard met. Backlog halved from 38 in Jan-25, to 19 in Mar-25.
Insufficient general anaesthetic capacity to meet UGI and LGI demand.	• General anaesthetic Endoscopy capacity to move from ad hoc lists to weekly allocated capacity. Clinical governance being reviewed to support go live from Jun-25 (delayed from Mar-25 due to clinical safety concerns).	• Consistent capacity for cancer patients.
Increase in complex patients requiring multiple investigations in Lung.	• Review of targeted lung health check impact and patients over day 62 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.	• Identification of actions to impact backlog reduction and 62-day performance.
Breast conversion to cancer increase from 5% to 10% during the second half of 2024/25 has led to insufficient capacity to meet demand for surgical and oncological breast treatment.	• Business case development underway to implement an alternative clinical approach to establishing the location of the tumour.	• Reduction in re-excision therefore improving productivity and patient experience.
	• Where possible theatre capacity is being increased, working closely with histopathology due to the implication on lab time by increasing breast cancer case volumes.	• Increase timely surgical capacity, restricted to 10 cases per week due to histopathology capacity.
	• Implementation of a triage MDT to increase timeliness of MDT decision to manage demand.	• Improvement in 62-day.

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Best Value Care

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Domain Summary: Best Value Care

Overview	Lead: Chief Financial Officer

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

The month one position is a deficit of £0.9m, which is in line with the planned deficit in month.

Given the challenging nature of the financial plan there are key risks. These include non-delivery of efficiency, unfunded national pay awards if no further funding flows into the organisation, maintaining non-pay inflation, emergency care pathway growth and any potential movement on the band 4-9 nursing profiles.

The annual Financial Improvement Programme (FIP) target is £45.8m in 2025/26. Month one saw a delivery of £1.4m against a month one plan of £2.2m. To support efficiency delivery, a Financial Efficiency Delivery Specialist unit has been created. This is a multidisciplinary group. This unit combines leads from Finance, the Improvement faculty, analytical and clinical colleagues.

The 2025/25 Capital Expenditure Plan has been prepared and submitted as part of the overall financial plan with an in-year plan of £39.12m. Expenditure for Apr-25 totalled £0.35m, which was £0.32m under plan, with the variance relating to VAT recovery in month one.

Closing cash on 30 April was £24.72m, a reduction of £1.0m in month, compared to a planned reduction of £3.32m. 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 Mar-25. This balance will unwind in 2025/26 quarter one as closing capital creditors are paid. 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 Trusts agency expenditure in Apr-25 is £0.748m which is significantly lower than the 2024/25 run rate expenditure manly due to the cessation of the winter plan expenditure and some Elective Recovery Fund (ERF) schemes not having been fully re-instated during Apr-25. 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 was 2% in Apr-25 compared to an average of 4% in 2024/25. The largest proportion of our agency spend is on medical pay. A medical transformation programme is in place and is tasked with national NHS England directive of reducing agency spend by 40% compared to our month eight forecast spend in 2024/25.

The following pages contain more detailed performance information across the best value care domain.

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Scorecard: Best Value Care

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

At a Glance	Indicator	2024/25 Standard	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	2024/25 Final
Finance	Income & expenditure against plan	≥£0.00m	✗-£0.02	✓£0.02	✗-£0.61	✗-£0.33	✗-£0.31	✓£0.44	✗-£0.17	✗-£0.79	✗-£0.10	✗-£2.68	✗-£2.60	✓£7.14	✓£0.00	✓£0.01
	Financial Improvement Programme (FIP) against plan	≥£0.00m	✗-£0.54	✓£1.48	✓£0.66	✗-£1.61	✗-£1.40	✗-£1.43	✓£4.70	✗-£1.97	✗-£0.20	✓£0.26	✗-£0.04	✓£0.15	✗-£0.81	✓£0.08
	Capital expenditure against plan	≤£33.61m	✓-£0.52	✗£2.26	✗£1.27	✗£1.10	✗£1.38	✗£1.26	✗£1.41	✗£1.01	✗£1.92	✗£2.43	✗£1.62	✗£18.40	✗£0.35	✓£33.58
	Cash balance	≥£1.45m	✗£1.34	✓£1.73	✓£1.50	✗£0.32	✗-£0.15	✗£0.05	✓£9.46	✓£4.17	✗£1.28	✗-£0.53	✓£13.00	✓£24.72	✓£24.72	✓£26.53
	Implied Productivity 2023/24 v 2024/25	3.1%	-	-	-	✓6.7%	✓5.2%	✓6.1%	✓6.9%	✓5.4%	✓4.6%	✓4.6%	✓4.4%	-	-	✓4.6%
	Value weighted elective activity	105%	✗103.5%	✓110.9%	✓112.0%	✓108.8%	✓118.7%	✓118.5%	✓119.1%	✓113.6%	✓114.4%	✓123.1%	✓125.5%	✓124.3%	-	✓119.1%
	Agency expenditure against plan	≥£0.00m	✗-£0.19	✗-£0.29	✗-£0.29	✗-£0.39	✗-£0.24	✓£0.01	✗-£0.17	✗-£0.09	✓£0.14	✗-£0.03	✗-£0.15	✗-£0.20	✗-£0.44	✗-£1.89
	Reported agency spend		£1.27	£1.28	£1.32	£1.44	£1.17	£0.93	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£13.70
	Reported bank spend		£2.25	£2.88	£2.59	£2.75	£2.89	£2.22	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£30.55

Indicator in Focus: Income and Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- 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 is in line with the planned deficit of £0.9m in 2025/26 month one.

Risks		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.	• Delivery of annual plan.
Pay award.	• Current plan assumes a national pay award of 2.8%. If the national pay award is higher than this with no further funding, then it will cause pressure on our income and expenditure position.	
Maintaining non-pay Inflation.	• Current plan assumes national planning guidance inflationary levels. This needs to be maintained to not cause pressure on our income and expenditure position.	
Variable activity plan.	• We need to ensure as a Trust we maintain our variable elements of our activity to ensure we maintain the level of income associated with this.	
Nursing profiles.	• If there is any change to the national position on Band 4 to Band 9 nursing profiles, then it may impact our income and expenditure position if there is no further funding.	

Data

Indicator in Focus: Financial Improvement Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust Financial Improvement Plan (FIP).
- The Trust has a £45.73m efficiency programme for 2025/26, which is currently £0.81m behind plan.

Root causes	Actions and timescale	Impact
• Resources to support delivery.	• Financial Efficiency Delivery Specialist unit (FEDs) has been established. This is a multidisciplinary group to look at supporting the efficiency delivery. This unit combines leads from finance, the improvement faculty, analytical and clinical colleagues. The unit will look to support delivery and identify potential gaps, de-risk aspects of the programme and ensure the 'route to cash' for all savings opportunities is transparent. • The current weighted forecast reported to NHS England is full delivery of the target.	• Deliver annual plan.
• Risk adjusted forecast.	• Currently the weighted target is £21.33m which is 46.5% of the target. An increase to this is required at pace which is how the new FEDs unit will support.	
	• A weekly report, highlighting movements (particularly in the context of scheme maturity) will be developed and used to ensure 'real time' monitoring.	
• Non-delivery of Financial Improvement Programme.	• Given we are only at the beginning of the financial year this is a risk. However, the actions above with FEDs establishment and de-risking the FIP programme will ensure the continued focus on efficiency delivery.	

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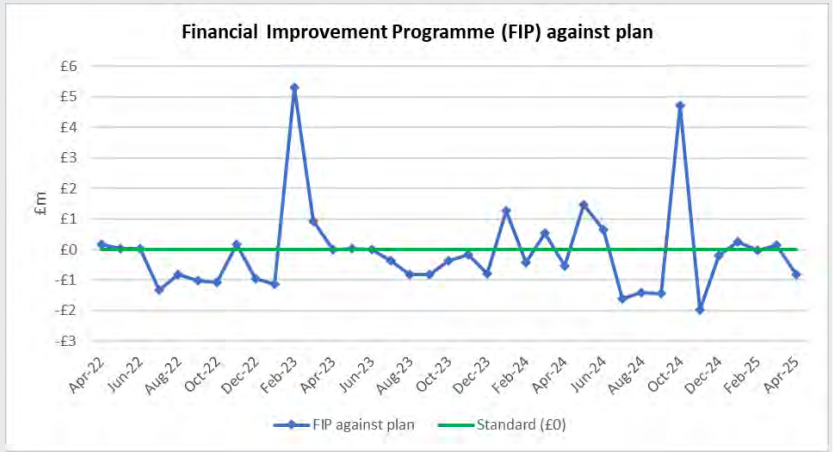

Indicator in Focus: Capital Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- 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 precommitments in the 2025/26 plan.
- Return to Constitutional standards funding requires further supporting submissions in 2025/26 quarter one and detailed monitoring to ensure delivery in-year to plan.

Root causes	Actions and timescale	Impact
Pre commitments to Trust priorities limiting business as usual capital.	• Monitoring of spend to ensure pre-commitments deliver within plan. • Allocation agreed with Integrated Care System (ICS) partners for 2025/26.	• Delivery of Capital Plan.
Requirement for Public Dividend Capital (PDC) to support ICB plan £32.93.	• PDC request to be prepared and submitted in Q2 2025/26.	• Spending at risk without formal approval, impacting available cash to meet revenue payments as they fall due.
Significant National funding for return to constitutional standards for which submissions are required to NHS England.	• Submission of additional information in 2025/26 quarter one to enable Memorandums of Understandings to be issued in quarter two. • Monitoring of in-year spend to ensure delivery to funding envelope.	• Overspends impacting in other capital delivery requirements.

Data

Indicator in Focus: Cash Balance

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- 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 Apr-25, cash in bank was £24.72m 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 which will be submitted in 2025/26 quarter two.	• Extended payment terms to suppliers. • Failure to achieve Better Payment Practice code. • 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.

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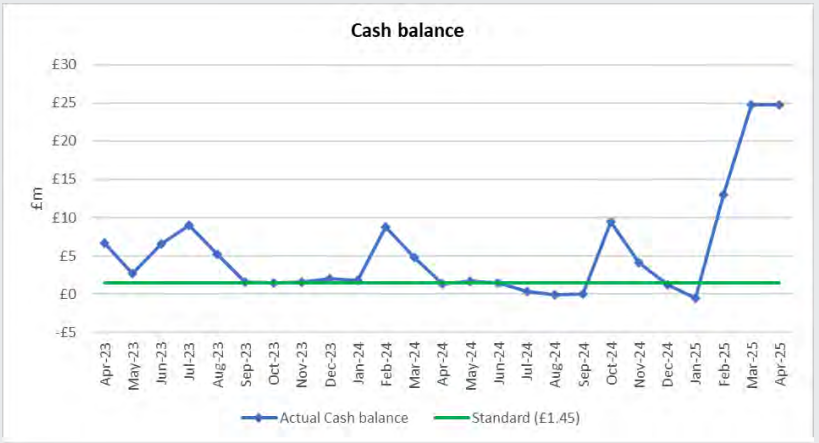


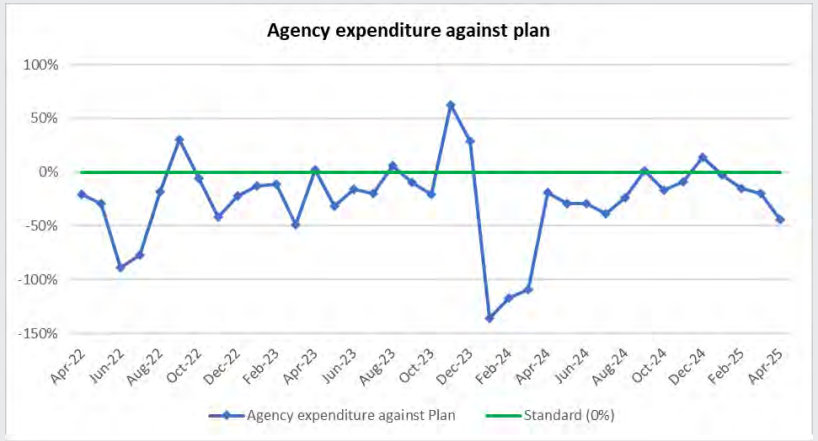
Indicator in Focus: Agency Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the planned agency expenditure for 2025/26.
- The Trust has reported agency expenditure of £0.78m in Apr-25; this is £0.44m adverse to the planned level of spend.
- Agency expenditure in Apr-25 accounts for 2% of our total pay bill, a reduction from our 2024/25 run rate.
- The 40% agency reduction target was achieved in 2025/26 month one.

Data



Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Medical and Nursing and AHP transformation programmes are tasked with achieving the required 40% reduction in agency expenditure compared to our month eight 2024/25 forecast.	• Reduced agency run rate to achieve financial plan.
	• Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews and Divisional Finance Committees.	
	• Medical posts being filled and reviewed at medical specialty groups.	
	• 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.	

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Scorecard: Activity (for context)

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

At a Glance	Indicator	2024/25 Standard	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	2024/25 Final
Urgent Care	A&E attendances (inc. PC24)	≤Plan	✗ 111.5%	✗ 106.8%	✗ 104.1%	✗ 106.5%	✓ 96.7%	✗ 102.0%	✗ 105.9%	✗ 107.4%	✗ 107.7%	✓ 99.5%	✓ 99.2%	✗ 110.3%	✓ 95.2%	✗ 104.8%
	Non-elective admissions	≤Plan	✗ 111.3%	✗ 110.4%	✗ 103.3%	✗ 105.5%	✗ 102.1%	✓ 99.1%	✓ 98.1%	✓ 96.1%	✗ 101.2%	✗ 103.0%	✓ 98.7%	✗ 106.2%	✓ 87.6%	✗ 102.8%
Electives	Average daily elective referrals		343	340	325	348	320	347	374	350	304	346	362	330	-	341
	Outpatients - first appointment	≥Plan	✗ 99.3%	✗ 84.0%	✗ 94.0%	✗ 90.5%	✗ 87.5%	✗ 96.0%	✗ 82.9%	✗ 83.4%	✗ 78.8%	✗ 78.3%	✗ 81.0%	✗ 82.2%	✗ 89.0%	✗ 86.4%
	Outpatients - follow up	≤Plan	✓ 100.0%	✗ 102.4%	✓ 94.1%	✓ 99.1%	✓ 92.2%	✓ 97.2%	✓ 97.2%	✓ 92.6%	✓ 92.7%	✓ 95.7%	✓ 99.8%	✓ 97.7%	✗ 102.3%	✓ 96.7%
	Outpatients - procedures	≥Plan	✓ 133.0%	✓ 129.3%	✓ 114.4%	✓ 122.7%	✓ 118.7%	✓ 139.0%	✓ 139.9%	✓ 126.9%	✓ 148.9%	✓ 147.3%	✓ 137.1%	✓ 121.1%	✗ 94.3%	✓ 130.8%
	Day case	≥Plan	✗ 96.3%	✗ 96.1%	✗ 96.0%	✓ 102.7%	✓ 101.3%	✓ 100.0%	✗ 95.8%	✓ 101.4%	✗ 97.3%	✗ 99.7%	✗ 94.9%	✗ 90.6%	✗ 92.0%	✗ 97.7%
	Elective inpatient	≥Plan	✗ 92.5%	✗ 94.6%	✗ 90.0%	✗ 84.0%	✗ 99.8%	✗ 96.7%	✓ 108.0%	✓ 109.9%	✗ 98.5%	✗ 87.7%	✗ 89.2%	✗ 93.6%	✗ 90.8%	✗ 95.4%
Diagnostics	Diagnostics	≥Plan	✓ 102.6%	✓ 109.2%	✗ 98.1%	✓ 104.9%	✓ 111.4%	✓ 112.5%	✓ 120.5%	✓ 114.9%	✓ 114.6%	✓ 115.9%	✓ 108.8%	✓ 115.7%	✓ 105.9%	✓ 110.7%

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Appendix A: Integrated Scorecard & Graphs for each indicator

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

Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

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

How are we different?

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

Why are we different?

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

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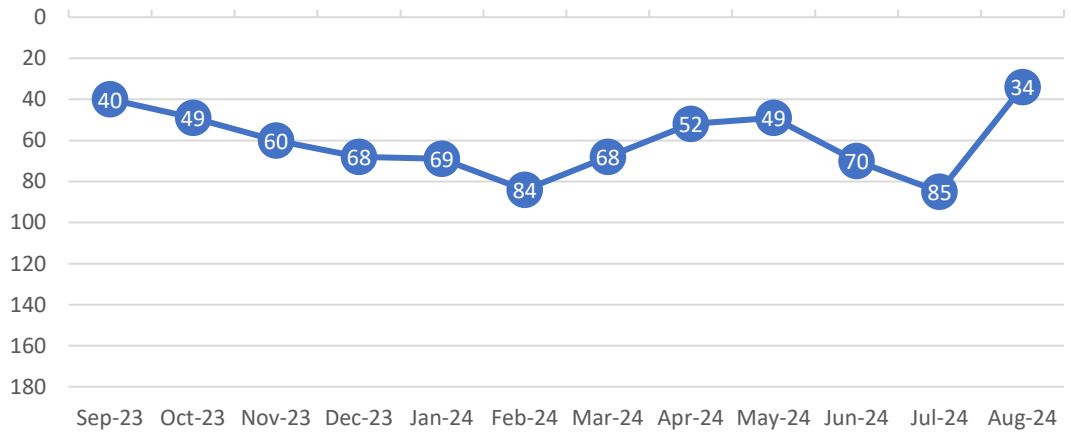
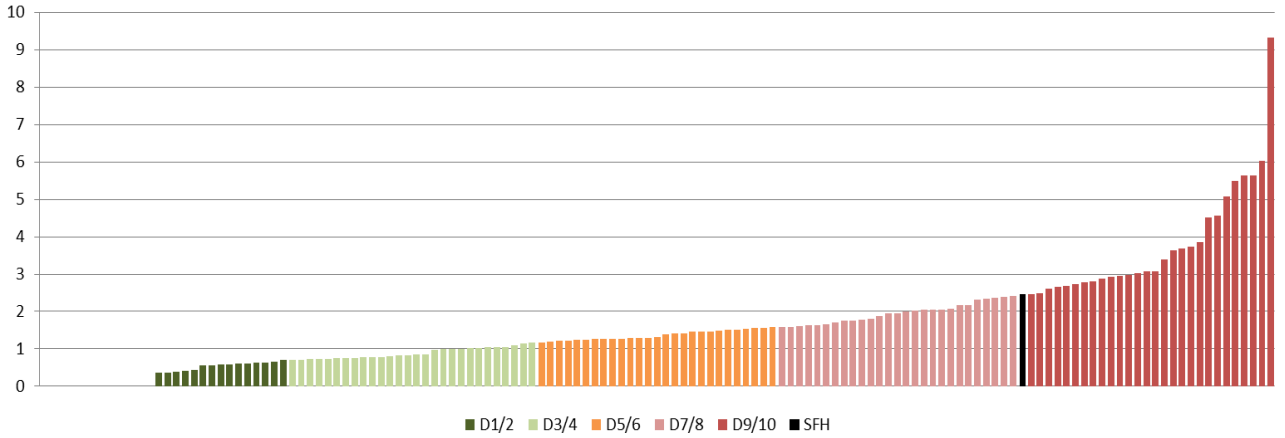
Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



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

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

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

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

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

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

April 2025 (Qtr 1)

