Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 1st October 2026**
Time: **09:00 – 13:00**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome and 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)*	-	-
2.	09:00	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest**:-** Register of Interest | Sherwood Forest Hospitals *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.	09:05	**Staff Experience – Digital Transformation** Presentation by the Chief Digital Information Officer	Assurance	Presentation
4.	09:15	**Patient Experience – It's in your hands to save someone's life. (Rob's Cardiac Arrest)** Presentation by the Chief Nurse	Assurance	Presentation
5.	09:25	**Minutes of the meeting held on 6th August 2026** To be agreed as an accurate record	Agree	Enclosure 5
6.	09:30	**Action Tracker**	Update	Enclosure 6
7.	09:35	**Chair's Report** • **Council of Governors Highlight Report**	Assurance Assurance	Enclosure 7 Enclosure 7.1
8.	09:45	**Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	10:10	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Perinatal Quality and Safety** Report of the Chief Nurse, Chief Medical Officer, and Director of Midwifery • **Perinatal Safety Champions Update** Report of the Chief Nurse, Chief Medical Officer, and Director of Midwifery • **Thirlwall Inquiry Outcomes** Report of the Chief Nurse • **Learning from Deaths Report** Report of the