Cover Page | Charts | Definitions

Integrated Report

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

Category	At a Glance	Indicator	2024/25 Standard	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	Jan-25	Feb-25	Mar-25	2024/25 Qtr 4	Apr-25	2024/25 Final
Quality of Care	Safe	Falls with lapse in care	≤2	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1
		Falls per 1000 occupied bed days	≤6.63	6.2	5.8	6.7	6.3	6.7	5.9	6.2	6.3	6.0	7.4	7.3	6.9	7.9	7.2	5.3	6.8	-	6.6
		Never events	0	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	2
		MRSA reported in month	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1
		Cdifficile reported in month	≤13 qtr	4	4	5	13	4	3	4	11	7	4	6	17	4	5	5	14	7	55
		Ecoli blood stream infections (BSI) reported in month	≤22 qtr	5	1	4	10	3	5	2	10	4	6	0	10	4	1	3	8	4	38
		Klebsiella BSI reported in month	≤1 qtr	0	1	2	3	1	1	0	2	1	1	0	2	1	0	2	3	2	10
		Pseudomonas BSI reported in month	≤3 qtr	0	0	1	1	0	0	0	0	0	1	0	1	0	0	0	0	0	2
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care		0	0	0.1	0.1	0	0	0	0	0.2	0.1	0	0.1	0.1	0.2	0	0.1	0	0.1
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	1	1	2	0	0	1	1	0	0	2	2	1	0	0	1	0	6
		Patient Safety Incident Investigations (PSII)		3	4	0	7	0	2	2	4	1	0	2	3	2	1	0	3	0	17
	Caring	Complaints per 1000 occupied bed days	≤1.9	0.7	1.5	0.9	1.0	1.5	0.8	0.8	1.0	0.8	0.8	0.4	0.7	1.4	0.7	0.8	1.0	1.3	0.9
		Compliments received in month		161	138	151	450	155	120	119	394	204	160	147	511	140	152	184	476	155	1831
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	104	103	102	102	102	102	103	103	103	103	101	103	101	102	102	102	103	102
		SHMI	≤100	109	108	107	107	106	106	106	106	106	106	106	106	106	106	107	106	106	107
		Still birth rate	≤4.4	0	3.2	4.2	2.3	0.0	6.8	6.4	4.4	3.4	10.3	0	4.5	3.5	15.5	0.0	6.2	0	4.3
		Early neonatal deaths per 1000 live births	≤1	0	0	0	0	0	0	3.2	1.1	0	0	0	0	0	0	0	0	0	0.3
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	-	-	-	6.8	-	-	-	6.8	-	-	-	7.1	-	-	-	-	-	6.9
	Growing the Future	Vacancy rate	≤8.5%	8.2%	8.0%	8.1%	8.1%	8.4%	7.7%	7.4%	7.9%	8.4%	8.3%	8.1%	8.3%	7.8%	7.7%	7.7%	7.7%	9.3%	8.0%
		Turnover in month	≤0.9%	0.5%	0.3%	0.6%	0.5%	0.5%	0.6%	0.5%	0.5%	0.4%	0.5%	0.7%	0.5%	0.5%	0.4%	0.7%	0.5%	0.6%	0.7%
		Appraisals	≥90%	88.5%	90.1%	88.8%	89.1%	90.3%	90.0%	89.7%	90.0%	88.8%	86.9%	88.8%	88.2%	88.4%	88.2%	90.0%	88.9%	90.0%	89.0%
		Mandatory & statutory training	≥90%	91.0%	91.0%	91.0%	91.0%	91.4%	91.3%	90.9%	91.2%	90.9%	90.7%	91.8%	91.1%	92.4%	92.8%	92.9%	92.7%	92.2%	91.5%
	Looking after our People	Sickness absence	≤4.2%	4.3%	4.4%	4.7%	4.4%	4.9%	4.2%	4.7%	4.6%	5.6%	5.7%	6.1%	5.8%	5.9%	5.0%	4.6%	5.1%	4.9%	5.0%
		Total workforce loss	≤7.0%	6.4%	6.4%	6.8%	6.5%	6.9%	6.3%	6.7%	6.6%	7.6%	7.8%	8.1%	7.8%	7.8%	6.9%	6.6%	7.1%	7.1%	7.01%
		Flu vaccinations uptake (front line staff)	≥75%	-	-	-	-	-	-	-	-	35.3%	43.6%	47.1%	47.1%	47.7%	47.8%	-	47.8%	-	47.8%
		Employee relations management	<17	20	23	15	19	20	20	21	20	19	20	18	19	20	25	31	25	23	21
	New Ways of Working	Bank usage	≤8.5%	8.3%	10.3%	9.3%	9.3%	9.8%	10.3%	8.1%	9.4%	7.3%	7.8%	9.1%	8.0%	9.7%	8.0%	8.8%	8.8%	6.3%	8.9%
		Agency usage	<3.2%	4.6%	4.6%	4.7%	4.6%	5.1%	4.2%	3.4%	4.2%	3.6%	3.7%	3.2%	3.5%	3.6%	3.8%	3.5%	3.6%	2.5%	4.0%
		Agency (off framework)	0.0%	0.1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0.01%
		Agency (over price cap)	≤40.0%	55.1%	55.6%	59.7%	57.1%	60.3%	53.6%	55.5%	56.4%	45.1%	43.1%	48.1%	45.4%	46.0%	47.3%	61.5%	52.2%	55.3%	52.9%
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	96.6%	96.5%	95.1%	96.1%	95.6%	96.8%	93.5%	95.3%	93.7%	87.4%	80.6%	87.1%	86.3%	86.3%	89.0%	87.2%	92.1%	91.4%
		Ambulance delays >60 mins	0.0%	0.2%	0%	0%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	1.7%	2.5%	1.5%	1.4%	1.2%	0.8%	1.1%	0.6%	0.7%
		ED 4-hour performance	≥76%	74.2%	73.4%	70.9%	72.8%	71.7%	82.0%	73.6%	75.6%	69.2%	66.5%	61.7%	65.8%	65.3%	68.2%	75.2%	69.8%	77.3%	71.0%
		ED 12-hour length of stay performance	≤2%	3.1%	2.2%	2.3%	2.5%	2.9%	0.9%	3.0%	2.3%	3.9%	4.8%	6.3%	5.0%	5.5%	4.2%	1.7%	3.7%	2.1%	3.4%
		SDEC rate	≥33%	38.2%	37.7%	38.6%	38.2%	38.1%	41.3%	39.0%	39.4%	40.1%	39.4%	36.7%	38.7%	37.8%	40.1%	39.3%	39.0%	38.9%	38.8%
		Adult G&A bed occupancy	≤92%	93.6%	94.8%	94.7%	94.4%	95.5%	92.2%	93.8%	93.9%	95.4%	94.7%	94.8%	94.9%	96.1%	94.4%	94.0%	94.9%	94.6%	94.5%
		Long length of stay (21+) occupied beds	≤Plan	124	96	91	110	102	105	103	104	96	97	106	100	115	106	97	106	99	103
		Inpatients medically safe for transfer for greater than 24 hours	≤40	91	64	71	75	84	65	57	69	57	56	59	57	65	48	50	54	53	64
	Electives	Advice & guidance	≥16%	24.5%	25.8%	22.0%	24.1%	25.2%	24.6%	22.3%	24.0%	24.7%	23.9%	24.2%	24.2%	23.5%	23.1%	25.5%	24.0%	26.3%	24.1%
		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	6.0%	5.9%	5.9%	5.9%	6.2%	6.1%	6.3%	6.2%	6.0%	6.0%	6.0%	6.0%	5.3%	6.1%	6.2%	5.8%	6.6%	6.0%
		Outpatient attends that are first or follow up with a procedure	≥Plan	43.3%	40.7%	43.9%	42.6%	42.2%	42.9%	43.1%	42.7%	41.5%	41.7%	41.7%	41.6%	41.4%	40.7%	40.9%	41.0%	-	42.0%
		Incomplete RTT waiting list	≤Plan	36,584	35,858	35,720	35,720	35,251	35,165	35,507	35,507	35,440	34,538	34,147	34,538	33,876	34,438	35,324	35,324	35,319	35324
		Incomplete RTT pathways +52 weeks	≤Plan	1,312	1,162	1,177	1,177	1,080	1,019	870	870	786	709	569	569	609	553	469	469	453	469
		Incomplete RTT pathways +65 weeks	≤Plan	140	129	109	109	77	105	50	50	44	36	40	40	28	32	22	22	32	22
		Incomplete RTT pathways +78 weeks	0	2	1	0	0	2	1	0	0	0	0	0	0	2	0	0	0	0	0
	Diagnostics	Diagnostic DM01 backlog		3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	1,427	989	940	940	920	499	642	642	978	642
		Diagnostic DM01 performance under 6-weeks	≥Plan	71.6%	72.7%	70.5%	70.5%	69.5%	70.2%	76.3%	76.3%	85.6%	89.8%	89.4%	89.4%	88.7%	94.4%	93.1%	94.4%	88.9%	93.1%
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	75.3%	79.8%	79.2%	78.2%	81.6%	81.6%	78.2%	80.5%	79.9%	78.4%	76.1%	78.2%	71.6%	79.7%	78.0%	76.4%	-	78.3%
		Cancer 31-day treatment performance	≥Plan	89.8%	87.5%	88.3%	88.6%	95.0%	91.1%	95.0%	93.8%	94.3%	89.8%	92.4%	92.0%	86.9%	96.1%	95.4%	93.1%	-	91.9%
		Cancer 62-day treatment performance	≥Plan	71.8%	56.3%	70.3%	66.1%	71.4%	67.9%	61.2%	67.0%	66.1%	69.7%	61.2%	65.8%	55.0%	66.9%	55.1%	59.2%	-	64.4%
		Suspected cancer patients waiting over 62-days		100	80	81	81	75	99	95	95	98	86	92	92	107	100	86	86	87	86
Best Value Care	Finance	Income & expenditure against plan	≥£0.00m	-£0.02	£0.02	-£0.61	-£0.61	-£0.33	-£0.31	£0.44	-£0.20	-£0.17	-£0.79	-£0.10	-£1.06	-£2.68	-£2.60	£7.14	£1.87	£0.00	£0.01
		Financial Improvement Programme (FIP) against plan	≥£0.00m	-£0.54	£1.48	£0.66	£1.60	-£1.61	-£1.40	-£1.43	-£4.44	£4.70	-£1.97	-£0.20	£2.53	£0.26	-£0.04	£0.15	£0.37	-£0.81	£0.08
		Capital expenditure against plan	≤£33.61m	-£0.52	£2.26	£1.27	£3.01	£1.10	£1.38	£1.26	£3.74	£1.41	£1.01	£1.92	£4.34	£2.43	£1.62	£18.40	£22.45	£0.35	£33.58
		Cash balance	≥£1.45m	£1.34	£1.73	£1.50	£1.50	£0.32	-£0.15	£0.05	£0.05	£9.46	£4.17	£1.28	£1.28	-£0.53	£13.00	£24.72	£13.00	£24.72	£26.53
		Implied Productivity 2023/24 v 2024/25	3.1%	-	-	-	-	6.7%	5.2%	6.1%	6.1%	6.9%	5.4%	4.6%	4.6%	4.6%	4.4%	-	-	-	4.6%
		Value weighted elective activity	105%	103.5%	110.9%	112.0%	108.8%	108.8%	118.7%	118.5%	115.3%	119.1%	113.6%	114.4%	115.7%	123.1%	125.5%	124.3%	124.3%	-	119.1%
		Agency expenditure against plan	≥£0.00m	-£0.19	-£0.29	-£0.29	-£0.77	-£0.39	-£0.24	£0.01	-£0.62	-£0.17	-£0.09	£0.14	-£0.12	-£0.03	-£0.15	-£0.20	-£0.38	-£0.44	-£1.89
		Reported agency spend		£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£1.18	£1.14	£0.90	£3.22	£1.03	£1.05	£1.00	£3.08	£0.75	£13.70
		Reported bank spend		£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£2.36	£2.41	£2.61	£7.38	£2.81	£2.22	£2.51	£7.54	£1.88	£30.55
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan	111.5%	106.8%	104.1%	107.3%	106.5%	96.7%	102.0%	101.7%	105.9%	107.4%	107.7%	107.0%	99.5%	99.2%	110.3%	103.1%	95.2%	104.8%
		Non-elective admissions	≤Plan	111.3%	110.4%	103.3%	108.3%	105.5%	102.1%	99.1%	102.2%	98.1%	96.1%	101.2%	98.4%	103.0%	98.7%	106.2%	102.6%	87.6%	102.8%
	Electives	Average daily elective referrals	-	343	340	325	336	348	320	347	338	374	350	304	342	346	362	330	346	-	341
		Outpatients - first appointment	≥Plan	99.3%	84.0%	94.0%	92.3%	90.5%	87.5%	96.0%	91.3%	82.9%	83.4%	78.8%	81.8%	78.3%	81.0%	82.2%	80.4%	89.0%	86.4%
		Outpatients - follow up	≥Plan	100.0%	102.4%	94.1%	98.9%	99.1%	92.2%	97.2%	96.2%	97.2%	92.6%	92.7%	94.2%	95.7%	99.8%	97.7%	97.6%	102.3%	96.7%
		Outpatients - procedures	≥Plan	133.0%	129.3%	114.4%	125.3%	122.7%	118.7%	139.0%	126.1%	139.9%	126.9%	148.9%	137.8%	147.3%	137.1%	121.1%	134.7%	94.3%	130.8%
		Day case	≥Plan	96.3%	96.1%	96.0%	96.1%	102.7%	101.3%	100.0%	101.3%	95.8%	101.4%	97.3%	98.1%	99.7%	94.9%	90.6%	95.0%	92.0%	97.7%
		Elective inpatient	≥Plan	92.5%	94.6%	90.0%	92.4%	84.0%	99.8%	96.7%	93.3%	108.0%	109.9%	98.5%	105.7%	87.7%	89.2%	93.6%	90.2%	90.8%	95.4%
	Diagnostics	Diagnostics	≥Plan	102.6%	109.2%	98.1%	103.2%	104.9%	111.4%	112.5%	109.5%	120.5%	114.9%	114.6%	116.7%	115.9%	108.8%	115.7%	113.4%	105.9%	110.7%

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

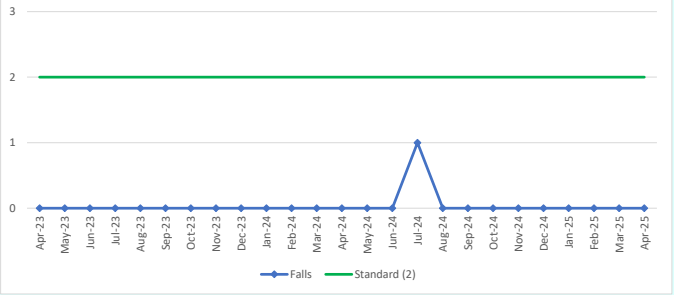
April 2025 (Qtr 1)

Cover Page | Definitions

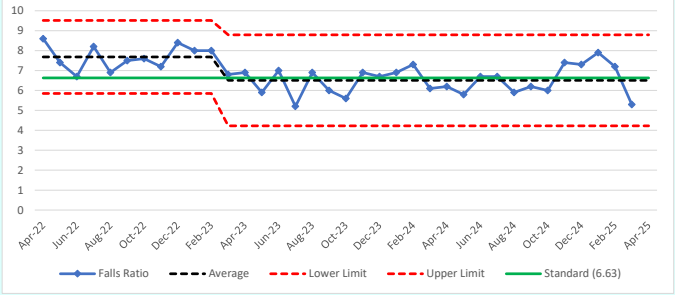
Charts

Quality of Care

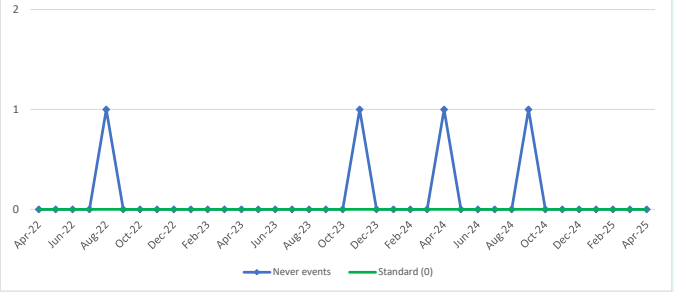
Falls with lapse in care



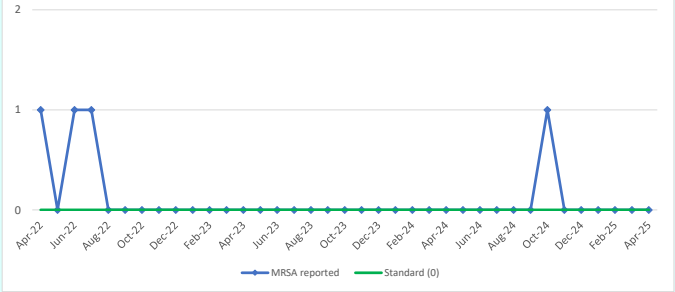
Falls per 1000 occupied bed days



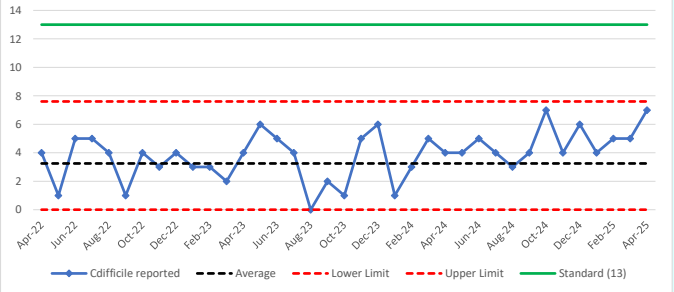
Never events



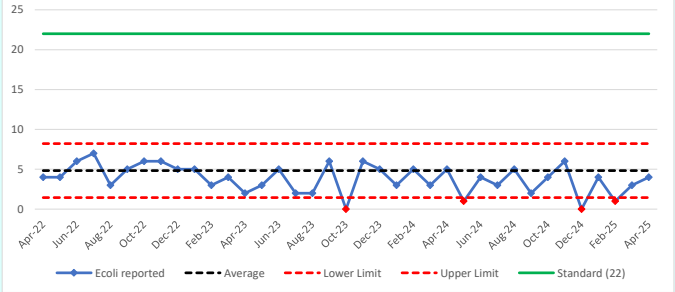
MRSA reported in month



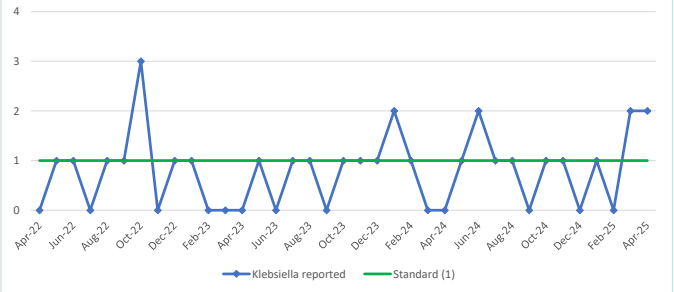
Cdifficile reported in month



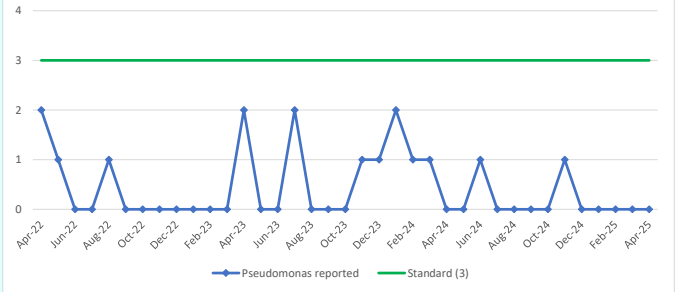
Ecoli blood stream infections (BSI) reported in month

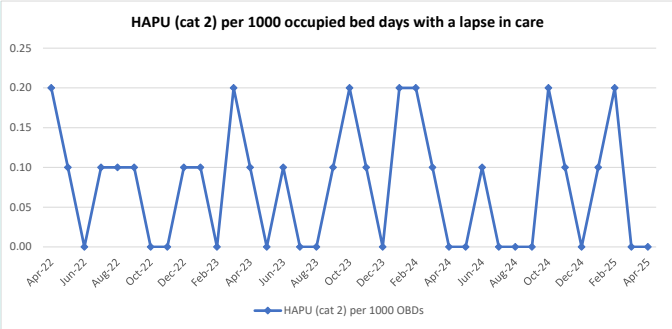


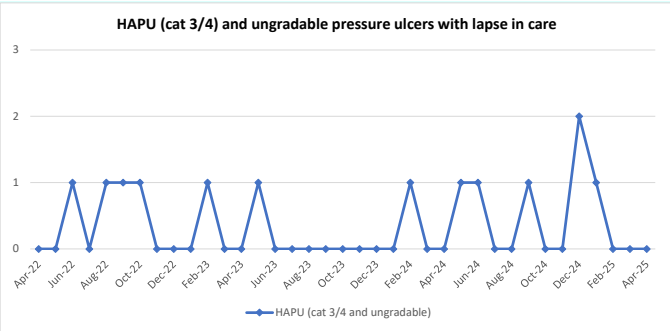
Klebsiella BSI reported in month

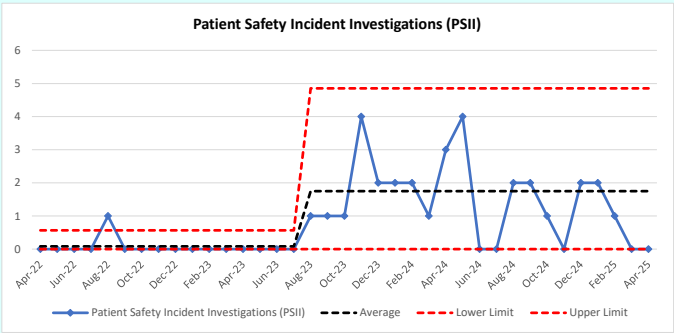


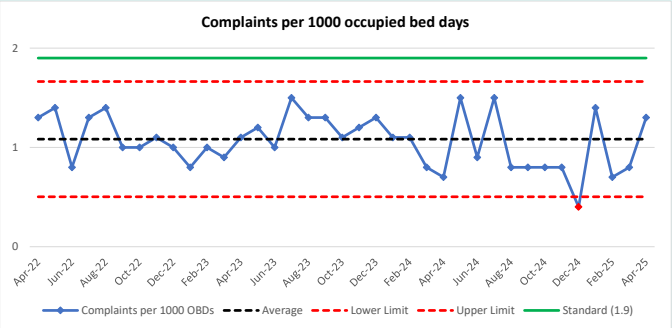
Pseudomonas BSI reported in month

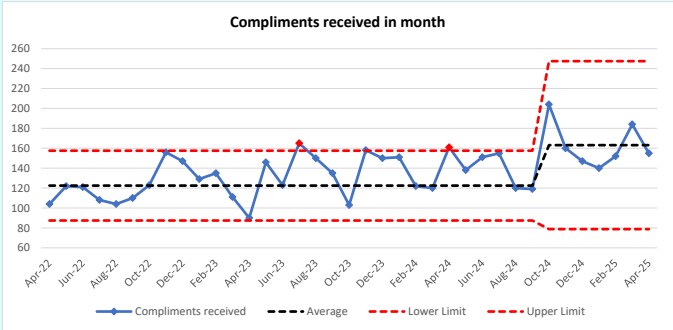


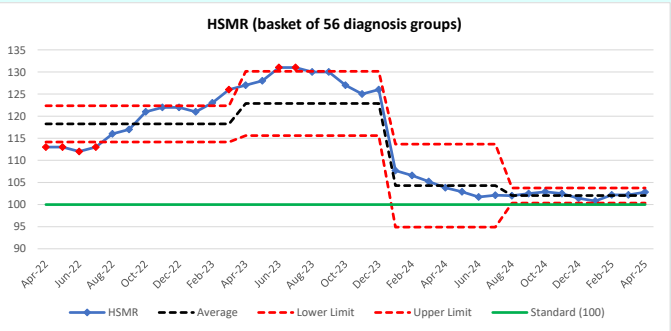

HAPU (cat 2) per 1000 occupied bed days with a lapse in care
HAPU (cat 2) per 1000 OBDs

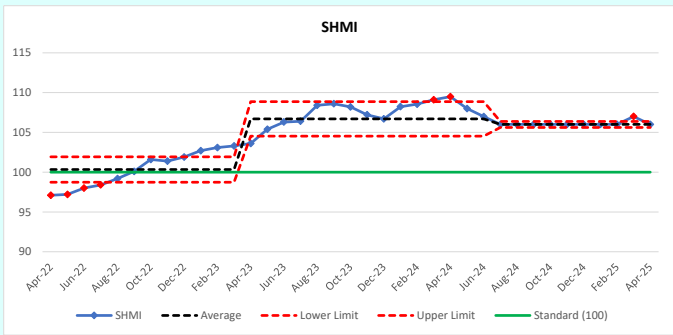

HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care
HAPU (cat 3/4 and ungradable)

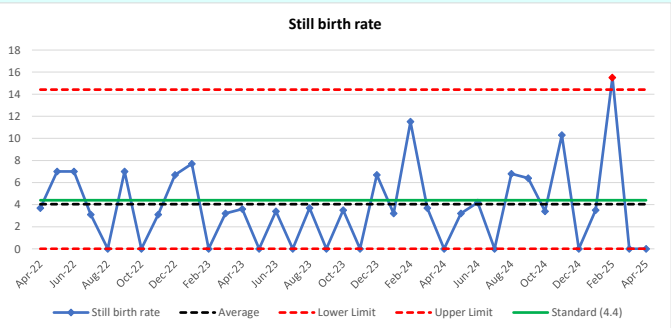

Patient Safety Incident Investigations (PSII)
Patient Safety Incident Investigations (PSII)
Average
Lower Limit
Upper Limit

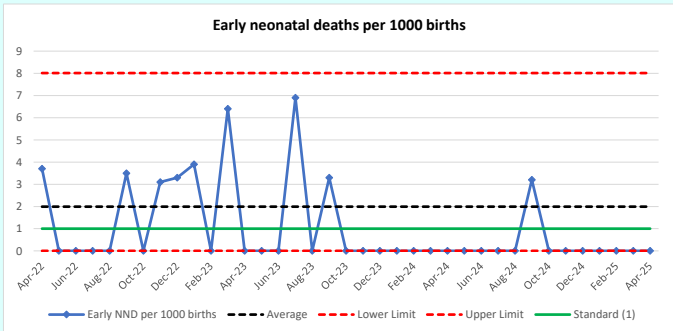

Complaints per 1000 occupied bed days
Complaints per 1000 OBDs
Average
Lower Limit
Upper Limit
Standard (1.9)


Compliments received in month
Compliments received
Average
Lower Limit
Upper Limit


HSMR (basket of 56 diagnosis groups)
HSMR
Average
Lower Limit
Upper Limit
Standard (100)

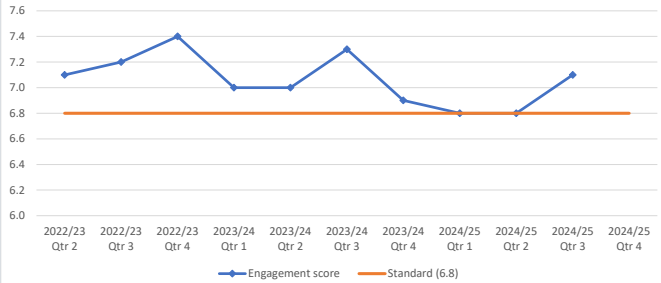

SHMI
SHMI
Average
Lower Limit
Upper Limit
Standard (100)


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

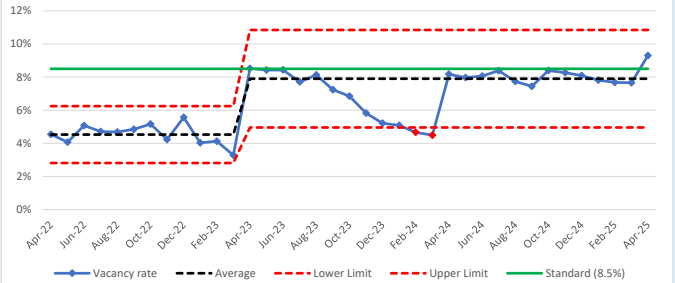

Early neonatal deaths per 1000 births
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard (1)

People and Culture

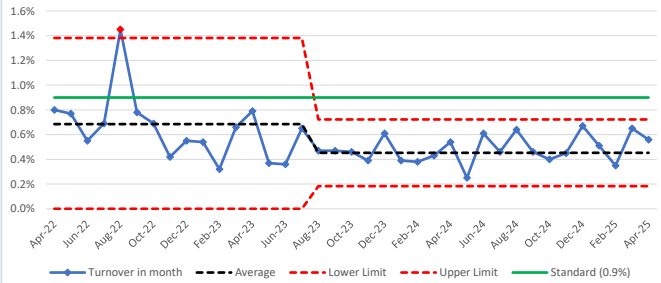
Engagement score



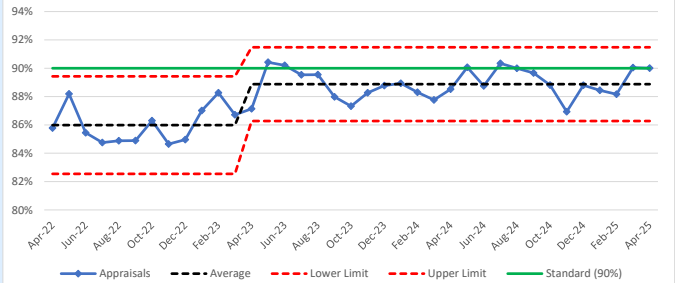
Vacancy rate



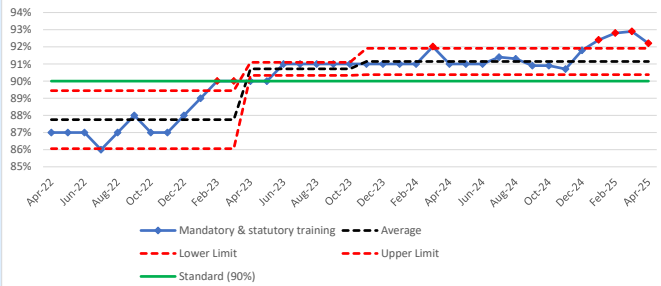
Turnover in month



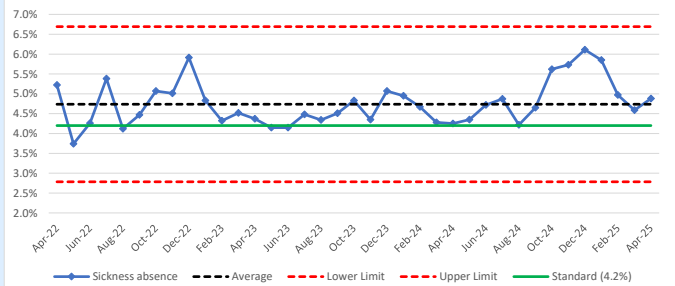
Appraisals



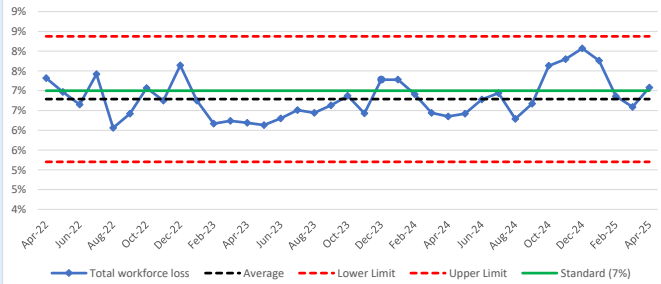
Mandatory & statutory training



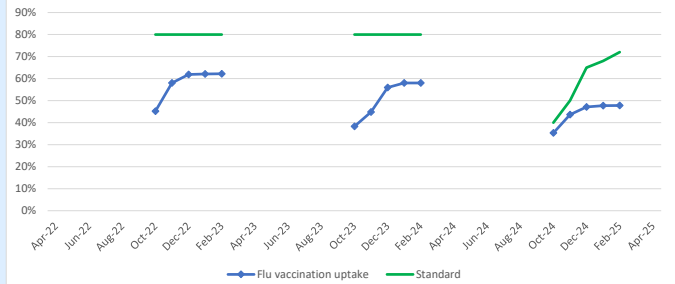
Sickness absence

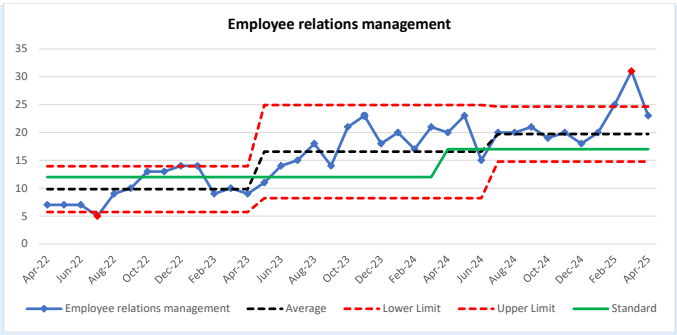


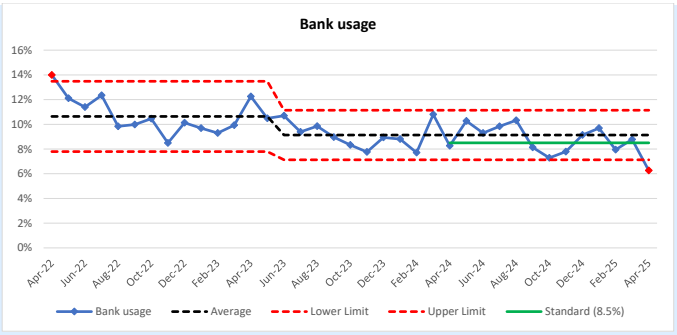
Total workforce loss

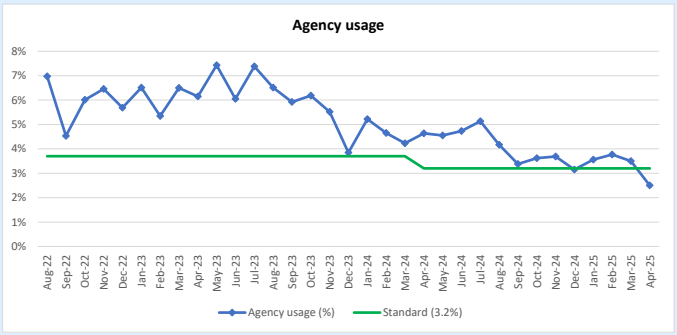


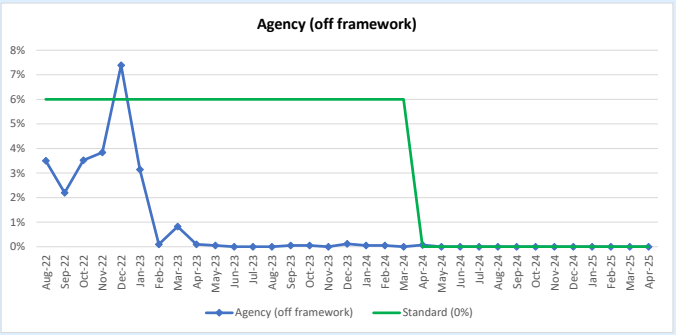
Flu vaccinations uptake (front line staff)

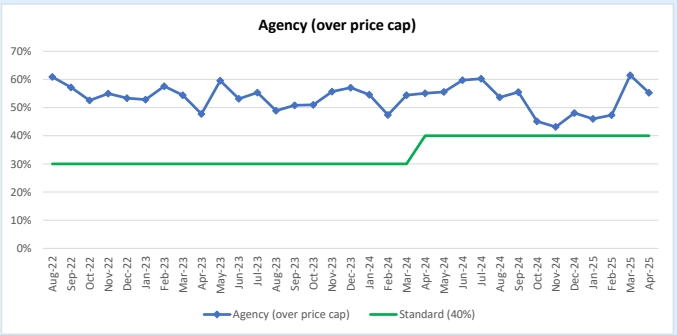



Employee relations management
35
30
25
20
15
10
5
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Employee relations management
Average
Lower Limit
Upper Limit
Standard


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
Bank usage
Average
Lower Limit
Upper Limit
Standard (8.5%)

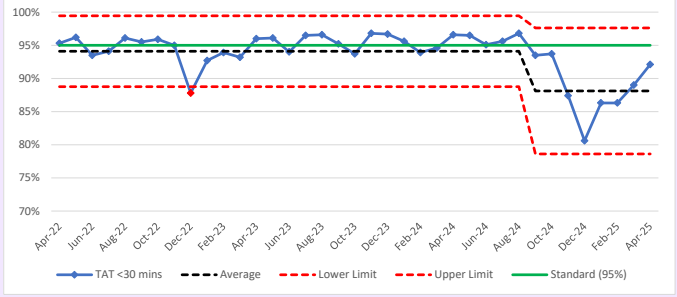

Agency usage
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
Agency usage (%)
Standard (3.2%)


Agency (off framework)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
Agency (off framework)
Standard (0%)

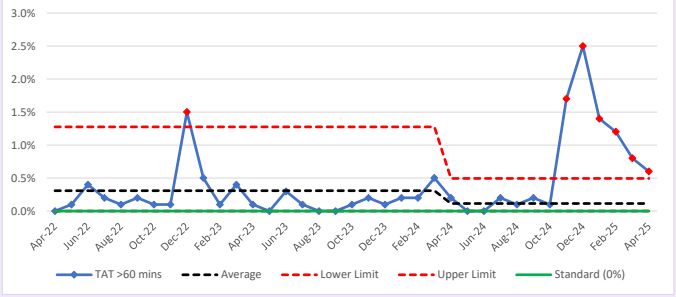

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
Agency (over price cap)
Standard (40%)

Timely Care

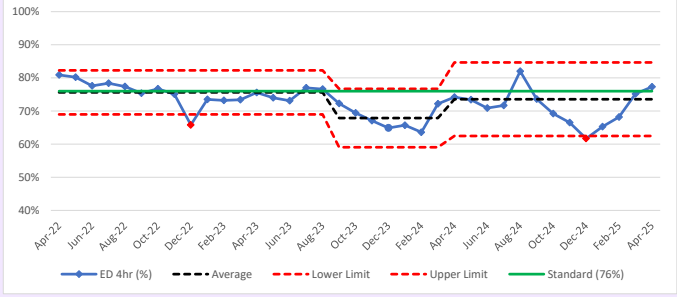
Ambulance turnaround times <30 mins



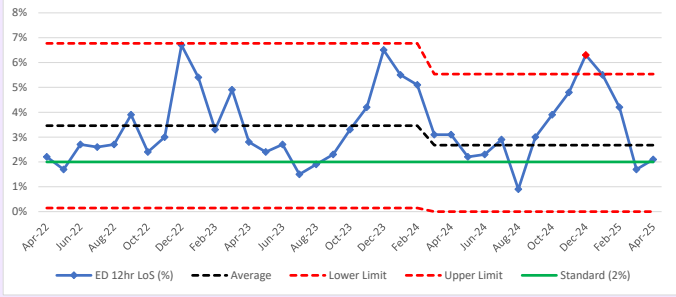
Ambulance delays >60 mins



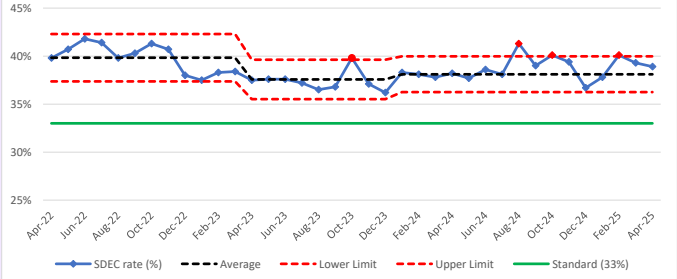
ED 4-hour performance



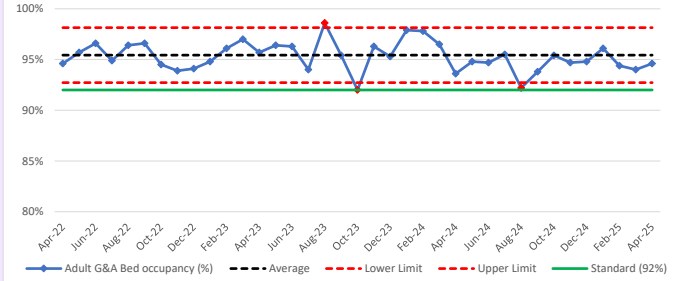
ED 12-hour length of stay performance



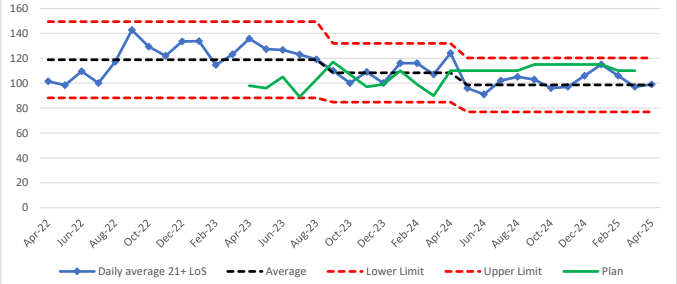
SDEC rate



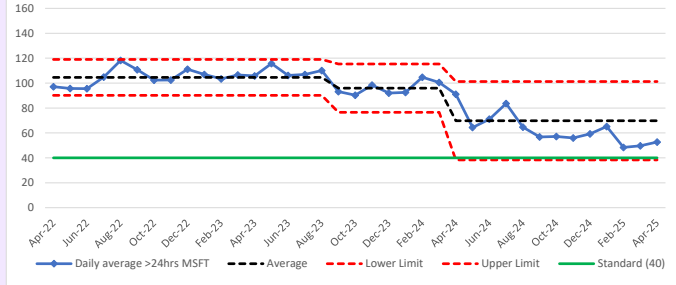
Adult G&A bed occupancy

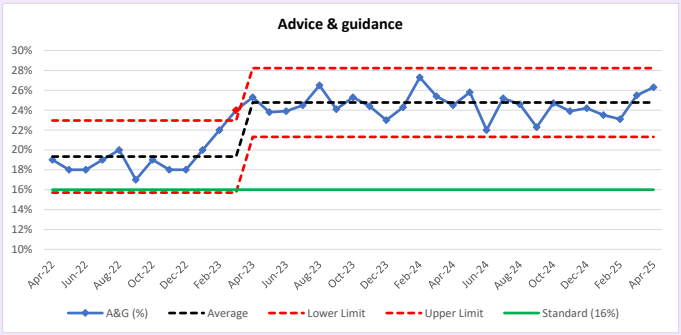


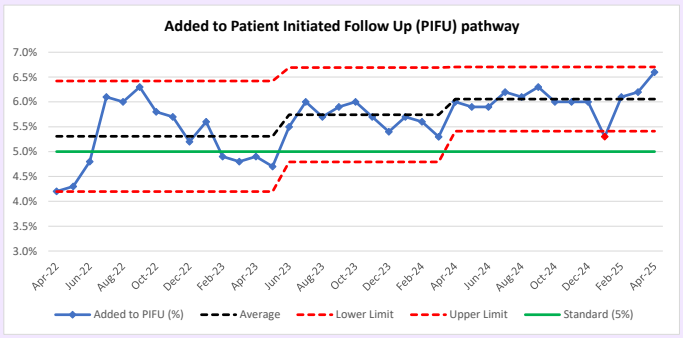
Long length of stay (21+) occupied beds

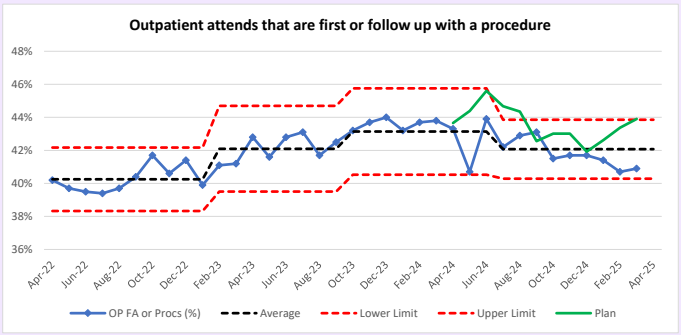


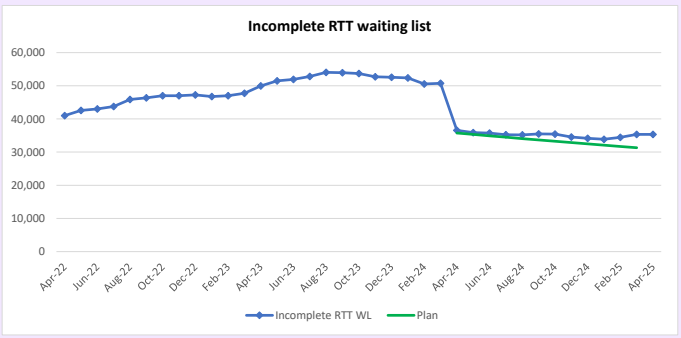
Inpatients medically safe for transfer for greater than 24 hours

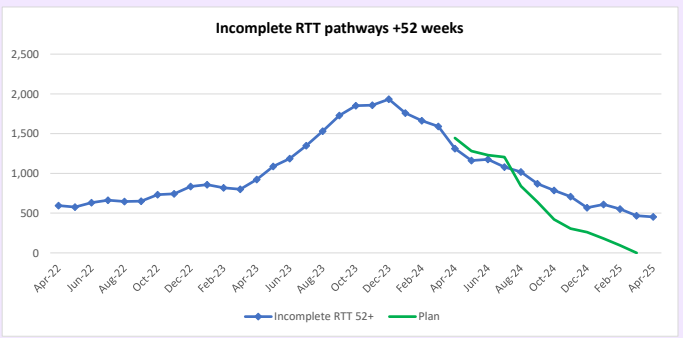


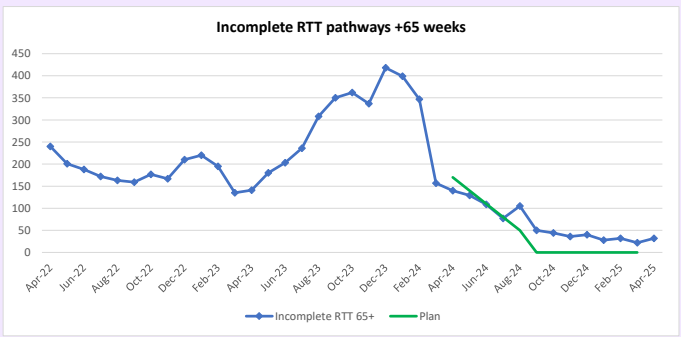

Advice & guidance
A&G (%)
Average
Lower Limit
Upper Limit
Standard (16%)

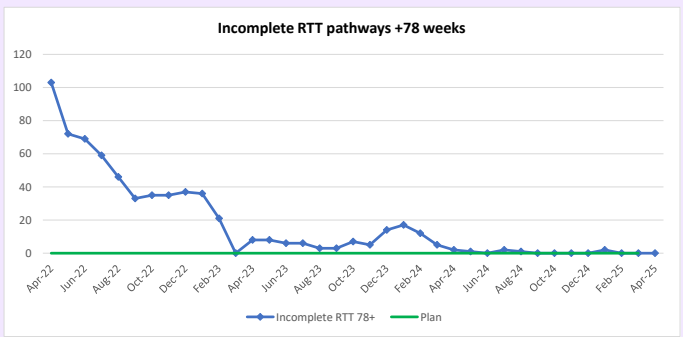

Added to Patient Initiated Follow Up (PIFU) pathway
Added to PIFU (%)
Average
Lower Limit
Upper Limit
Standard (5%)

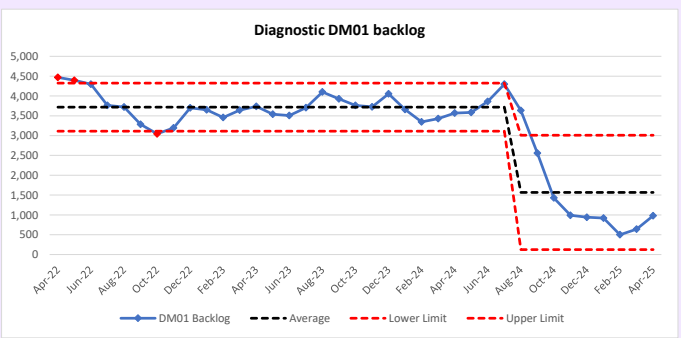

Outpatient attends that are first or follow up with a procedure
OP FA or Procs (%)
Average
Lower Limit
Upper Limit
Plan

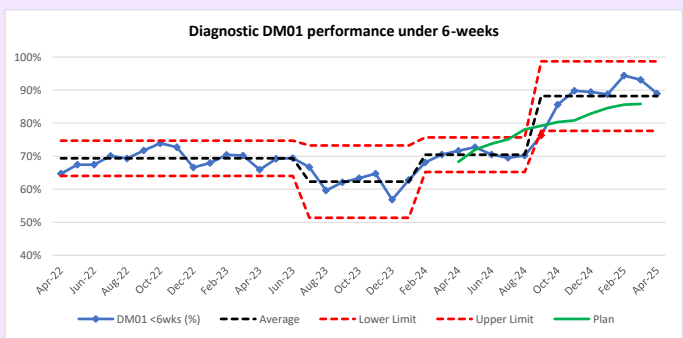

Incomplete RTT waiting list
Incomplete RTT WL
Plan

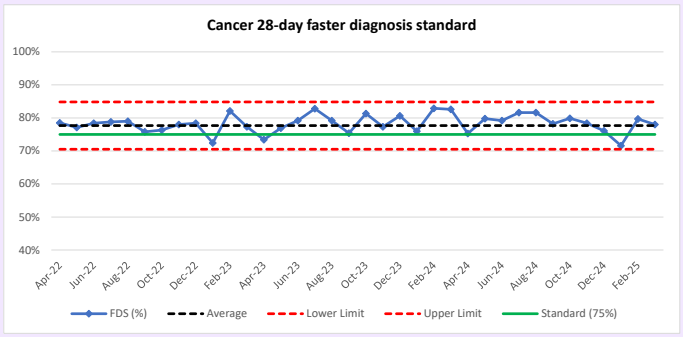

Incomplete RTT pathways +52 weeks
Incomplete RTT 52+
Plan

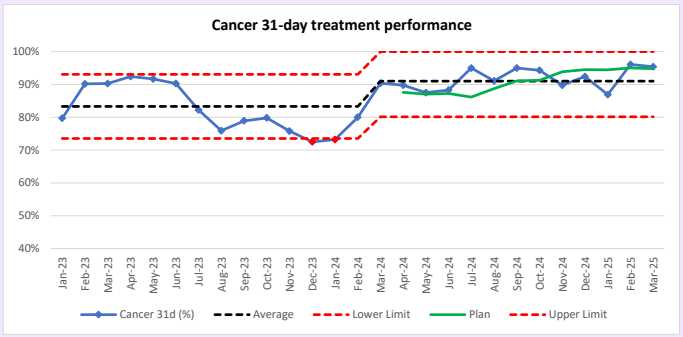

Incomplete RTT pathways +65 weeks
Incomplete RTT 65+
Plan

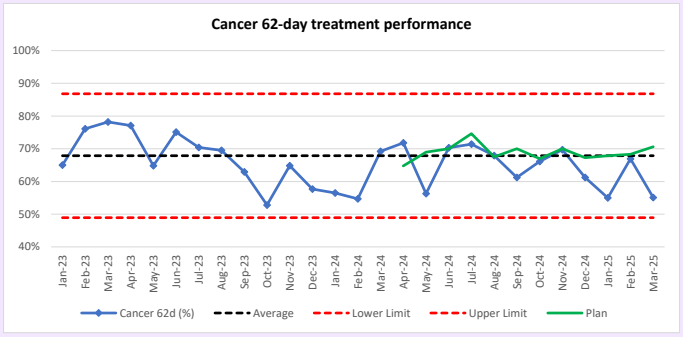

Incomplete RTT pathways +78 weeks
Incomplete RTT 78+
Plan

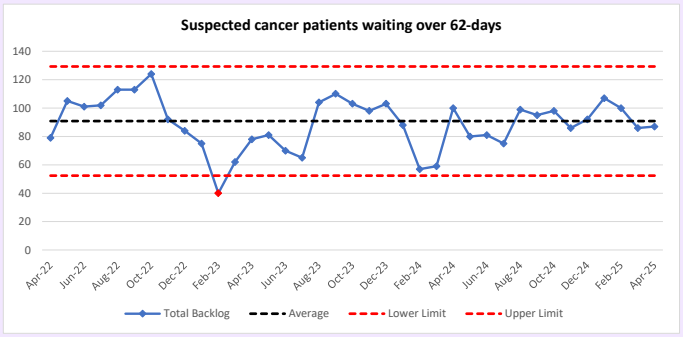

Diagnostic DM01 backlog
DM01 Backlog
Average
Lower Limit
Upper Limit


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

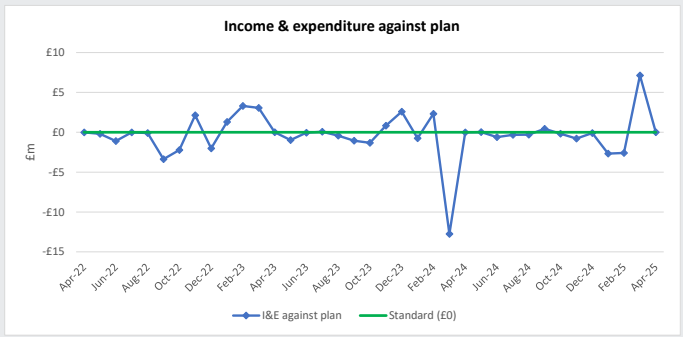


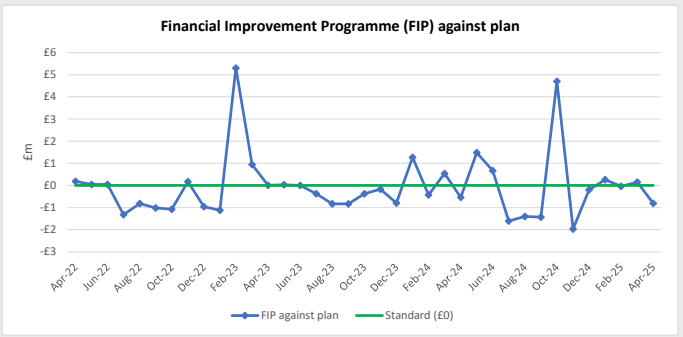


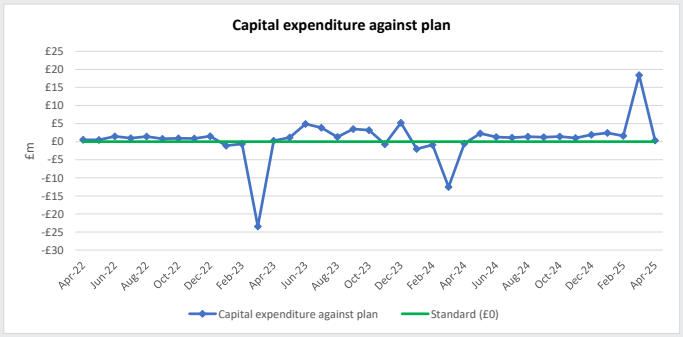


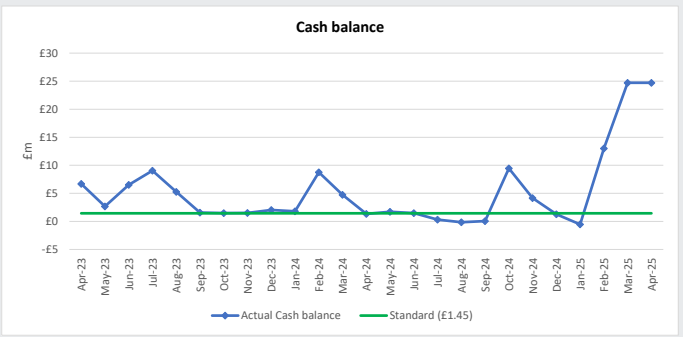


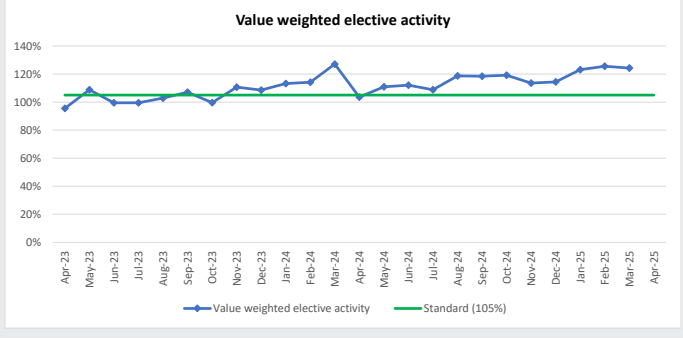
Best Value Care

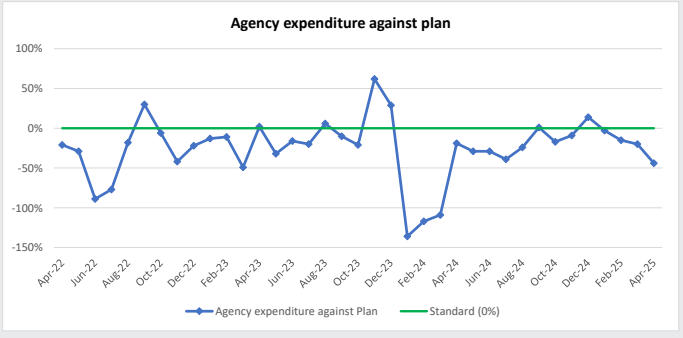


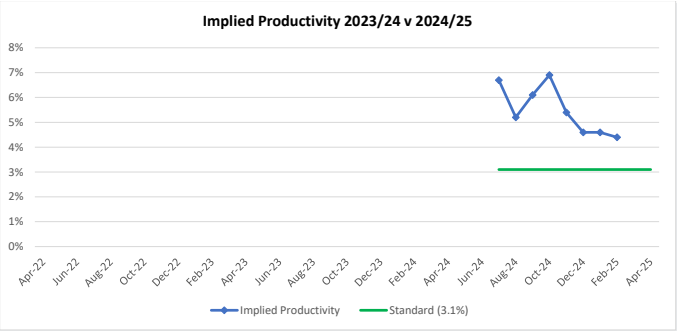


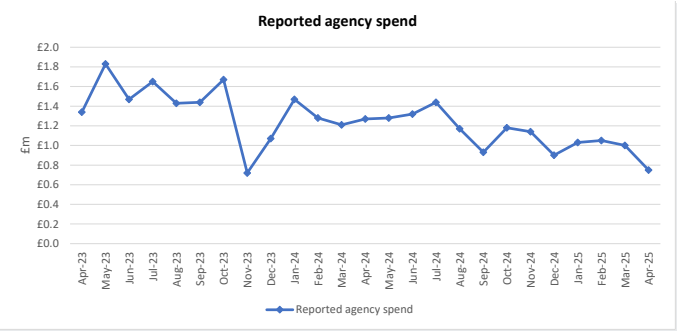


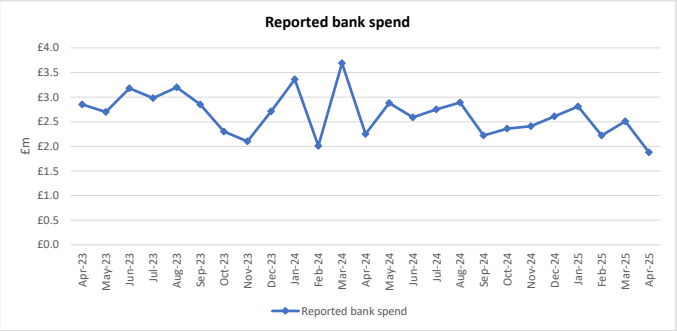




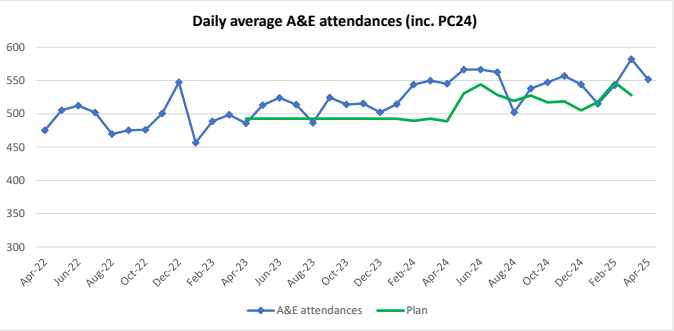


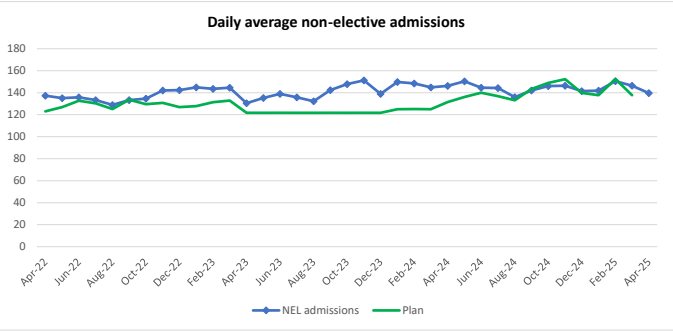


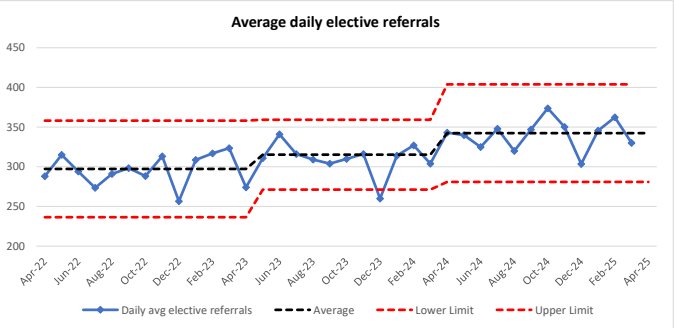


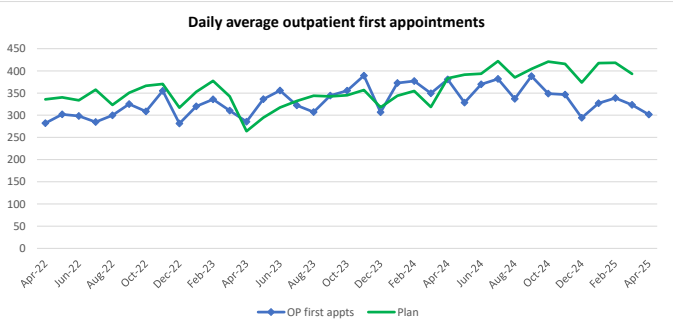


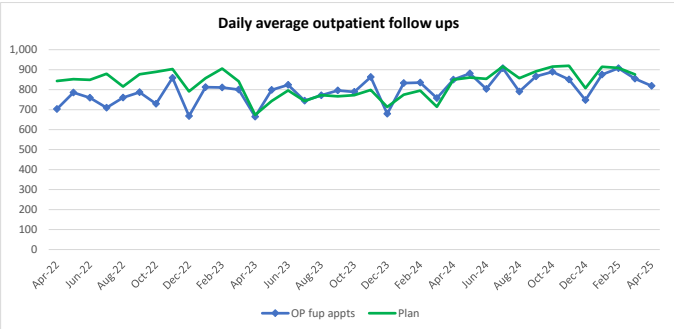
Activity (for context)

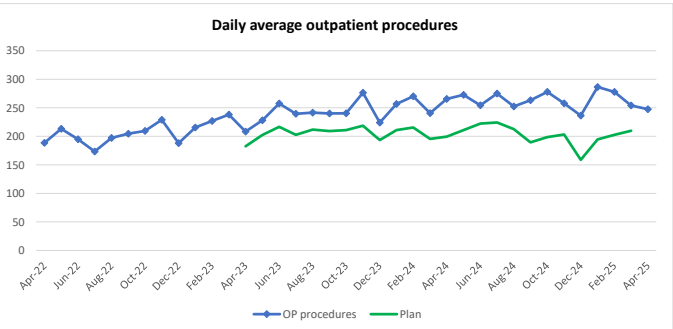


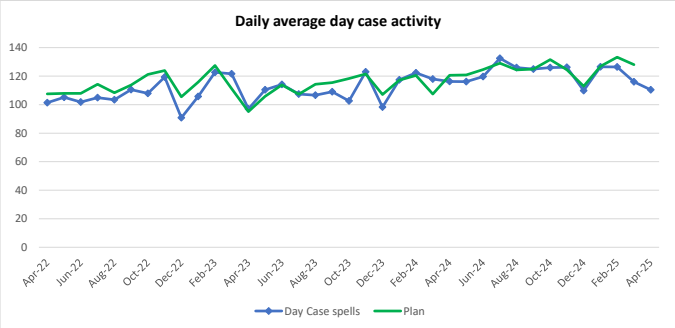


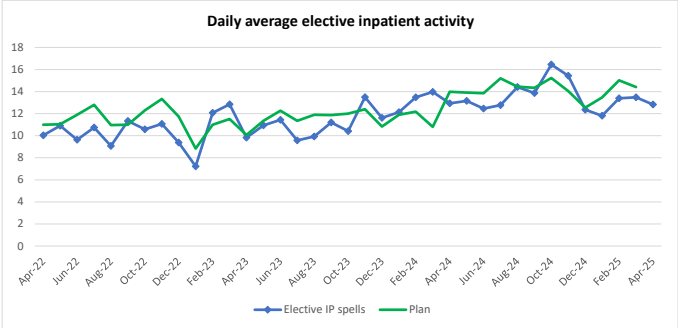









Daily average day case activity
140
120
100
80
60
40
20
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Day Case spells
Plan


Daily average elective inpatient activity
18
16
14
12
10
8
6
4
2
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
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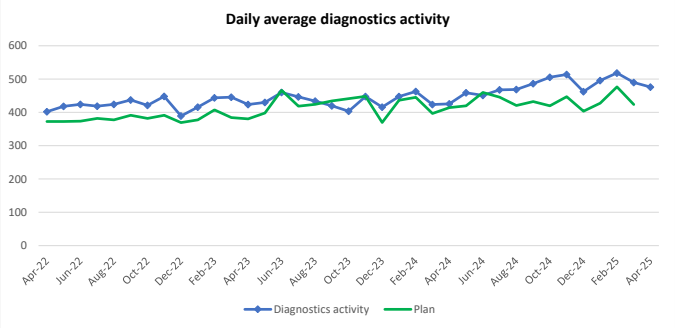
Apr-25
Elective IP spells
Plan


Daily average diagnostics activity
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500
400
300
200
100
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
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Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Diagnostics activity
Plan

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

April 2025 (Qtr 1)

Timely Care Benchmarking

Mar-25

At a Glance	Indicator	Source	Rate	Rank	Of	Decile
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	89.7%	37	175	3
	Ambulance delays >60 mins	Summary Emergency Department Indicator Table (SEDIT)	0.6%	29	175	2
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	75.2%	61	140	6
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	2.9%	25	175	2
	SDEC rate	Summary Emergency Department Indicator Table (SEDIT)	36.7%	98	178	6
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	93.7%	68	179	4
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	*	*	*	*
	Incomplete RTT pathways +52 weeks	RTT waiting times data	1.3%	55	151	4
	Incomplete RTT pathways +65 weeks	RTT waiting times data	0.1%	93	151	7
	Incomplete RTT pathways +78 weeks	RTT waiting times data	0.0%	1	152	1
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	93.1%	35	135	3
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	78.0%	89	135	7
	Cancer 31-day treatment performance	Cancer Waiting Times standards	95.4%	66	135	5
	Cancer 62-day treatment performance	Cancer Waiting Times standards	55.1%	126	135	10

Sherwood Forest Hospitals NHS Foundation Trust

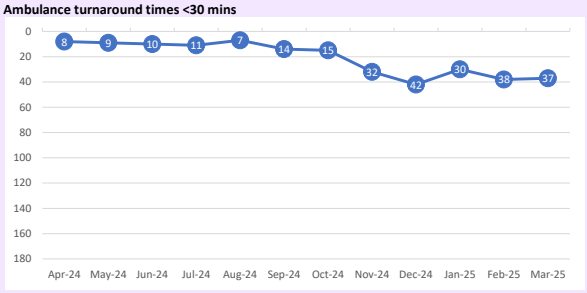
Integrated Performance Report 2025/26

April 2025 (Qtr 1)

Timely Care Benchmarking Charts

Timely Care Benchmarking

Ambulance turnaround times <30 mins



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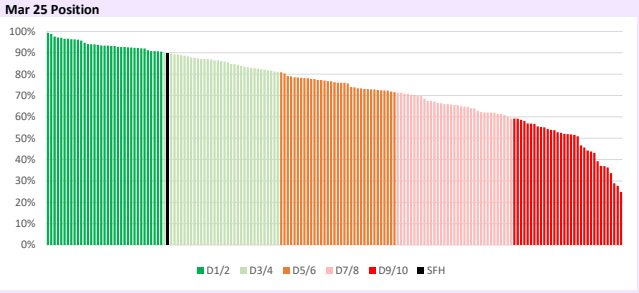
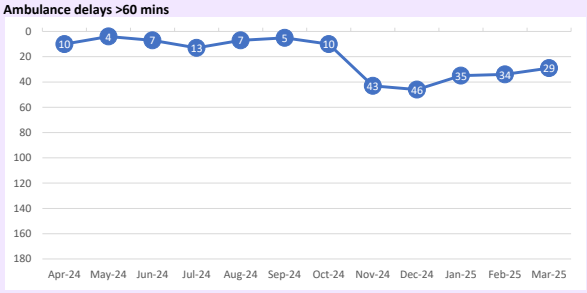


Ambulance delays >60 mins



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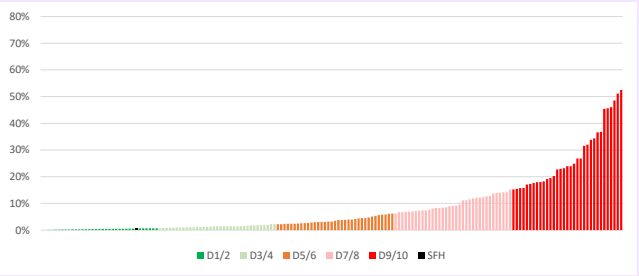
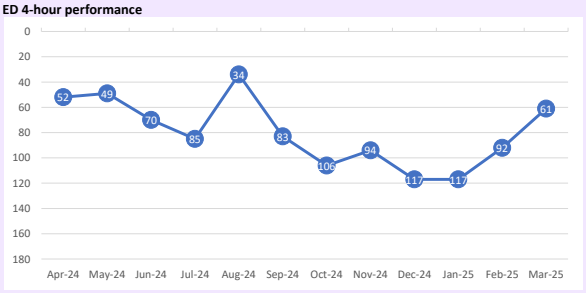


ED 4-hour performance



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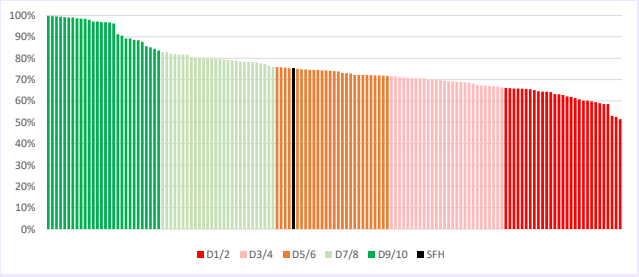
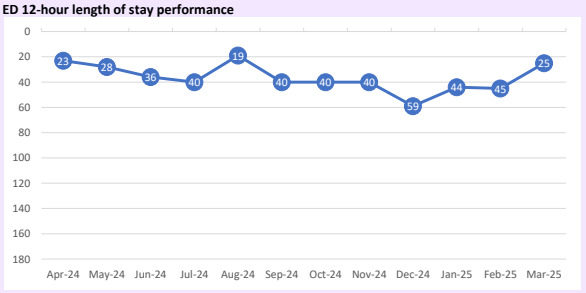


ED 12-hour length of stay performance



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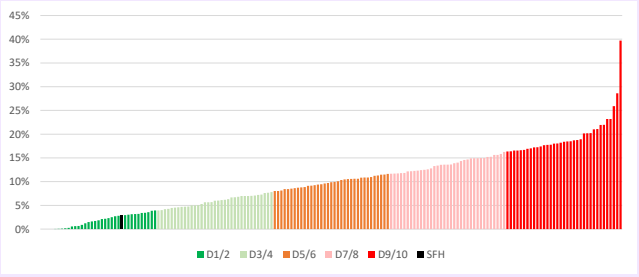
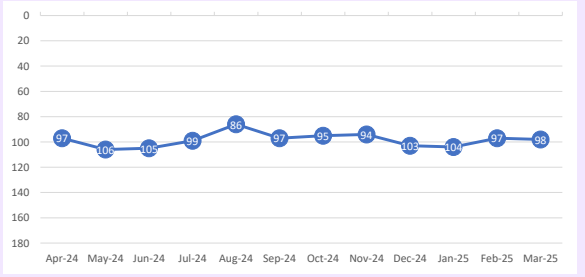


SDEC rate



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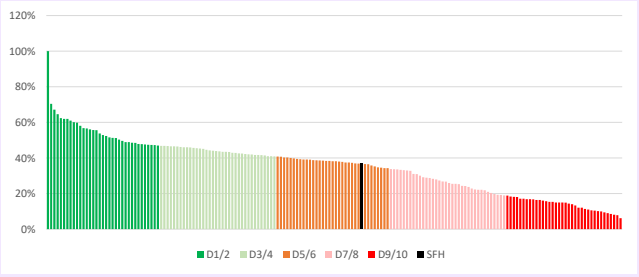
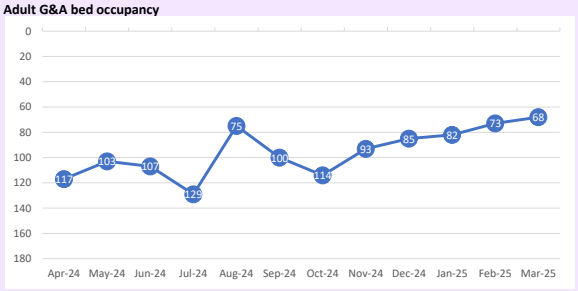


Adult G&A bed occupancy



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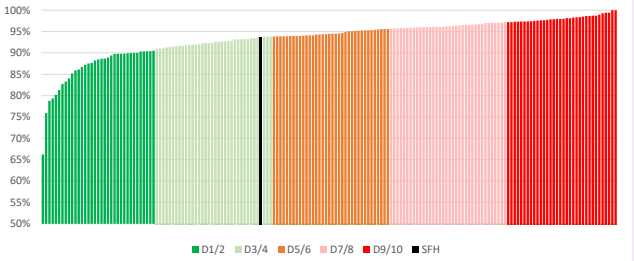
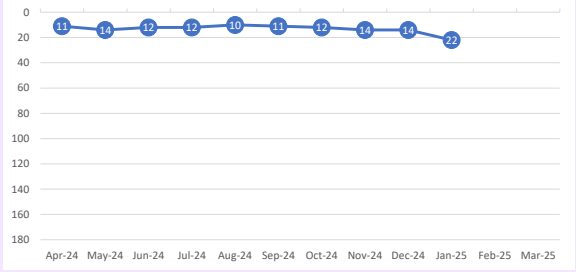


Added to Patient Initiated Follow Up (PIFU) pathway



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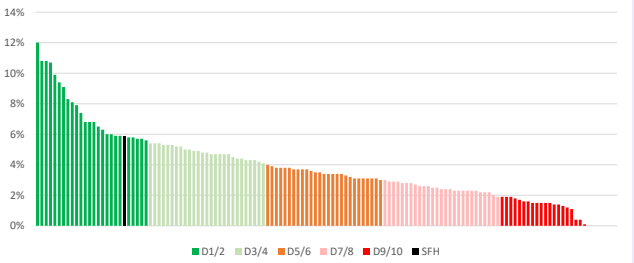
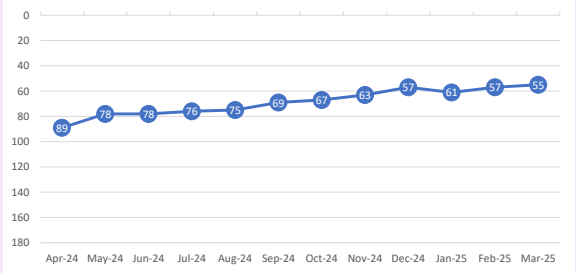


Incomplete RTT pathways +52 weeks



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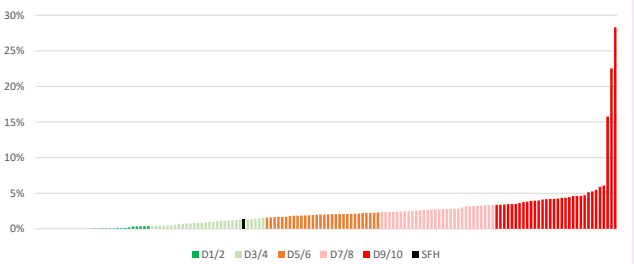

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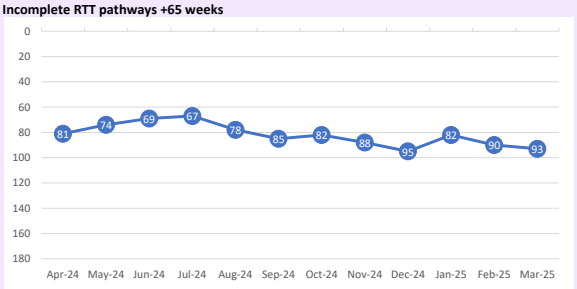

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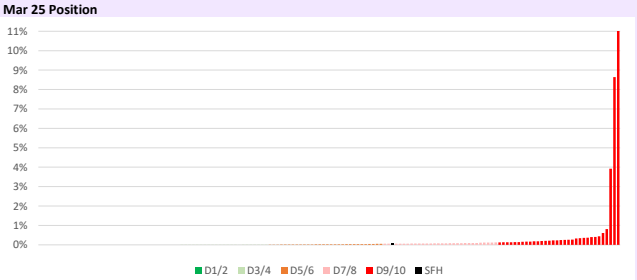
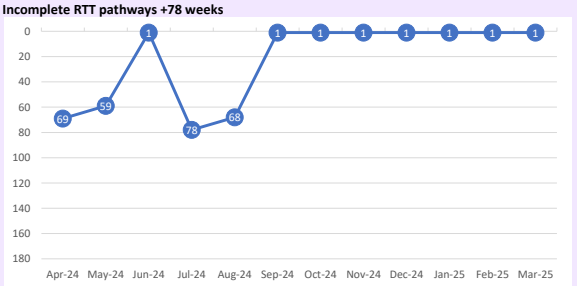


Incomplete RTT pathways +78 weeks



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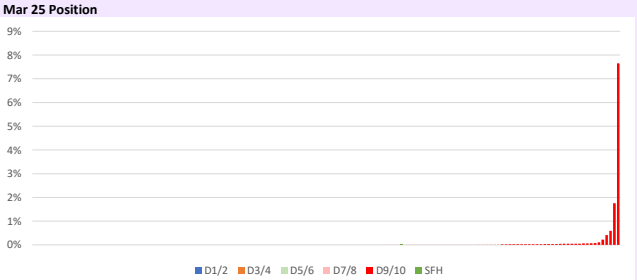
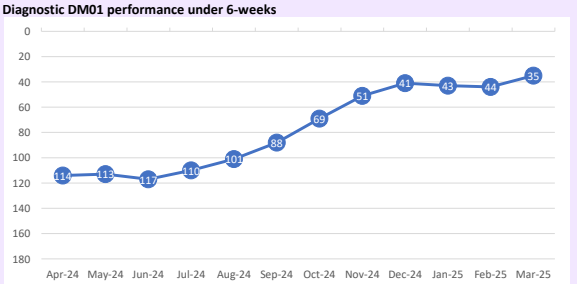


Diagnostic DM01 performance under 6-weeks



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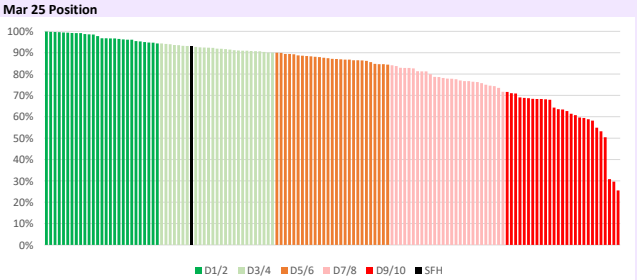
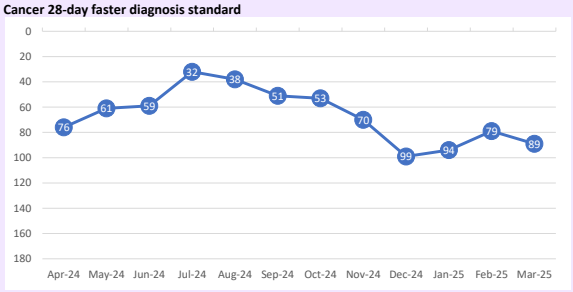


Cancer 28-day faster diagnosis standard



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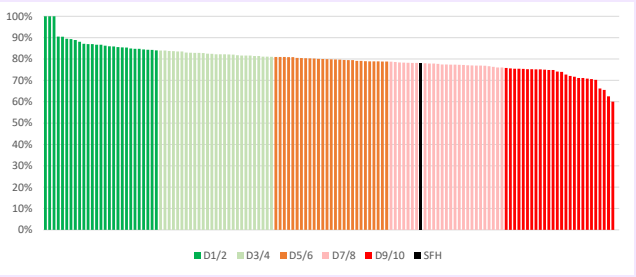
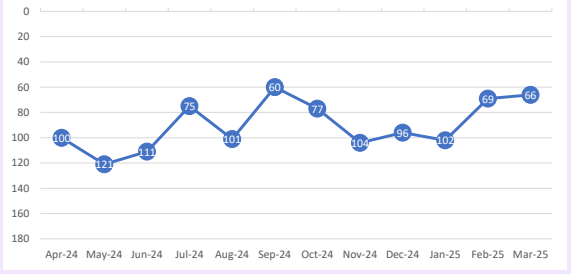


Cancer 31-day treatment performance



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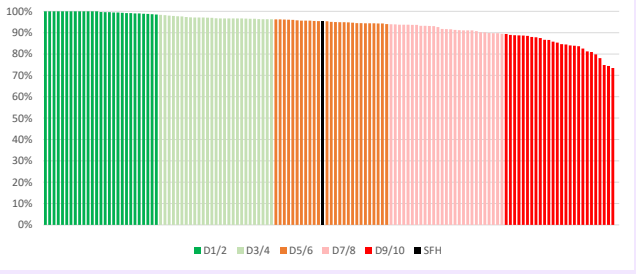
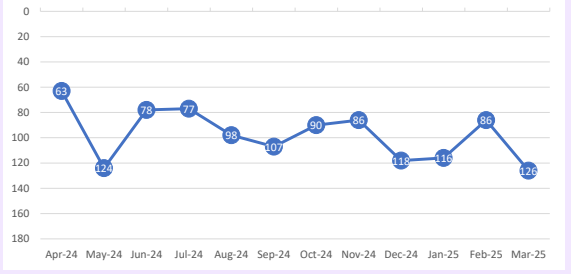


Cancer 62-day treatment performance



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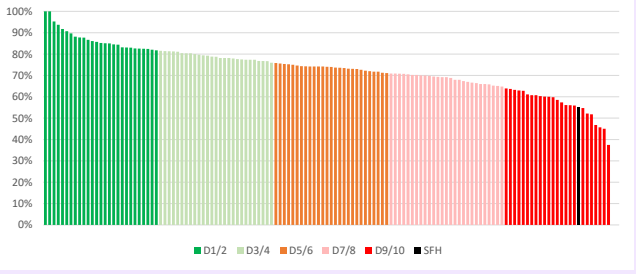

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report (IPR) Annual Review	**Date:**	5 June 2025
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Rachel Eddie, Chief Operating Officer		
Presented By:	Mark Bolton, Associate Director of Operational Performance		

Purpose		
To update Trust Board on the annual review of the Integrated Performance Report (IPR) and seek approval to report on a revised set of indictors which will commence in the next IPR report to Trust Board in August 2025.	**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

Relevant Trust Board sub-committees have reviewed appropriate domains, specifically:

- Finance Committee: Best Value Care
- People Committee: People and Culture
- Quality Committee: Quality of Care and Timely Care.

Acronyms

A&E: Accident and Emergency
BSI: Bloodstream Infection
ED: Emergency Department
HAPU: Healthcare Acquired Pressure Ulcer
IV: Intravenous
PTL: Patient Tracking List
SDEC: Same Day Emergency Care
VTE: Venous Thromboembolism

All other acronyms are defined within the paper.

Executive Summary

An annual review of the Integrated Performance Report (IPR) has been completed. A structured approach has been followed and relevant Executives (and/or deputies) engaged in the process.

The review of the balanced scorecard indicators has considered updated national guidance and priorities including:

- The 2025/26 National Operational Planning guidance
- The 2025/26 NHS Standard Contract (including the quality schedule)
- The 2025/26 NHS Performance Assessment Framework (in draft and in consultation until the end of May 2025 – when this paper was written)
- Any other relevant national or local guidance for the respective domain.

The structure of the IPR is proposed to remain unchanged. The paper details proposed changes to the indicators with the rationale. In summary we are proposing:

- 15 indicators to be added
- 15 indicators to be removed
- 15 indicators to be amended (including metrics to be combined, reframed or targets updated).

Based on all proposed changes being accepted, the number of indicators per domain on the balanced scorecard would be:

- 17 indicators in the Quality of Care domain (previously 17 indicators)
- 14 indicators in the People and Culture domain (previously 13 indicators)
- 15 indicators in the Timely Care domain (previously 21 indicators)
- 11 indicators in the Best Value Care domain (previously 9 indicators)
- 9 indicators in the activity section, which provides supporting context for all of the above domains (remains unchanged).

A sample of the revised balanced scorecard is included in Appendix A of the report.

In 2024/25 we introduced benchmarking data in the timely care domain. In 2025/26 we intend to roll out the benchmarking information further into the other domains where data is available. This will support Trust Board understanding our performance relative to other Trusts in the country.

The final update we are proposing to make is to introduce data quality assurance indicators/kitemark to each metric. Data quality assurance indicators are used to help give context and assurance as to the reliability and quality of the data being used to assess each metric; it is good practice and will identify areas for improvement in our data collection, audit and validation.

Trust Board is requested to:

1. Note the contents of the paper.
2. Agree to the indicator changes detailed in the paper. If agreed, these will be reflected in the 2025/26 report presented to August 2025 Trust Board.
3. Agree to benchmarking data being rolled out across all domains where benchmarking data exists in the public domain.
4. Agree to the introduction of data quality assurance indicators to help give context and assurance as to the reliability and quality of the data being used.
5. Agree to receive further reports on an annual basis.

ANNUAL REVIEW OF THE INTEGRATED PERFORMANCE REPORT (IPR)

JUNE 2025

Sherwood Forest Hospitals Foundation Trust (SFH) undertake a full review of the IPR indicators annually to ensure that they reflect changing guidance and priorities.

The 2025/26 review consisted of a 'sense check' of indicators with each responsible Executive (or their representative) to agree any changes to the IPR indicators for 2025/26. All areas have engaged in the process. Colleagues were asked to review considering:

- The 2025/26 National Operational Planning guidance
- The 2025/26 NHS Standard Contract (including the quality schedule)
- The 2025/26 NHS Performance Assessment Framework (in draft and in consultation until the end of May 2025 – when this paper was written)
- Any other relevant national or local guidance for the respective domain.

The proposed changes to indicators reported in IPR to Board are detailed in the tables below.

Table 1: Indicators to Add

Indicator	Reason for Addition	Lead Director
Number of mental health patients spending over 12 hours in A&E	Part of the draft 2025/26 NHS Performance Assessment Framework.	Chief Operating Officer
Average number of days between planned and actual discharge date	Part of the draft 2025/26 NHS Performance Assessment Framework and referenced in the 2025/26 Operational Plan.	
Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18-weeks	Constitutional standard that has returned to prominence and is part of: (1) the 2025/26 operational plan; (2) the 2025/26 NHS Performance Assessment Framework; and (3) a national quality requirement in the NHS Standard Contract. The target for SFH as set in the 2025/26 Operational Plan is a 5% improvement on Nov-24 position to be delivered by Mar-26. To note: the NHS Standard Contract still references the delivery of 92% at specialty level.	
Percentage of RTT waits over 52 weeks for incomplete pathways	Part of: (1) the 2025/26 Operational Plan; (2) the draft 2025/26 NHS Performance Assessment Framework; and (3) a national quality requirement in the NHS Standard Contract. The target is <1% of total incomplete PTL by Mar-26. This metric will be based on the numerator and denominator which are already included in the IPR (and proposed to be retained).	

Indicator	Reason for Addition	Lead Director
Rate of inpatients to suffer a new hip fracture	Part of the draft 2025/26 NHS Performance Assessment Framework.	Chief Nurse / Chief Medical Officer
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	A national quality requirement in the NHS Standard Contract.	
Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	A national quality requirement in the NHS Standard Contract.	
VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	A national quality requirement in the NHS Standard Contract.	
Time to hire	Nationally, we are now reporting time to hire metrics within the provider workforce return (PWR). This metric is being added to ensure we align our reporting with national reporting. We have only been reporting since Feb-25, so there is not a large amount of data to set a benchmark; however, it is proposed that we use the lower quartile figures from the Corporate Benchmarking exercise (2024/25) which was reported at 53.1 working days as our initial target.	Chief People Officer
Medical job plan Compliance	Nationally, we are reporting job planning compliance metrics within the PWR. National compliance for this metric is 95%.	
Financial surplus/deficit	Part of the draft 2025/26 NHS Performance Assessment Framework. All providers are expected to deliver a breakeven position.	Chief Financial Officer
Risk adjusted efficiency forecast to plan (%)	To provide a view on the risk inherent in the efficiency forecast. This will help the Board to assess the level of confidence in delivery of financial plan, which is part of the draft 2025/26 NHS Performance Assessment Framework.	

Indicator	Reason for Addition	Lead Director
BPPC: • Percentage of bills paid within target (by number) • Percentage of bills paid within target (by value)	Better Payment Practice Code (BPPC) performance is a key cash performance metric measured by NHS England.	Chief Financial Officer
Liquidity: • Operating expenditure days	To better reflect the cash position and risks. Liquidity metrics can be used to assess the Trust's ability to service the costs of its operations and service debts. Operating expenditure days: Measures the number of days of operating expenditure that could be serviced based on the cash (and cash equivalents) balance.	

Table 2: Indicators to Remove

Indicator	Reason for Removal	Lead Director
Proportion (%) of patients admitted via emergency methods or SDEC Direct who were discharged same day	Not referenced in the draft 2025/26 Performance Assessment Framework or the NHS Stand Contract. This metric will continue to be tracked via our Emergency Care Steering Group.	Chief Operating Officer
Mean number of occupied beds for adult patients who have been in the hospital >=21 days (long length of stay)	Not referenced in the draft 2025/26 Performance Assessment Framework or the NHS Stand Contract. This metric will continue to be tracked via our Emergency Care Steering Group.	
Advice and guidance	Not referenced in the draft 2025/26 Performance Assessment Framework or the NHS Stand Contract. This metric will continue to be tracked via our Planned Care Steering Group.	
Proportion (%) of total Outpatient attendances that are first or follow up with a procedure	A new indicator that was introduced during 2024/25 due to it forming part of the 2024/25 Operational Planning guidance. No longer referenced in the 2025/26 guidance nor the draft 2025/26 Performance Assessment Framework or the NHS Standard Contract. Oversight of the metric will take place at the Planned Care Steering Group.	
Incomplete RTT waiting list	Not referenced in the draft 2025/26 Performance Assessment Framework or the NHS Stand Contract. This metric will continue to be tracked via our Planned Care Steering Group.	
Incomplete RTT pathways +52 weeks	Replaced by new indicator 'percentage of RTT waits over 52 weeks for incomplete pathways'.	

Indicator	Reason for Removal	Lead Director
Incomplete RTT pathways +65 weeks	National focus is now on minimising the number of patients over 52-weeks with associated metrics included in the IPR. Local tracking will continue with exception reporting and oversight by the Planned Care Steering Group.	Chief Operating Officer
Incomplete RTT pathways +78 weeks	National focus is now on minimising the number of patients over 52-weeks with associated metrics included in the IPR. Local tracking will continue with exception reporting and oversight by the Planned Care Steering Group.	
Number of patients on the diagnostic DM01 waiting list who have waited >6 weeks at month end snapshots	Board to focus on key Diagnostic DMO1 standard which are referenced in the draft NHS Performance Assessment Framework and the NHS Standard Contract. The number of patients in the backlogs will continue to be tracked locally via weekly reports disseminated to key operational colleagues. Oversight will be maintained by the Planned Care Steering Group and at weekly PTL meetings.	
Cancer 62-day backlog	Board to focus on three key Cancer standards which are referenced in the draft NHS Performance Assessment Framework and/or the NHS Standard Contract. Cancer backlogs will continue to be tracked locally via daily emails to key operational colleagues with a link to a Power BI dashboard. Oversight will be maintained by the Cancer Services Steering Group and at weekly PTL meetings.	
Falls with lapse in care and Falls per 1000 occupied bed days	Not referenced in the draft 2025/26 Performance Assessment Framework or the NHS Stand Contract. New falls metric recommended to be added in alignment with the draft 2025/26 Performance Assessment Framework.	Chief Nurse / Chief Medical Officer
Total workforce loss	Not a focus, as duplicates with sickness absence metric.	Chief People Officer
Cash balance	The reporting of the cash balance provides a snapshot picture but fails to recognise the cash risks and challenges at different times through the month. It is recommended that this indicator is removed and replaced with the new indicators earlier in this report.	Chief Financial Officer
Value weighted elective activity	No longer recommended as an indicator within the Best Value domain, as the value of income will form part of the other financial metrics.	

Table 3: Indicators to Change

Indicator	Details of Change	Lead Director
Percentage of patients waiting ≤4 hours for admission or discharge from ED	Update target to at least 78% by Mar-26 as referenced in: (1) the 2025/26 Operational Planning guidance and (2) the NHS Standard Contract.	Chief Operating Officer
Diagnostic DM01 performance under 6-weeks	Update target to 95% as referenced in the NHS Standard Contract. Previously, we worked to the historic 99% national standard. Ambition remains to deliver as strong performance as possible regardless of target.	
Percentage of patients receiving treatment within 31 days of their diagnosis	Updated target to 96% as referenced in the NHS Standard Contract. Previous tracked against our operational plan. Our operational plan submission for 2025/26 was 96% each month.	
Ecoli blood stream infections; Klebsiella BSI reported in month; and Pseudomonas BSI reported in month	Combine metrics and report as 'gram-negative bloodstream infections' as per the NHS Standard Contract.	Chief Nurse / Chief Medical Officer
Patient Safety Incident Investigations (PSI)	Combine with Duty of Candour as referenced in the NHS Standard Contract.	
Staff engagement	On reviewing the staff survey results for 2024/25, we are suggested we align the standard to the national average (6.9%)	Chief People Officer
Turnover	Align to the NHS performance metrics consultation, where it is being consulted that all trust report 'percentage of NHS Trust staff to leave in last 12 months' (a rolling 12-month reporting period). The proposed target of 10% sits in the range of nationally expected turnover level (between 9-11%).	
Employee relations	Over 2024/25 we have seen an elevated level within our employee relation cases and have sat above our 2023/24 standard (17). We are proposing to uplift the target to 21 for the 2025/26 period. This is in relation to a recognised increase and some volatility around terms and conditions over 2025/26.	
Bank usage	To support the Trust ambition, deliver on financial improvements during 2025/26 and to balance to NHS England planning expectations, we are proposing a bank usage target of 7.8% for the Trust. We have aligned this target to the expected 15% bank reduction.	
Agency usage	To support the Trust ambition, deliver on financial improvements during 2025/26 and to balance to NHS England planning expectations, we are proposing an agency usage target of 1.9% for the Trust. We have forecast to see a 40% reduction to agency usage levels and are proposing the target based on this.	

Indicator	Details of Change	Lead Director
Income & expenditure against plan	Revise wording to 'Variance Year-to-Date to Financial Plan' to align to the draft 2025/26 NHS Performance Assessment Framework.	Chief Financial Officer
Financial Improvement Programme (FIP) against plan	Revise wording to 'Financial Efficiency Variance Year-to-Date to Plan'.	
Implied Productivity 2023/24 v 2024/25	Revise wording to 'Rate of productivity (year on year)' to align to the draft 2025/26 NHS Performance Assessment Framework.	

Within the IPR balanced scorecard we will continue to present an activity section. The activity items are contextual metrics which impact across multiple domains. The activity section will include the following metrics:

- Number of A&E attendances
- Number of non-elective admissions
- Average daily elective referrals
- Outpatients - first appointment
- Outpatients - follow up
- Outpatient - procedures
- Day case activity
- Elective inpatient activity
- Diagnostics activity.

We will not have a specific exception report(s) for the activity metrics; they are contextual information that will support narrative relating to either delivery, or under delivery, against key metrics in the domain reports.

A sample of the key performance indicators proposed to be included in the 2025/26 balanced scorecard is included in Appendix A.

In 2024/25 in the timely care domain, we introduced benchmarking information in both the balanced scorecard and the main report. In 2025/26 we intend to roll out the benchmarking information further into the other domains where benchmarking data is publicly available.

The final update we are proposing to make for 2025/26 reporting is to introduce data quality assurance indicators. Data quality assurance indicators are used to help give context and assurance as to the reliability and quality of the data being used. The standard practice is that a subject matter expert for each indicator will work with colleagues in our information team to assess each indicator against several domains e.g. timely and complete, robust systems and data capture, audit and accuracy, sign off and validation. The outputs of the assessment will be used to identify areas that we need to improve to ensure we have high quality, timely and robust data sources and metrics.

Trust Board is requested to:

1. Note the contents of this paper.
2. Agree to the indicator changes detailed above. If agreed, these will be reflected in the 2025/26 report presented to August 2025 Trust Board.
3. Agree to benchmarking data being rolled out across all domains where benchmarking data exists in the public domain.
4. Agree to the introduction of data quality assurance indicators to help give context and assurance as to the reliability and quality of the data being used.
5. Agree to receive further reports on an annual basis.

Appendix A: Proposed indicator list for 2025/26

At a Glance		Indicator	Standard	Executive	NHS PAF (draft)	NHS Standard Contract	Operational Plan
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	tbc	CN	Y		
		Never events	0	CN/CMO			
		MRSA reported in month	0	CN	Y	Y	
		Cdifficile reported in month	≤13	CN	Y	Y	
		Number of gram-negative bloodstream infections reported in month	tbc	CN		Y	
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care		CN	Y		
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	CN	Y		
		Duty of Candour and Patient Safety Incident Investigations (PSI)		CN		Y	
		Emergency attends who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	tbc	CN/CMO		Y	
		Inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	tbc	CN/CMO		Y	
		Percentage of inpatient Service Users undergoing risk assessment for VTE	tbc	CN/CMO		Y	
	Caring	Complaints per 1000 occupied bed days	≤1.9	CN			
		Compliments received in month		CN			
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	CMO			
		SHMI	≤100	CMO	Y		
		Still birth rate	≤4.4	CN			
		Early neonatal deaths per 1000 live births	≤1	CN			
People and Culture	Belonging in the NHS	Engagement score	≥6.9%	CPO	Y		
	Growing the Future	Vacancy rate	≤8.5%	CPO			
		Time to Hire	53.1 days	CPO			
		Turnover in month	≤10%	CPO	Y		
		Appraisals	≥90%	CPO		Y	
		Mandatory & statutory training	≥90%	CPO		Y	
		Medical Job Plan Compliance	>95%	CPO			
	Looking after our People	Sickness absence	≤4.2%	CPO	Y	Y	
		Flu vaccinations uptake (front line staff)	≥80%	CPO	Y	Y	
		Employee relations management	<21	CPO			
	New Ways of Working	Bank usage	≤7.8%	CPO			
		Agency usage	<1.9%	CPO		Y	
		Agency (off framework)	0	CPO		Y	
		Agency (over price cap)	≤40%	CPO		Y	
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	COO		Y	
		Ambulance delays >60 mins	0	COO		Y	
		ED 4-hour performance	≥78% (by Mar-26)	COO	Y	Y	Y
		ED 12-hour length of stay performance	≤2%	COO	Y	Y	Y
		Number of mental health patients spending over 12 hours in A&E	0	COO	Y		
		Adult G&A bed occupancy	≤92%	COO			Y
		Average number of days between planned and actual discharge date	tbc	COO	Y		Y
		Inpatients medically safe for transfer for greater than 24 hours	≤40	COO			
	Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	COO			Y
		Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18-weeks	≥Plan	COO	Y	Y	Y
		Percentage of RTT waits over 52 weeks for incomplete pathways	≤1%	COO	Y	Y	Y
	Diagnostics	Diagnostic DM01 performance under 6-weeks	≥95%	COO	Y	Y	Y
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	COO	Y	Y	Y
		Cancer 31-day treatment performance	≥96%	COO		Y	Y
		Cancer 62-day treatment performance	≥75% (by Mar-26)	COO	Y	Y	Y
Best Value Care	Financial Performance	Financial surplus/deficit	≥£0.00m	CFO	Y		Y
		Variance YTD to financial plan	≥£0.00m	CFO	Y		Y
	Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	CFO			Y
		Risk adjusted efficiency forecast to plan (%)	100%	CFO			Y
	Variable Pay	Reported agency expenditure		CFO	Y		Y
		Reported bank expenditure		CFO			Y
	Rate of Productivity	Implied productivity growth (YTD compared to last year)	2%	CFO	Y		
	Cash & Liquidity	BPPC - Number of bills paid within target	95%	CFO			Y
		BPPC - Value of bills paid within target	95%	CFO			Y
		Operating expenditure days	≥5	CFO			Y
	Capital	Capital expenditure against plan	≤£0.00m	CFO			Y
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan				Y
		Non-elective admissions	≤Plan				Y
	Electives	Average daily elective referrals					Y
		Outpatients - first appointment	≥Plan				Y
		Outpatients - follow up	≤Plan				Y
		Outpatients - procedures					Y
		Day case	≥Plan				Y
		Elective inpatient	≥Plan				Y
	Diagnostics	Diagnostics	≥Plan				Y

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Board of Directors Meeting in Public - Cover Sheet

Subject:	Post-Winter Plan Debrief	**Date:**	5th June 2025
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Rachel Eddie, Chief Operating Officer		
Presented By:	Mark Bolton, Associate Director of Operational Performance		

Purpose		
To provide Trust Board with a summary of our reflections on winter 2024/25 and the lessons learned that we are incorporating into our planning for winter 2025/26.	**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

Winter Planning Group.

Acronyms

A&E – Accident and Emergency
ED – Emergency Department
GP – General Practitioner
NEL – Non Elective (activity type)
NEWS – National Early Warning Score
PCI – Percutaneous Coronary Intervention
PTL – Patient Tracking List
RTT – Referral To Treatment
SDEC – Same Day Emergency Care
SSU – Short Stay Unit

All other acronyms are defined within the paper.

Executive Summary

The attached pack provides Trust Board with a summary of our reflections on winter 2024/25 and the lessons learned that we are incorporating into our planning for winter 2025/26.

Key messages include:

- **Bed model**: The 2024/25 bed model analysis shows actual bed requirements closely matched forecasted mitigated demand. Variances in August 2024 and March 2025 are explained. We were unable to fully mitigate the forecasted pressures during the peak demand months.
- **Winter reserve**: £1.71m spent between October 2024 and March 2025. Underspend was due to schemes that we did not mobilise (in some cases due to staffing constraints). The underspend of circa £562k was returned to support the Trust financial bottom line.
- **Scheme evaluations**: Four schemes have been identified to be repeated in winter 2025/26. Five schemes are being reviewed as it is felt they could have a positive impact year-round. Two schemes need reviewing and changing for winter 2025/26; and three schemes have been identified not to be repeated.
- **Performance observations**: There was deterioration in headline urgent and emergency care (UEC) key performance indicators over winter as patient acuity increased (to higher levels than the previous winter). Issues over winter centred on challenges in having sufficient beds to admit patients in a timely manner which caused crowding in our Emergency Department (ED) adversely impacting on timely patient care. Curtailments in elective orthopaedic for six weeks presented significant challenges for the specialty including halting the progress in reducing elective long waits. Performance improvements across UEC pathway were seen in March and April 2025 as length of stay reductions for patients over 65 years old freed up hospital beds and allowed more timely flow of patients through and out of our ED.
- **Lessons learned**: Positive lessons learned from 2024/25 include the accuracy of our bed modelling, effective surge plans, and positive clinician feedback on several winter schemes. Challenges include the difficulty in mobilising some schemes; the need for our wards to go ‘two-over’ at peak periods; attendance surges (particularly at Newark Urgent Treatment Centre); and adverse impact on elective orthopaedics caused by their ward being converted to a medical ward during the peak winter period.

Trust Board is requested to comment on the report and be assured that lesson learned will be incorporated into planning for winter 2025/26.

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Winter Plan 2024/25 Reflections

This document describes reflections on winter 2024/25.

Lessons learned are being incorporated into 2025/26 planning.

June 2025

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Contents

- Reflecting on our 2024/25 bed model
- Reflecting on our 2024/25 spend
- Reflecting on our 2024/25 schemes
- Performance observations from winter 2024/25
- Lessons learned from winter 2024/25.

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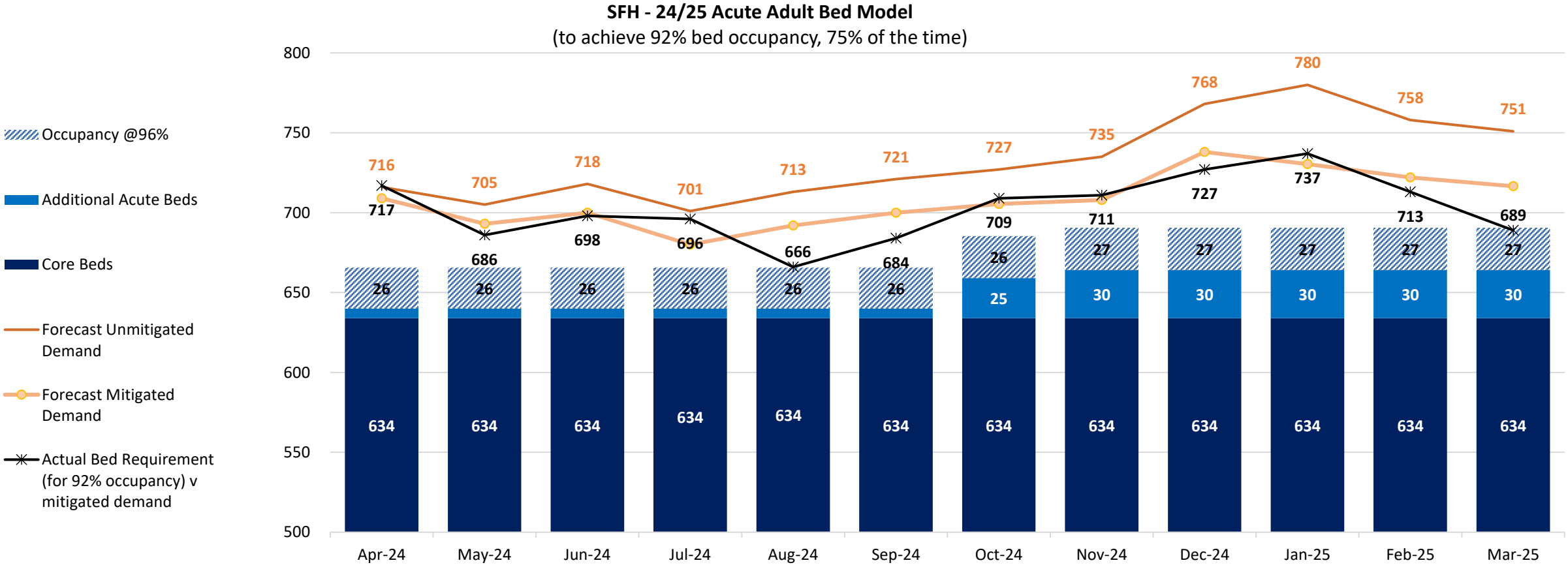
Reflecting on our 2024/25 Bed Model



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.

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 SDEC
     2. Surgical day case overnight use.
  b) Two approved schemes were not mobilised:
     1. Cardiology afternoon 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.

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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; quantitative impact under review before deciding next steps.*
- **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 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.*

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 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. 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. Clinical consideration of the surgical SDEC offer. 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.*

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.
- Emergency Department (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 decision to admit. 12-hour length of stay showed similar seasonality to 4-hours. Improvements in Mar-25 have been seen which were sustained into Apr-25 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.

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. 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 daycase 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 PTL size. 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 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.

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Lessons Learned from 2024/25

What worked well	Areas for improvement
▪ **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 A&E 4-hour performance	▪ 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 'two-over'.** We require additional 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 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 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.

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Board of Directors – Public – Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date:**	5th June 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 6th February:

- Quality Committee: PR1, PR2 and PR5 – March and May (deferred to 2nd June)
- People Committee: PR3 – March and May
- Finance Committee: PR4 and PR8 – February, March, April and May
- Partnerships and Communities: PR6 – April
- Risk Committee: PR7 – February, March, April and May

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 2nd of June Quality Committee meeting, there may be further changes agreed at that meeting that are not on the attached BAF report.

The following statement was included in the cover sheets for lead committees to note at May meetings.

'The BAF audit carried out by 360 Assurance highlighted changes to timescales for some actions.

Committee members are requested to note the resultant audit action of *"Committees to review the actions on the BAF to confirm they are appropriate and timescales for implementation are achievable. Committees to understand the reasons for any significant slippage in the implementation of actions".*'

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
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

Acronym	Description
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): May 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

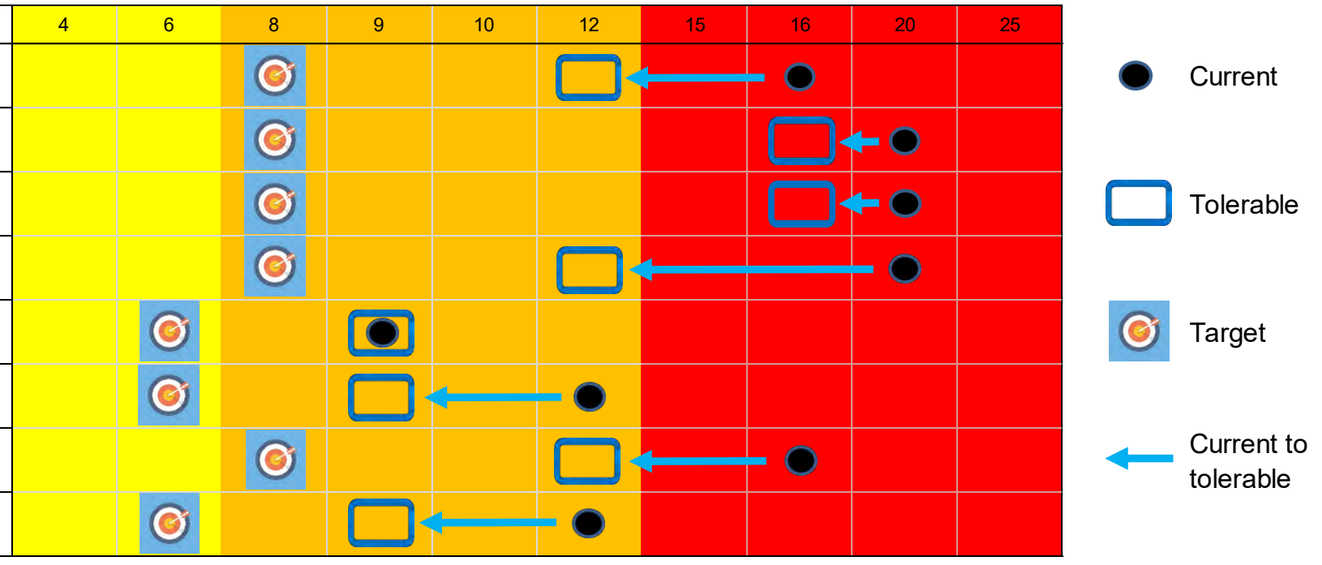
Red = Limited assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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:

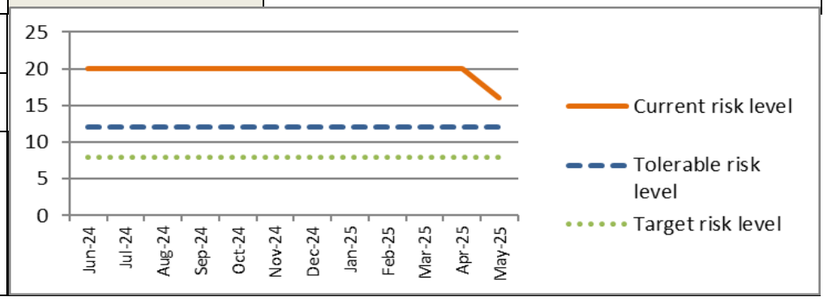
		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Chief Medical Officer Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Chief People Officer	People
PR4	**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**	Acting Director of Strategy and Partnerships	Quality
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Acting 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): May 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						
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**	~~5. Very likely~~ 4. Somewhat likely	3. Possible	2. Unlikely		
Last reviewed	02/06/2025	**Risk rating**	~~20~~16. Significant	**12. High**	**8. Medium**		
Last changed	02/06/2025						

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**
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 ▪ Digital Strategy Group ▪ Enhanced actions to full capacity protocol	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 Inability to re-provide MDT or other outpatients appointments in a timely way, impacting on patient pathway metrics and overall patient care Financial restraints, including the need to reduce bank and agency spend,	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:** Medical Director / Chief Nurse **Progress:** ~~Review completed – developing d~~Dashboard in development, but delayed due to capacity within the Information Services team **Timescale:** ~~February~~ August 2025 Further development and implementation of the UEC improvement plan, tracked through the Patient Safety Committee **SLT Lead:** Medical Director / Chief Nurse **Timescale:** September 2025 Monitoring of fill rates and quality impact **SLT Lead:** Medical Director / Chief Nurse **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 External Accreditation/Regulation annual assessments and reports of: - Pathology (UKAS) - Endoscopy Services (JAG)	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	Moderate Last changed January 2025

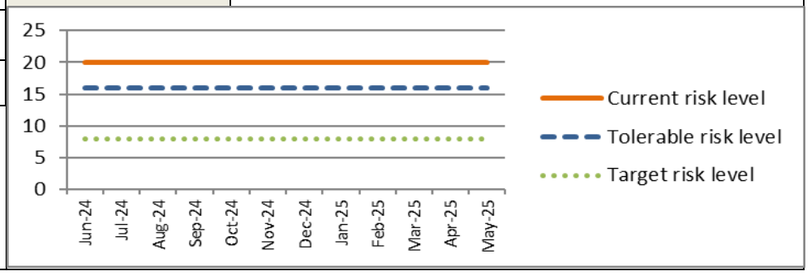
Board Assurance Framework (BAF): May 2025

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
		may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing 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 of bed capacity and conversion of unconventional bed space **SLT Lead:** Medical Director / Chief Nurse **Progress:** Scoping work completed – further discussion at DLT **Timescale:** ~~February~~ 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	- 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:** ~~January~~ May 2025 Communications to staff around the importance of vaccinations **SLT Lead:** Medical Director / Chief Nurse **Timescale:** ~~throughout winter 2024/25~~Complete Review influenza vaccination programme to understand the reasons for low take-up **SLT Lead:** Director of People **Timescale:** August 2025	**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		~~Significant~~ Moderate Last changed ~~November 2022~~March 2025

Board Assurance Framework (BAF): May 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	02/06/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	02/06/2025						

Strategic objective	Provide outstanding care in the best place at the right time



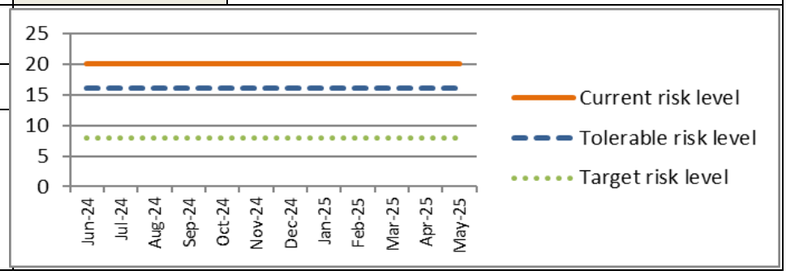
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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	Continuation of March 2024 Emergency Department schemes to support non-admitted breach reduction **SLT Lead:** Chief Operating Officer **Timescale:** ~~throughout Q1 and Q2, and continuing into Q3~~Complete Trial of frailty SDEC co-located within Medical Day Case **Progress:** ~~Part of 2024/25 Winter Plan, opened in November 2024~~Trial evaluation under way and business case being developed for delivery in 2025/26 **SLT Lead:** Chief Operating Officer **Timescale:** ~~March 2025~~Complete Develop a transformation business case for Geriatrics services **SLT Lead:** Chief Operating Officer **Timescale:** July 2025 Undertake an options appraisal to increase bedded capacity **SLT Lead:** Chief Operating Officer **Timescale:** October 2025	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board quarterly; 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 **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 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): May 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, which is showing positive progress in 2024/25 Q1 and Q2	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 2025 Emerging risk of lack of packages of care to meet demand – System conducting a demand and capacity review to inform commissioning	Significant Last changed January 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 Deep dive being undertaken by the ICS into specific identified issues with inequity of same-day GP access	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	Moderate Last changed January 2025

Board Assurance Framework (BAF): May 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							**Strategic objective**	Empower and support our people to be the best they can be
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	27/05/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	27/05/2025								



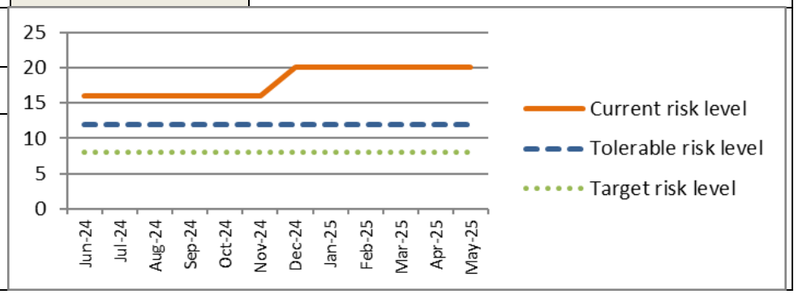
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 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 ~~Inability to achieve the system workforce efficiency programme target~~	Deliver the People Strategy – Year 3 priorities and objectives **SLT Lead:** Director of People **Timescale:** ~~March 2025~~Complete Deliver the 2025-28 People Strategy – Year 1 **SLT Lead:** Chief People Officer **Timescale:** March 2026 Work with provider collaborative colleagues to deliver the Vanguard programme in relation to workforce portability / passporting recruitment KPIs **SLT Lead:** Director of People **Progress:** Pilot ~~for resident doctors commenced in November~~ **Timescale**: ~~March 2025~~Complete Deliver the plan to replace premium pay and agency staff with substantive workforce **SLT Lead:** Director of People **Timescale:** ~~March 2025~~Complete 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	**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 ~~with enhanced controls regarding recruitment and a reduction in bank rates of pay (from 11th November 2024)~~ Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels **SLT Lead:** Director of People **Timescale:** ~~March 2025~~Complete 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 Potential impact of industrial unrest due to the job matching and profile review for Nursing and Midwifery staff Develop a working group to review the profiles and job descriptions **SLT Lead:** Director of People **Timescale:** ~~March 2025~~Complete 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): May 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
		Fragile services, including workforce gaps, in some services/specialties	Develop a Clinical Services Strategy, including an associated workforce plan **SLT Lead:** Chief Medical Officer **Timescale:** December 2025			
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 ~~Concerns over sexual safety in the workplace~~ Influenza vaccination uptake is below target levels	Include actions to address inequalities in staff inclusivity within the new People Strategy **SLT Lead:** Director of People **Timescale:** April 2025 Develop and Implement the Violence Prevention and Reduction action plan **SLT Lead:** Director of People **Timescale:** ~~March 2025~~Complete Revise and implement the Violence Reduction and Prevention action plan **SLT Lead:** Chief People Officer **Timescale:** September 2025 People Promises work taking forward a plan to address sexual safety in the workplace **SLT Lead:** Director of People **Timescale:** ~~March 2025~~Complete Review the influenza vaccination programme to understand the reasons for low take-up **SLT Lead:** Chief People Officer **Timescale:** September 2025	**Management:** Staff Survey Action Plan to Board Apr ~~24~~25; Staff Survey Annual Report to Board Apr ~~24~~25; 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 ~~24~~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 ~~May 24~~ 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 Develop a communications plan to engage the workforce regarding the current financial and operational challenges **SLT Lead:** Chief People Officer **Timescale:** September 2025 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	~~Significant~~ Moderate Last changed ~~September 2024~~March 2025

Board Assurance Framework (BAF): May 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	27/05/2025	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**		
Last changed	27/05/2025						



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	▪ ~~2024/25~~ 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 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 in most divisions~~ ▪ ~~NHSE Financial controls self-assessment completed and working group set up to undertake improvement actions~~ ▪ Financial Resources Oversight Group (FROG) ~~established and~~ meeting monthly ▪ Executive level Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ ~~Weekly 'Grip & Control Arbitration' panels established~~ ▪ Financial Recovery Cabinet (monthly) ~~and Financial Efficiency Review (weekly)~~ meetings ~~established~~	~~Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework~~ ~~Risk adjusted efficiency forecast falls short of the annual target of £38.5m~~ ~~Financial Recovery Plan required to demonstrate a route to a break-even financial position by March 2026~~	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** Finance Strategy ~~presented at January Finance Committee for approval, and to be presented to Board in March~~ approved by Board of Directors in April 2025 **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~March 2025~~Complete De-risking programme under way on all schemes to increase confidence in delivery of the 2024/25 target. **Progress:** ~~Weekly Financial Efficiency Oversight meetings and monthly Financial Recovery Cabinet established. Weekly reports shared with the Executive Team. As of 10th January, risk-adjusted forecast equates to 98.3% of target.~~ 2024/25 Financial Efficiency target delivered in full **SLT Lead:** Chief Financial Officer **Timescale:** ~~Ongoing with a target of December 2024 for a risk-adjusted forecast that meets the target~~Complete Financial Recovery workstreams to be established, plan to be developed and appointments of Associate Director of Financial Recovery and Sustainability to be made **Progress:** ~~Associate Director of Financial Recovery and Sustainability recruited~~ ~~Financial Recovery Plan for Q4 (including difficult decisions list) presented to January Finance Committee~~2025/26 Financial Plan meets the breakeven position required by NHS England **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2025~~Complete Develop a Financial Recovery Plan for 2025/26 **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2025~~Complete	**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 reports to ~~Trust Management Team;~~ 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 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)	Nottinghamshire system selected for NHSE initiated Investigation and Intervention Process (I&I) **Progress:** ~~Phase 2 concluded with close-down report presented to January Finance Committee. SFH evaluation to February Finance Committee.~~ SFH review of I&I process undertaken and presented to Finance Committee in March 2025 **Lead:** Chief Financial Officer **Timescale:** ~~March 2025~~Complete 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. **SLT Lead:** Chief Financial Officer **Timescale:** July 2025	Moderate Last changed January 2025

Board Assurance Framework (BAF): May 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
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 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			**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 Internal Audit on Cash Management scheduled for 2025/26 Q2 **SLT Lead:** Deputy Chief Financial Officer **Timescale:** January 2026	~~Limited~~ Moderate Last changed ~~January~~ May 2025
ICB system financial performance challenge leads to disinvestment in SFH	▪ ~~2024/25~~ 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 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	~~ICB Medium/Long Term Financial Strategy to be developed~~ 2025/26 NHS Standard Contract not yet signed between SFH and ICB	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Update to be provided in November 2024 with timeline for launch to be confirmed~~ Changes in NHS landscape mean that it is unlikely that an ICB level Financial Strategy will be developed in the immediate future **SLT Lead**: Deputy Chief Financial Officer **Timescale:** ~~March 2025~~N/A 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 2025	**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)	Impact of ICS partner financial recovery actions on SFH to be assessed Progress: Increasing prevalence of ICB savings that impact on SFH finances – CEO and CFO taking action to understand and mitigate this risk **Lead:** Chief Financial Officer **Timescale:** ~~Ongoing as recovery actions are developed~~Completed – 2024/25 financial position aligned to plan across the ICS	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 ▪ 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). **SLT Lead:** Chief Financial Officer **Timescale:** June 2025	**Management:** Board approved 2024/25 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	Further Internal Audit of capital expenditure process to be undertaken by 360 Assurance to provide independent assurance. **Lead:** Head of Financial Services **Timescale:** ~~March 2025~~ Completed (Audit report published May-25) Recommendations and actions arising from Capital Internal Audit Report to be completed to agreed timescales. **SLT Lead:** Chief Financial Officer **Timescale:** August 2025	~~Significant~~ Moderate ~~New threat added July 2024~~ Last changed May 2025

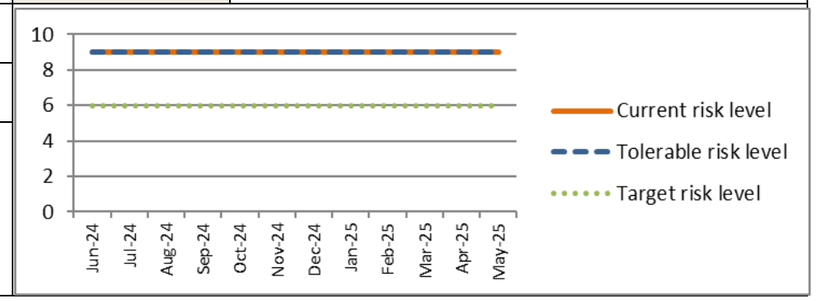
Board Assurance Framework (BAF): May 2025

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**
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 ▪ Weekly Financial Efficiency update report to the Executive Team (and Monthly to Trust Management Team), detailing recurrent and non-recurrent savings ~~▪ Weekly Financial Efficiency Oversight meetings established~~ ▪ Financial Recovery Cabinet in place to support longer-term decision making	~~Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework~~	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Finance Strategy presented at January Finance Committee for approval, and to be presented to Board in March~~ approved by Board of Directors in April 2025 **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2025~~Complete Planning and budget setting principles to be agreed to enable recurrent delivery of schemes currently deemed non-recurrent **Progress:** Completed – 62% of 2024/25 savings translated to recurrent **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~March 2025~~Complete	**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. **SLT Lead:** Chief Financial Officer **Timescale:** July 2025	Significant New threat added July 2024

Board Assurance Framework (BAF): May 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						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	~~Acting Director of Strategy and Partnerships~~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	02/06/2025	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	02/06/2025						

Strategic objective	Continuously learn and improve

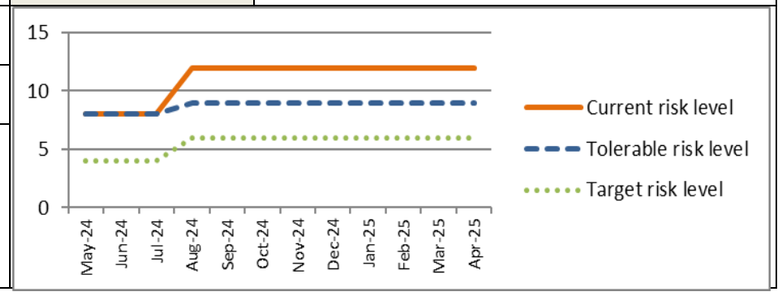


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 ▪ Leadership development programmes - opportunity for Trust leaders to gain improvement skills ▪ Talent management map ▪ Strategy & Partnerships 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 - 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 **SLT Lead:** ~~Acting Director of Strategy and Partnerships~~Chief Medical Officer **Timescale:** ~~February~~ May 2025 Develop and roll out a Continuous Improvement Strategy **Progress:** Paused until the new ~~Improvement Director is in post~~structure is in place **SLT Lead:** ~~Acting Director of Strategy and Partnerships~~Chief Medical Officer **Timescale:** ~~April~~ September 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:** ~~360 assessment in relation to Clinical Effectiveness - report May '22;~~ 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	Moderate Last changed October 2022

Board Assurance Framework (BAF): May 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**						
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	~~Acting~~ 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	15/04/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**		
Last changed	15/04/2025						

Strategic objective	Work collaboratively with partners in the community



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 ▪ 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	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Progress:** Report presented to private Board - approved **Timescale:** ~~February 2025~~Complete	**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): May 2025

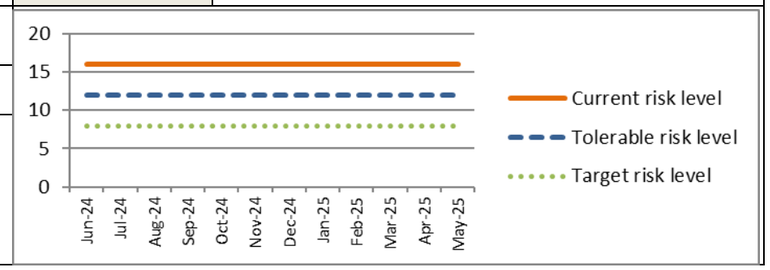
Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to 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
	▪ 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 ▪ 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 ▪ 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	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Progress:** Report presented to private Board - approved **Timescale:** ~~February 2025~~Complete	**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): May 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**
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	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Progress:** Report presented to private Board - approved **Timescale:** ~~February 2025~~Complete	**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): May 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							**Strategic objective** / Provide outstanding care in the best place at the right time
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	13/05/2025	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**			
Last changed	13/05/2025							



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**
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 Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project 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 days of inactivity – disabled after 80 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 ~~360 Assurance~~the IG Team ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead			**Management:** Data Security and Protection Toolkit submission to Board Jul 23- 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 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar24; 360 Assurance Data Security and Protection Toolkit audit Jun 23 – moderate assurance; Cyber Essentials Plus accreditation (NHIS) Dec 23	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		Finalise and issue the Trust Fire Safety Strategy documents **Progress:** Gaps in controls addressed – documents to be considered by the Operational Fire Safety Group in February **SLT Lead:** Chief Financial Officer **Timescale:** ~~February~~ ~~2025~~ Complete	**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:** ~~Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct22) – Substantial Assurance; MEMD ISO 9001:2015 Recertification (3-year) Mar 21; British Standards Institute MEMD Assessment Report Feb 22; External cladding report to Executive Team Jan 24; ARUP Fire Surveys included in Annual Fire Safety report to Risk Committee Apr 24; ARUP Milestone 2 (Fire) Reports issued in draft July 2024 for review~~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. Program is on track due for completion June 2025 **SLT Lead**: ~~Associate~~ Director of Estates & Facilities **Timescale:** June 2025	Moderate Last changed March 2024

Board Assurance Framework (BAF): May 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. ~~Execs briefed on the ARUP findings on 4th September~~. ~~Awaiting final version from CNH following Trust comments.~~ Risk assessment to be updated following further works **SLT Lead**: ~~Associate~~ Director of Estates & Facilities **Timescale:** ~~February~~ June2025	
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:** ~~Industrial Action debrief report to Executive Team Mar 23, and following each subsequent period of industrial action;~~ 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): May 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	27/05/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	27/05/2025								

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:** ~~January 2025~~ June 2025	**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	Car Parking Strategy: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Director of Estates and Facilities **Timescale:** ~~April 2025~~Complete Travel Plan: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Director of Estates and Facilities **Timescale:** ~~April 2025~~Complete	Moderate Last changed December 2023

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Annual Reflection Report - Documents Sealed and Signed (1st April 2024 – 31st March 2025)	**Date:**	5th June 2025
Prepared By:	Rachel Bates, Corporate PA		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal, ensuring transparency and accountability in its application.	**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

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

N/A

Acronyms

None

Executive Summary

This annual reflection report provides an overview of the documents sealed and signed by the Board during the period 1st April 2024 – 31st March 2025. In accordance with Standing Order 10 and the delegated authority in the Scheme of Delegation, the Sherwood Forest Hospitals (NHS) Foundation Trust Official Seal has been affixed to the following documents during the 2024/2025 financial year:

Seal number 115

Between:

Sherwood Forest Hospitals NHS FT, Newark & Sherwood District Council

Details of the contract:

Lease of Car Park, Bowbridge Road, Newark Hospital

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 25th April 2024

Seal number 116

Between:
Sherwood Forest Hospitals NHS FT, Nottinghamshire County Council

Details of the contract:
Lease of Car Park, Northfield Road, King's Mill Hospital

Signed/Sealed by the Chief Executive and Director of Corporate Affairs
Dated 7th May 2024

Seal number 117

Between:
Sherwood Forest Hospitals NHS FT and Central Nottinghamshire Hospitals PLC

Details of the contract:
Deed of Variation in respect of the PFI Soft FM Market Testing

Signed/Sealed by the Acting Chief Executive and Chief Financial Officer
Dated 30th September 2024

Seal number 118

Between:
Sherwood Forest Hospitals NHS FT and Principal Supply Chain Partner (Kier)

Details of the contract:
P22 FA Template A: Major Work Project Stage 4 Contract (Mansfield Community Diagnostic Centre)

Signed/Sealed by the Chief Financial Officer and Witnessed by the Acting Chief Executive
Dated 7th October 2024.

Seal number 119

Between:
Sherwood Forest Hospitals NHS Trust and Nottingham University Hospitals Trust

Details of the contract:
Dialysis Unit Lease (Renewal)

Signed/Sealed by the Chief Financial Officer and Director of Corporate Affairs
Dated 22nd January 2025.

The Board is asked to **NOTE** the use of the Trust Seal.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Application of Trust Seal	**Date:**	5th June 2025
Prepared By:	Rachel Bates, Corporate PA		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal in the period since the last report to the Board on 3rd March 2025, ensuring transparency and accountability in its application.	**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

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

N/A

Acronyms

None

Executive Summary

In accordance with Standing Order 10 and the delegated authority in the Scheme of Delegation, the Sherwood Forest Hospitals (NHS) Foundation Trust Official Seal has been affixed to the following documents:

Seal number 120

Between:

Sherwood Forest Hospitals NHS Trust and Kier Infrastructure and Overseas Ltd

Details of the contract:
Kings Mill MRI Unit (SFHT) P220213.02

Signed/Sealed by the Acting Chief Executive and Director of Corporate Affairs
Dated 15th April 2025.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Provider Licence Self Certification declaration	**Date:**	5th June 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
The Board is asked to confirm in the public domain that the annexed Self-certification declaration required under Condition 7 of the Provider Licence (Continuity of Services condition – Availability of Resources) has been approved and signed by the Chair and Acting Chief Executive and note its publication on the Trust website.	**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					

Identify which Principal Risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
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

May 2024 Board in public

Acronyms

CoS – Continuity of Service

Executive Summary

The Trust holds a provider licence which forms part of NHS England (NHSE) oversight arrangements for NHS providers. Updates to the provider licence were made by NHSE with effect from April 2023 to reflect changes to the statutory and operating environment, including the shift of emphasis from economic regulation and competition to system working and collaboration. At the same time the application of the provider licence was also extended all NHS provider trusts.

In updating the licence, the requirement for licensees to self-certify against a number of specific licence conditions and the requirement to prepare a Corporate Governance Statement were removed. The new licence has, however, retained the requirement to self-certify against condition CoS7 (Availability of Resources).

The Board is expected to make a self-certification, not later than two months from the end of the financial year (i.e.by the end of May), as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate. The form of this certification must

be one of the three options - (a), (b) or (c) – specified under CoS7 and set out in the declaration that comprises the attachment to this paper. In making its certificate the Board is required to describe the main factors it has considered.

Exceptionally, it was necessary to bring this item to the meeting of the Board held in private on 1st May 2025 for decision, and at the same time agreed that it would be presented to the next meeting of the Board in public in June 2025 for noting.

This was necessary as a consequence of the Board's recent agreement to move from monthly to bi-monthly public meetings, as a consequence of which it was necessary to re-allocate items on the Board workplan. The need for a Board decision on this self-certification requirement had to be made in May this year, but in future it has been allocated to the April Board meeting held in public.

At its May 2025 meeting held in private, the Board agreed with the recommended that statement (a) be made to align with conclusions drawn from the going concern assessment process reported within the Trust's 2024/25 Annual Report and Accounts as presented to the Audit Committee on 17th April 2025. This states:

(a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

The Trust has subsequently published its self-certification, signed by the Chair and Acting Chief Executive, on its website and retained copies for record keeping purposes, noting there is no longer a requirement to submit them to NHSE. A copy of the completed self-certification is appended to this paper for information.

The Board is asked to note that from 2026 the Provider Licence self-certification item on its Workplan has been re-scheduled from May to the April meeting of the Board in public, following the recent decision to move to bi-monthly public Board meetings. Hence the presentation of this item to the private Board in May 2025 was a one-off, solely to enable the timetable to be met.

RECOMMENDATION

That the Board is **ASSURED** that following its approval of the self-certification against Provider Licence condition CoS7 (Availability of Resources) at its meeting in private in May 2025, it has been signed by the Chair and Acting Chief Executive and published on the Trust website and has therefore met the requirements to do so by the end of May 2025.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions CoS7

Sherwood Forest Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "CoS7"

Financial Year to which self-certification relates 2024/2025

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 Continuity of services condition 7 - Availability of Resources (designated CRS only)

EITHER:

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — **Confirmed**

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Going Concern Statement within the draft Accounts for 2024/25 agreed by the Audit Committee 17 April 2025
Operational and Financial Plan 2025/26 approved by the Board and submitted in line with NHSE timescale requirements 3 April 2025
2024/25 Capital Expenditure Plan approved by the Board 4 July 2024
Enhanced financial management oversight including via Financial Recovery Cabinet and Vacancy Control Panel
Annual Governance Statement 2023/24
External Well Led Reviews 2021 and 2024
Board Committee Terms of Reference and Workplans
Board Assurance and Governance Frameworks
Risk Management processes

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Graham Ward	**Name**	David Selwyn
Capacity	Chair	**Capacity**	Acting Chief Executive
Date	01 May 2025	**Date**	01 May 2025

Further explanatory information should be provided below where the Board has been unable to confirm declarations.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Audit and Assurance Committee Chair's Highlight Report to Board

Subject:	Audit and Assurance Committee	**Date:**	17th April 2025
Prepared By:	Andrew Rose–Britton, Vice-Chair of Audit and Assurance Committee		
Approved By:	Manjeet Gill		
Presented By:	Manjeet Gill		
Purpose:			
Assurance report to the Trust Board of Directors following the Audit and Assurance Committee meeting on 17th April 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Draft accounts 2024/25 projected figures showing a £0.01m surplus on a control total basis for the Trust compared to recently projected end of year loss. Vaccine Programme loss £34.4K.	External Auditors to start final audit in week commencing 21st April with audited accounts to be presented for final Board approval in June 2025. Preparation of the Quality Account continues.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Internal Audit Progress Report. Interim Head of Internal Audit Opinion. Draft Annual Accounts. IFR17 update confirmed with no likely exposure. Valuation Process and Assumptions. Draft Trust Annual Report, including AGS Preparation is progressing. Losses and Special payments noted, including arising from the Vaccine Programme. No Conflict-of-Interest Breaches reported.	Draft annual accounts approved for submission in line with the national timetable. Chair given delegated power to approve the final amendments to the Committee's Annual Report to Board of Directors. Agreement to continue to adopt the going concern basis in preparing the accounts.
Comments on effectiveness of the meeting	
Good discussion on agenda items and very productive meeting.	

Items recommended for consideration by other Committees
Draft Annual Accounts 2024/25 to Finance Committee.
Progress with Actions
Please answer the following regarding progress on actions: Number of actions considered at the meeting - 12 Number of actions closed at the meeting – 8 Number of actions carried forward - 4 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.

Annual Report from the Audit and Assurance Committee – 2024/25

1. Summary

This report provides an overview of Audit and Assurance Committee activities undertaken throughout the Trust between April 2024 and March 2025. For assurance, the committee has carried out its obligations in accordance with its Terms of Reference and work programme.

The key aims are to enhance confidence in the integrity of the Trust's processes and procedures relating to governance, risk management and internal control, and corporate reporting.

These aims are put into practice by:

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities
- Reviewing management's independent assurance provider reports on the effectiveness of systems for internal financial control, financial reporting and risk management
- Ensuring that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards
- Reviewing the work and findings of the External Auditor appointed by the Governors and consider the implications and management's responses to their work

2. Background

The Audit and Assurance Committee meets bi-monthly and reports to the Board of Directors.

The Committee's membership is set out below:

- Three Non-Executive Directors, one of whom is nominated as Chair and one as Vice Chair. The Chair of the Committee is appointed by the Board of Directors. The Chair of the Trust shall not be a member of the Committee.

In routine attendance:

- Chief Financial Officer (and/or Deputy)
- Director of Corporate Affairs
- Internal Auditors
- External Auditors
- Local Counter Fraud Specialist
- Risk and Assurance Manager

The committee determines operational attendees as required to fulfil its work programme.

3. Work Programme

The Committee reviews reports throughout the year in accordance with its approved Terms of Reference and work plan. These include Counter Fraud, Internal Audit, External Audit, Risk & Compliance and Management, and undertakes an annual health check / self-assessment.

At each meeting, a highlight report from the Risk Committee is received. This outlines items of concern and for escalation, including emerging risks and horizon scanning, from reports received by the Risk Committee.

The Committee also receives the Board Assurance Framework twice per year, to gain assurance of the review process.

4. Meetings

The Committee meets bi-monthly, plus an extraordinary meeting to review the draft annual accounts, and 7 meetings were held during the period covered by this report. All meetings were quorate.

Attendance of members and regular attendees (or a nominated deputy) at meetings during the period covered by this report is detailed below:

Name	Actual	Possible
Graham Ward	1	1
Manjeet Gill	6	7
Andrew Rose-Britton	5	7
Steve Banks	5	7
Neil McDonald	1	1
Richard Mills	7	7
Sally Brook Shanahan	6	7
Internal Audit	7	7
External Audit	7	7
Counter Fraud	5	5

5. Committee effectiveness review

The committee carried out an effectiveness review which was reported in July 2024. It is based on the National Audit Office (NAO) self-assessment checklist for audit committees and is divided into 5 sections:

- Roles and responsibilities
- Membership and independence
- Skills and experience
- Scope of work
- Communication

The self-assessment tool reviews governance arrangements, checks appropriate systems are in place and identifies areas for improvement. Evidence to support the assessment was reported with no actions required. This is an annual standing item on the work plan.

6. Areas of focus

The Committee's objectives for 2024/25 were:

- Maintain the review and control processes currently in place, including a strengthened focus on internal audit actions implementation tracking and improving the implementation compliance rate
    - This has been achieved by further scrutiny of progress on audit actions and the Committee maintaining oversight of processes
- Maintain focus and review of the compliance rate of the Register of Interests and timely reviews of non-clinical policies
    - The Register of Interests report is a standing item on the Committee agenda for each meeting – there is evidence of significant improvement in compliance across the Trust and strengthened processes and procedures to address non-compliance
- Maintain oversight of Integrated Care System updates pertinent to the Trust and gain assurances from the ICB sub-committees
    - 'Integrated Care System update' is a standing agenda item for each Committee meeting

- Ensure the alignment of trust internal control processes with the outcomes of the Hewitt report on governance within Integrated Care Systems
    - Relevant controls are in place with the development of the Partnerships & Communities Committee, and the role including “assess key updates from strategic forums in the System”, “analyse gaps in partnerships arrangements and propose options for solutions” and “assess the impact of the Provider Collaborative at Scale and monitor the effectiveness of the Trust’s response”
- Ensure Trust alignment of governance processes relating to provider collaboratives and other strategic partnerships
    - The Partnerships & Communities Committee is progressing and developing partnerships to contribute to delivery of the Trust strategic objectives and to assess the priorities and benefits from strategic partnerships

The Committee’s objectives for 2025/26 are:

- Maintain oversight of Integrated Care System updates pertinent to the Trust and ensure alignment of the Trust's governance processes with system working
- Ensure the alignment of trust internal control processes with the outcomes of the Hewitt report on governance within Integrated Care Systems
- Ensure Trust alignment of governance processes relating to provider collaboratives and other strategic partnerships
- Ensure the Trust’s alignment of governance processes, strategies and controls relate to the national operational planning frameworks for 25/26 and the ten-year plan for the short and medium term
- Ensure the Trust’s governance processes and controls provide adequate oversight of the financial position, ensuring the Trust's plans adequately address financial sustainability and take into account national directions regarding productivity and other specifics as directed

7. Matters for escalation

The Audit and Assurance Committee Chair provides a highlight report to the Board of Directors. This provides items for escalation, areas of positive assurance, work commissioned, and decisions made, including:

Matters of Concern or Key Risks:

- First follow up implementation rate of Internal Audit actions
- Concern about capacity to deliver the Trust Strategy, improvements and innovation
- Fracture Liaison Database – further assurance is sought via Quality Committee
- Updates to the Standing Financial Instructions and Scheme of Delegation - increase in value of petty cash from £100 - £150 and delegated authority limit from £1m to £1.25m
- Mental Capacity Act and Deprivation of Liberty Safeguards (Limited Assurance Audit Report) - the level of ongoing and visible assurance to Board considering the ongoing risks to patients and Trust
- Letter received from the CEO of the ICS describing the current uncertainty, including the potential risk of being unable to meet its statutory duties, the need for clarity on the roles of ICSs is required
- External Audit Plan 2024/25 - one significant risk identified about sustainability
- Single Tender Waivers - challenges raised: the £800K value of STWs; mitigating urgent requests; challenges of both the ADU and print contracts

Positive Assurances:

- 2023/24 Internal Audit Annual report (including Head of Internal Audit Opinion) - Significant Assurance from Internal Audit
- 2023/24 Counter Fraud Annual report - compliance in all key areas
- 2023/24 Annual Audited Accounts, including the Management Representation Letter and The Going Concern Assessment
- Draft Annual Report and Annual Governance Statement (AGS) preparation

- Register of Conflicts of Interest - assurance received on the process and that no breaches had been identified
- Timely renewal of non-clinical Trust policies
- Due diligence processes for contract management, procurement and single tender waivers
- 'No Purchase Order No Pay' process
- Medicines stocktake and process for control
- Losses and Special payments, with assurance on how to improve debt collection and prevent debt
- 2023/24 Data Security Protection Toolkit - assessment by 360 Assurance provides substantial assurance
- Risk Committee quadrant reports - good assurance overall noting the substantial assurance from the work around Digital risk management, in particular
- Counter Fraud and Internal Audit Progress Reports
- Progress on implementation of Internal Audit actions
- Preparation of the Quality Account is on track
- Internal Audit Reports providing Significant assurance

Decisions Made:

- The updates to the Standing Financial Instructions and Scheme of Delegations were approved and a recommendation agreed for them to be ratified by the Board of Directors
- Standing Orders approved
- Final 2023/24 Annual Report (including the Annual Governance Statement) approved and recommended to Board for approval
- Final 2023/24 Quality Accounts approved and recommended to Board for approval
- 2024/25 Internal Audit Plan approved replacing Theatres Scheduling Review with Automated Information Reporting
- 2025/26 Annual Counter Fraud Plan approved subject to inclusion of the CF Functional Standard
- 2025/26 Annual Internal Audit Plan approved
- 2024/2025 Accounts External Audit Plan approved
- Escalate the Mental Capacity Act and Deprivation of Liberty Safeguards assurance concerns to Board
- Committee Maturity Assessment Action Plan approved
- Committee Effectiveness Self-Assessment approved
- Committee Terms of Reference approved
- Committee Workplan approved
- Committee Annual Report to Board of Directors approved subject to final sign off by the Committee Chair
- Stock Management Policy approved
- Losses and special payments noted and approved
- Single Tender Waivers agreed

8. Conclusion

The Committee self-assessments of compliance with Terms of Reference, the review of effectiveness, the robust work programme and escalations to the Board of Directors provide assurance that the Committee continues to be effective in discharging its responsibilities.

The Committee has discharged its responsibilities for in relation to oversight of internal controls, governance and risk management systems.

Manjeet Gill

Audit and Assurance Committee Chair

April 2025

Outstanding Care,
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Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:**	5th June 2025
Prepared By:	Graham Ward – FC Chair		
Approved By:			
Presented By:	Andrew Rose-Britton – FC Vice Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee meetings of 27th May 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• Month 1 Financial Position (to NOTE) – Month 1 showed a deficit of £900K which was on plan. It was noted though that FIP delivery was only £1.4M against a plan of £2.2M. • Financial Planning (to NOTE) – ICB have commissioned a third party to undertake a rapid assessment of efficiency plans across the system. • Committee Membership (for ACTION) – Need to consider appropriate executive participation in committees to ensure triangulation.	• FIP Programme – further work continues on the FIP programme, including understanding of workforce, with regular reporting back to the Committee. • PFI – Hard FM performance continues to be an issue and delays to finalising the settlement agreement due to issues raised by the PFI Provider. Work is ongoing to resolve these issues. • PFI Accounting Treatment – Independent review underway and a report on their findings will be presented to this committee and Audit Committee.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• NHIS – Noted the performance and financial outturn position for the last quarter of 2024/25. • Month 1 Finance Report – Noted and welcomed the new format for the report. • Cash Management Plan – Noted that the position is very tight and requires FIP delivery to be cash releasing. Agreed to circulate the Treasury Management Policy and the Cashflow / Payments and Reporting Operational Procedure to the rest of the Board for awareness and triangulation (please see attached).	• EPR : o Acknowledged EPR Full Business Case approval process and progress made. o Approved the Automated Testing solution (subject to funding through the EPR FBC) o Recommended Data Migration and Archiving to Board for approval (subject to funding through the EPR FBC) • Capital Plan – Agreed to recommend for approval by Board. • BAF – Agreed to hold risk scores for PR4 (Finance) and PR8 (sustainability) at 20 and 12 respectively.

• Procurement Forward View – Noted and agreed to develop new format further with details of how VFM will be achieved. • Sustainability – Noted the report and the issue of lack of progress on the potential additional car parking area with the Council. • National Cost Collection – Noted the timetable and progress to date.	

Comments on effectiveness of the meeting

All papers were of a high quality and clear which helped the meeting run smoothly and promoted good constructive challenge and discussion.

Items recommended for consideration by other Committees

- Audit Committee – to receive Grant Tornton report on the PFI accounting treatment when received.

Progress with Actions

Number of actions considered at the meeting – 15
Number of actions closed at the meeting – 13
Number of actions carried forward – 2
Any concerns with progress of actions – No

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

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Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	Monday 2nd June 2025
Prepared By:	Barbara Brady, Non-Executive Director/Chair		
Approved By:	Barbara Brady, Non-Executive Director/Chair		
Presented By:	Barbara Brady, Non-Executive Director/Chair		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
- Discussion held around the concerns about the quality safety agenda. This is to mitigate by the increase in frequency of QC meetings to monthly. - Issues noted with Data Quality and capacity and resources available to allow for processing of data into meaningful intelligence.	- Deep dive into Stroke SSNAP audit to be carried out and presented through PSC and up to QC. Timescale to be determined.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Moderate assurance taken in relation to the 360 Assurance report into the Patient Tracking List and Data Quality. Actions underway in relation to updating policies and addressing inaccuracies and risks. Actions to be tracked via the Audit & Assurance Committee. - Positive assurance taken from the Mortality and figures being in the 'expected' range for HSMR+ and SHMI. - Positive assurance taken from the End-of-Life Annual Report. - Positive assurance taken from the Medicines Optimisation Annual Report. - Positive assurance taken from the Radiation Safety Committee Annual Report. - Assurance provided against the IPR Reports for Timely &	- HSMR metrics to be removed from the IPR following discussion and proposals APPROVED going forward. - The Committee APPROVED the final draft of the Quality Account. - The Committee APPROVED the Quality Strategy and noted updates for the end of year positions. - BAF- The Committee APPROVED the reduction of the risk score for PR1 under current exposure to 16 (significant), with a further review in Winter. The Committee APPROVED PR2 with no changes to the current risk level. The Committee APPROVED PR5 with no changes to the current risk level. - The Committee APPROVED the change in frequency of meetings to monthly from July 2025.

Quality Care with the annual review. - Positive assurance taken from PSC, NMAHP and Perinatal Assurance Committee Reports. - Assurance provided against the Quality Impact Assessment Process.	- The Committee APPROVED the Quality Committee Effectiveness Review.

Comments on effectiveness of the meeting

Positive meeting held, with comprehensive reports provided, prompting a good level of discussion and challenge. Following discussions, Teams attending QC for reporting are to be coached in delivery of reports to ensure key concerns are discussed and allow more time for meaningful discussion and questions. A template for reporting to be considered to assist with this.

Items recommended for consideration by other Committees

NA

Progress with Actions

Number of actions considered at the meeting - 1
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 –

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People Committee Chair's Highlight Report to Board

Subject:	Chair's Report	**Date:**	27th May, 2025
Prepared By:	Steve Banks Non Executive Director		
Approved By:			
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**
Impact of financial challenges for 25/26 on staff and patient care, and risk to hitting WTE targets. Risk of Industrial action Headroom to deliver Leadership Development training	Leadership development offer availability increased for 25/26 following positive impact Workforce transformation detailed tracking and planning
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
There was much positive assurance provided including: Staff survey action planning Equality, diversity and inclusion annual report Deep dive into anaesthetics staffing Annual Volunteers report and strategy Medical people training and education update People promise progress	People Strategy for 2025 – 2029 approved following delegated authority from Board. Now includes enabling strategies to support the overall trust strategy, an increased focus on productivity and support required for colleagues during transformational change IPR changes to measures for 25/26 agreed to go to Board for approval BAF discussed; actions up to date and risks and assurance levels remain as is, but assurances and mitigations updated

Comments on effectiveness of the meeting
No observer present, but papers were of good quality, as was the debate
Items recommended for consideration by other Committees
Finance Committee with regard to workforce numbers, Quality Committee with regard to Quality Impact Assessments of staffing changes

Progress with Actions
Number of actions considered at the meeting - 6 Number of actions closed at the meeting – 6 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

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

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Partnership and Communities Committee Chair's Highlight Report to the Trust Board of Directors

Subject:	**Partnership and Communities Committee**	**Date:**	15th April 2025
Prepared By:	Barbara Brady, Non-Executive Director/Chair		
Approved By:	Barbara Brady, Non-Executive Director/Chair		
Presented By:	Barbara Brady, Non-Executive Director/Chair		
Purpose:			
Assurance report to the Trust Board of Directors following the Partnership and Communities Committee meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Period of significant national policy change relating to partnership working. Implications for SFHT not yet fully understood but likely to have profound impact. Ongoing concern regarding visibility and evidence of QIA undertaken within the system but that have implications for SFHT, links to ICB commissioning intentions	Ongoing development of the Health Inequalities index Partnership plan for year 2 (although this may be subject to change due to current partnership volatility) Implementation of partnership Evaluation Plan
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Ongoing development of the Health index Review of progress against year 1 plan highlights positive developments in: Working with West Notts College GP/SFHT interface work Health inequalities	Annual statement of Health inequalities BAF, PR6, no change at present (this agenda is subject to volatile working context and currently this is being worked through) Revised Terms of Reference and annual report
Comments on effectiveness of the meeting	
Good quality papers and discussion. Good to have attendance of new Public Health registrar	

Items recommended for consideration by other Committees

Clinical implication of health inequalities work to be considered at Quality committee

Progress with Actions

Please answer the following regarding progress on actions:

Number of actions considered at the meeting - 3
Number of actions closed at the meeting – 2
Number of actions carried forward - 1
Any concerns with progress of actions –No
If Yes, please describe –

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

Annual Report from the Partnerships and Communities Committee – January to December 2024.

1. Summary

This report provides an overview of Partnerships and Communities Committee activities undertaken throughout the Trust between January and December 2024. For assurance, the committee has carried out its obligations in accordance with its Terms of Reference and work programme.

The key aim of the Committee is to give assurance to the Board that the Trust is progressing and developing its partnerships to contribute to delivery of its Improving Lives strategy.

These aims were put into practice by:

- Assessing the priorities and benefits of strategic priorities
- Analysing gaps in partnerships arrangements and proposing actions for solutions
- Receiving, refining and reviewing the Trust's partnership plan and oversee its implementation
- Assessing the impact of provider collaboratives and monitoring the effectiveness of the Trust's response
- Monitoring the effectiveness of the Trust's role as an anchor organisation
- Monitoring and reviewing Principal Risk 6
- Receiving and assessing key updates from strategic forums in the health and care system
- Championing those aspects of its strategy that are executed through the Trust's strategic partnerships

2. Background

The Partnerships and Communities Committee meets quarterly and reports to the Board of Directors. Its Terms of Reference establish that its role is to provide assurance to the Board that the Trust is progressing and developing partnerships to contribute to delivery of the Trust strategic objectives and to assess the priorities and benefits from strategic partnerships.

The Committee's membership is set out below:

- Three Non-Executive Directors, one of whom is nominated as Chair and one as Vice Chair. The Chair of the Committee is appointed by the Board of Directors.

In routine attendance:

- Chief Executive
- Medical Director
- Director of Strategy and Partnerships
- Associate Director of Strategy and Partnerships
- Specialist Advisor to the Board
- Two Governor observers

The committee determines operational attendees as required to fulfil its work programme.

3. Work Programme

The Committee reviewed reports throughout the year in accordance with its approved Terms of Reference.

These included assurance updates on:

- outcomes from the partnership delivery plan (every meeting)
- outcomes from the anchor organisation plan (6-monthly)
- impact of provider collaboratives (every meeting)

It reviewed and approved the Partnerships Strategy 2024-2029.

The committee also received:

- chairs' reports from the Strategy and Partnerships Cabinet and the Health Inequalities Steering Group
- updates on the Nottingham and Nottinghamshire Integrated Care System strategy and Joint Forward Plan refresh
- a briefing on Mid Notts population health data
- the annual statement of health inequalities 2023/24

It also undertook an annual health check/self-assessment.

4. Meetings

The Committee met five times during 2024. All meetings were quorate.
The frequency of meetings was reviewed at the August Committee and changed from bi-monthly to quarterly.

Attendance of members and regular attendees (or a nominated deputy) at meetings during the period covered by this report is detailed below:

Name	Actual	Possible
Non-Executive Director - Committee Chair	4	5
Non-Executive Director - Deputy Committee Chair	4	5
Non-Executive Director	4	5
Director of Strategy and Partnership / Acting Director of Strategy and Partnership	4	5
Specialist Advisor to the Board	3	5
Chief Executive Officer / Acting Chief Executive Officer	5	5
Medical Director / Acting Medical Director	5	5
Associate Director of Strategy and Partnerships	4	5

{The committee is supported by the Strategy and Partnership Cabinet which meets bi-monthly prior to meetings of the formal Partnerships and Communities Committee to address actions raised in the committee.}

5. Committee effectiveness review

The committee carried out an effectiveness review which was reported in January 2025. It is based on the National Audit Office (NAO) self-assessment checklist for audit committees and is divided into 5 sections:

- Roles and responsibilities
- Membership and independence
- Skills and experience
- Scope of work
- Communication

The self-assessment tool reviews governance arrangements, checks appropriate systems are in place and identifies areas for improvement. Evidence to support the assessment was reported with no actions required. This is an annual standing item on the work plan.

6. Areas of focus

The Committee was established in November 2023. Areas of focus during 2024 were:

- Partnerships – the Trust's new Partnerships Strategy was reviewed and approved in January 2025 with four key workstreams
- Population health and health inequalities – overseeing delivery of the Trust's health inequalities plan, receiving an update on population health in Mid Nottinghamshire, endorsement of priorities for 2024/25 and receiving the first Annual Statement of Health Inequalities
- Provider collaboratives – strengthening the Trust's impact on and benefits from its provider collaboratives and other clinical partnerships
- Anchor activities – monitoring the benefits from anchor activities including increased volunteering, local employment opportunities and sustainability

7. Matters for escalation

The Partnerships and Communities Committee Chair provides a highlight report to the Board of Directors. This provides items for escalation, areas of positive assurance, work commissioned, and decisions made, including:

- Ongoing challenge of resources required to support partnership work and the needed to constantly prioritise work.
- Insufficient capacity to engage with external partnerships is challenging and requires continual review and prioritisation. In particular this is the case of the Health Inequalities agenda and fragile services.
- Ongoing focus on financial situation within SFHT has meant work on partnerships is not prioritised.
- Concerns regarding the terms of reference for various partnership forums potentially overlapping causing inefficiencies and confusion.
- Insufficient capacity to engage with external partnerships is challenging and requires continual review of prioritisation, in particular the Health Inequalities and fragile services.
- Opportunity cost within SFHFT has meant work on partnerships is not prioritised.
- Concerns regarding multiple workstreams with similar themes for various partnership forums potentially duplicating work and clarity of purpose.

8. Conclusion

The Committee self-assessments of compliance with Terms of Reference, the review of effectiveness, the robust work programme and escalations to the Board of Directors provide assurance that the Committee continues to be effective in discharging its responsibilities.

Barbara Brady

Partnerships and Communities Committee Chair

January 2025

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Charitable Funds Operational Group Chair's Highlight Report to Charitable Funds Committee

Subject:	Charitable Funds Committee update	Date:	5th June 2025
Prepared By:	Andrew Rose-Britton		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose:			
To provide an overview of the key discussion items from the Charitable Funds Committee on 22nd April 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
EOL single tender waiver. SFH Lottery Project Plan progressing, first draw targeted 19th July 2025.	EOL single tender waiver for the work on fitting out a further 14 wards. Concerns were raised as to the post project evaluation and prioritisation of bids. Promotion of SFH Lottery. Further work on the establishment of Staff and Wellbeing Fund. Application to be made to NHS Charities Together Workforce and Wellbeing Grant.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Assurance was received on Operational Group Highlight report. Community Involvement headline report. Fundraising and project update. Charity development update. Finance update. Investment update. Risk register. Implementation of Payroll giving.	The grant of £30K was approved for the purchase of a Dermatone equipment. Abseil fund raising event to be 3rd/4th October 2025. London Marathon place confirmed for April 2026. Terms of Reference work plan approved. Committee effectiveness report approved. Annual committee report to Trust Board approved. In principle it was agreed for the creation of Staff Wellbeing fund. Delegated powers to Sally Brook Shanahan to confirm wording on Charity Privacy Policy. The Risk register was amended to reflect changes in current environment. it will be further reviewed after meeting with Investment Advisors in July 2025.

Comments on effectiveness of the meeting
Good, robust decision on the agenda items.
Items recommended for consideration by other Committees
Audit and Assurance Committee to consider single tender waiver for EOL wards
Progress with Actions
Number of actions considered at the meeting - 5 Number of actions closed at the meeting – 2 Number of actions carried forward - 1 Any concerns with progress of actions – 0 If Yes, please describe

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

Annual Report from the Charitable Funds Committee - January to December 2024

1. Summary

This report provides an overview of charitable funds activities undertaken throughout the Trust between January and December 2024. For assurance, the committee has carried out its obligations in accordance with its Terms of Reference and work programme.

The Charitable Fund Committee manages the charitable funds under delegated authority. Under a scheme of delegated authority approved by the corporate trustee (Board of Directors), the Chief Financial Officer of the NHS Foundation Trust has responsibility for the management of the charitable fund, and the Head of Financial Services is the principal officer overseeing the day-to-day financial management and accounting for the charitable funds during the year.

The key aim is to serve the NHS patients of Sherwood Forest Hospitals NHS Foundation Trust by ensuring all grants made are in line with the Charity Commission guidance on Public Benefit. This aim is put into practice by:

- Enhancing the care our partner hospital can offer through new equipment and building improvements to deliver better facilities.
- Investment in people and in creating a caring environment for the patients receiving care, their families, and visitors.
- Provide direct support to patients by way of information, networking support, better facilities, and occasional grants.

2. Background

The Charitable Funds Committee meets quarterly and reports to the Board of Directors as the Corporate Trustee. Its Terms of Reference establish that its role is to provide the stewardship and effective management of funds which have been donated and bequeathed to the Sherwood Forest Hospitals Charitable Fund for charitable purposes.

The Committee's membership is set out below:

- Three Non-Executive Directors, one of whom is nominated as Chair and one as Vice Chair. The Chair of the Committee is appointed by the Board of Directors, acting as Corporate Trustee.

In routine attendance:

- Chief Financial Officer
- Director of Corporate Affairs
- Director of People
- Associate Director of Corporate Nursing
- Head of Financial Services
- Head of Communications
- Head of Charity Development
- Community Involvement Manager
- Governor observers
- Community Involvement Co-ordinator (Minutes)

The committee determines operational attendees as required to fulfil its work programme.

3. Work Programme

The Committee reviews throughout the year in accordance with its approved Terms of Reference. These include project/fundraising updates and evaluations, risk register, financial summaries, investment updates and undertakes an annual health check/self-assessment.

4. Meetings

The Committee meets quarterly, and four meetings were held during the period covered by this report. All meetings were quorate.

Attendance of members and regular attendees (or a nominated deputy) at meetings during the period covered by this report is detailed below:

Name	Actual	Possible
Andrew Rose-Britton, Non-Executive Director (Chair)	3	4
Steve Banks, Non-Executive Director (Vice Chair)	4	4
Barbara Brady, Non-Executive Director	4	4
Richard Mills Chief Financial Officer	4	4
Jen Leah, Deputy Chief Financial Officer (January to September 2024)	1	2
Sally Brook Shanahan, Director of Corporate Affairs	4	4
Rob Simcox, Director of People	3	4
Carly Rollinson, Associate Director of Corporate Nursing (from July 2024)	3	3
Shantell Miles, Director of Nursing (January to May 2024)	1	1
Rich Brown, Head of Communications	4	4
Michael Powell, Head of Financial Services	4	4
Ken Godber, Head of Charity Development (from March 2024)	3	3
Jo Thornley, Community Involvement Manager	4	4
Emma Musgrove, Community Involvement Co-ordinator	4	4
Liz Barrett, Governor observer	2	4
Jane Stubbings, Governor observer	1	4

The committee is supported by a Charitable Funds Operational Group which meets quarterly prior to meetings of the formal Charitable Funds Committee to consider papers for tabling at the committee's next meeting.

The work of the committee is supported by the Community Involvement Department who provide the first point of contact for donors, fundraisers and staff. Our hospital volunteers also provide support for the charity raising funds through the Café profits and daily fundraising stalls.

5. Committee effectiveness review

The committee carried out an effectiveness review which was reported in May 2024. It is based on the National Audit Office (NAO) self-assessment checklist for audit committees and is divided into 5 sections:

- Roles and responsibilities
- Membership and independence
- Skills and experience
- Scope of work
- Communication

The self-assessment tool reviews governance arrangements, checks appropriate systems are in place and identifies areas for improvement. Evidence to support the assessment was reported with no actions required. This has been incorporated into the work plan for future meetings.

6. Project Updates

The committee approves through delegation from the Corporate Trustee the funding of various charitable projects throughout the year.

NHS Charities Together

We are one of 230 NHS charities who are members of NHS Charities Together. This membership gives the charity the opportunity to apply for a number of grants but also the opportunity to seek guidance and support from member forums and network with charity colleagues both at national events and at East Midlands Group meetings.

The charity was successful in securing a £43K bid to secure OPUS Healthcare Musicians for a further 2 years and for additional seating for the main entrance and KTC courtyard. A supplementary bid was submitted in March 2024 and a further £78K was granted to fund furnishings in the new KTC wellbeing areas and the Level 6 Doctors' Mess.

All projects identified were considered against strict criteria set by NHS CT before funding was approved and will require a detailed evaluation in 2025. The NHS CT Grants Officer is in regular contact with the Community Involvement Manager and arranges periodic visits and calls to review progress.

End of Life Service Enhancement Appeal

Charitable Funds Committee approval was given in July 2020 to fund 16 enhanced EOL rooms at King's Mill Hospital (KMH). Commitments have been raised from the MIS022 EOL fundraising appeal (£46,088.30) and £81,911.70 from legacy LEG004.

In July 2024 the Associate Director of Corporate Nursing was tasked with rescoping the project and after navigating the procurement process, approval was given by the committee in October 2024 to proceed initially with refurbishment of 2 rooms. A specialist graphic designer who has a portfolio of work in palliative care settings both in the NHS and private sector, was commissioned to produce a specification. This work was completed in March 2025 and a work programme for the remaining rooms has commenced.

Dragons' Den

The Dragons' Den programme received a record number of applications from a wide range of departments for service improvement projects up to the value of £5K. Funding for these projects is provided by the King's Mill Hospital volunteers from profits raised in the Daffodil Café and fundraising stalls.

Members of the panel; Jill Smallwood (volunteer), Phil Bolton, Sally Brook Shanahan and Shantell Miles were delighted with the number of responses and the passion and enthusiasm shown by those who came to present their pitch.

Of the 28 applications received, the volunteers have committed to fund 13 projects totalling circa £50K. Projects included a portable project unit for Stroke Therapy, software to support patients with a brain injury, training models for the Tissue Viability Team, resources for the Dementia drop-in clinics, a low vision simulator for the orthotist service and handheld ultrasound for the MSK team.

A further 8 bids were supported by the Sherwood Forest Hospitals Charity from alternative appropriate restricted funds.

The Community Involvement Manager works in partnership with several fundraising groups who support our hospitals including the League of Friends (Mansfield & Sutton), Friends of Newark Hospital, Emily Harris Foundation and Amazon Breast Cancer Support Group.

Suitable projects are identified for their support and in 2024 the League of Friends (Mansfield & Sutton) kindly donated £58,844 to purchase specialist equipment for the newly opened one stop cataract clinic and paediatric orthoptist service at Ashfield Health Village. This includes a state-of-the-art instrument that accurately measures the eye in a non-invasive way, an ultrasound scanner, and a special microscope with a bright light attached to it that is used to look at different parts of the eye.

7. Approvals

In accordance with this, the Committee has considered and approved the following:

- Neptune Rover waste management system x 2 for Newark Theatres £40K
- Breast service expansion fundraising appeal (later withdrawn)
- Launch of charity lottery and development plan
- Harlequin CRM system £10K

The Committee also reviewed and approved the following business items:

- Committee annual report
- Terms of Reference
- Annual work plan
- Investment policy
- Privacy policy

8. Matters for escalation / referred to the Corporate Trustee

The Charitable Funds Committee Chair provides a highlight report to the Board of Directors. This provides items for escalation, areas of positive assurance, work commissioned, and decisions made.

The Corporate Trustee met specifically to approve the following items:

- Non-Consolidation of Charitable Funds into the Trust's annual account based on materiality
- Annual Report and Accounts 2023/24
- Launch of Charity lottery
- Review of charity performance and future development plan

9. Conclusion

The Committee self-assessments of compliance with Terms of Reference, the review of effectiveness, the robust work programme and escalations to the Board of Directors/Corporate Trustee provide assurance that the Committee continues to be effective in discharging its responsibilities.

Following a presentation to the Charitable Funds Committee and Corporate Trustee, the Head of Charity Development outlined priority actions for 2024/2025 which included the development of a corporate fundraising and communications strategy and engagement with corporate partners, including the development of a recognition policy. Progress with this work will be monitored by the Charitable Funds Committee.

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Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Annual Committee Effectiveness Report	**Date:**	5th June 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To provide the Board of Directors with assurance regarding the effectiveness of its Committees following their annual self-assessment.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

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

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	Insufficient financial resources available to support the delivery of services	**X**
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	**X**
PR7	Major disruptive incident	**X**
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	**X**

Committees/groups where this item has been presented before

Audit and Assurance Committee
Finance Committee
Quality Committee
People Committee
Partnerships and Communities Committee
Charitable Funds Committee

Acronyms

None

Executive Summary

To ensure effective governance the Board is supported by its Committees. On an annual basis each Board committee conducts a Committee Health Check self-assessment review based on the National Audit Office's self-assessment checklist for audit committees and following the process described in the Trust's Governance Framework (v.1.2 approved 8th January 2025). Its purpose is to assist the committees to demonstrate good practices and identify any areas for improvement.

All Board committees have conducted their self-assessments the outcomes from which are summarised below, including the actions identified and progress made with them.

The Terms of Reference and Work plans for all committees have also been reviewed and agreed for 2025. These are available in the reading room alongside each committee's self-assessment review.

Introduction

Effective Board Meetings and Committees of the Board are a key part of an effective governance structure it is therefore important to ensure the Trust's organisational governance aligns with best practice and national guidance.

Scope of Review of Effectiveness

The Trust has undertaken a review of the effectiveness of the Committees of the Board, based on the National Audit Office's audit committee Health check self-assessment tool. The checklist is divided into five sections:

- Role and responsibilities
- Membership and independence
- Skills and experience
- Scope of work
- Communication

The aim of the Health Check is to help committees to review their governance arrangements, check they have appropriate systems in place and identify areas where they could improve.

Members of the committees completed each question and considered the evidence available to determine where the committee is on the following scale:

- Fully Met: The committee is confident that the requirement is in place and there is evidence to support it
- Part Met: The committee partly carries out the requirement and there is some evidence to support it, but current practice needs adapting or improving
- Not Met: The committee does not meet the requirements practice and current practice needs adapting or improving.

The current governance for the Trust is provided through an appropriately constituted Board established in accordance with the Trust's Constitution. The Trust Board has the following committees:

- Quality
- Finance
- Audit and Assurance
- People
- Partnerships and Communities
- Charitable Funds Committee (established by the Board in its capacity as the Corporate Trustee)

The terms of reference and work plans for these committees were reviewed, in accordance with the annual requirement identified in the Terms of Reference.

Key Findings

The key findings for each of the Board's Committees are included in the reading room and are summarised
below:

Quality Committee

- No actions identified. All assessment criteria fully met.

Finance Committee

- One action was identified in relation to Assessment criteria 2 “Membership and Independence” relation to the Chair of the Committee being different to the Board. Following the resignation of the previous Board Chair on 24th May 2024, the then Chair of the Finance Committee was appointed Acting Board Chair. In order to resolve the position, Richard Cotton, a new non-executive director with extensive financial experience was appointed to the Board in February 2025 and joined the Finance Committee’s membership. With the benefit of an induction from the incumbent Committee Chair and the Chief Finance Officer, Richard will succeed as the Committee Chair with effect from the June 2025 meeting.

- All other assessment criteria fully met.

Charitable Funds Committee

- Two actions were identified. The first in relation to Assessment Criteria 3 “Skills and Experience” is for the Charity’s investment advisors to provide refresher training and an update for Trustees during the year. This is planned to take place in conjunction with the Committee’s meeting on 22nd July 2025. The second action relates to Assessment Criteria 5 “Communication” and is to launch a new Charity Ambassador role to actively promote and support the Charity and encourage fundraising and awareness. Following the preparation of a role description, the Charity Ambassador opportunity was presented at the Celebrating Excellence Event and has now been successfully launched.

Audit and Assurance Committee

- No actions identified. All assessment criteria fully met.

People Committee

- No actions identified. All assessment criteria fully met.

Partnership and Communities Committee

- No actions identified. All assessment criteria fully met.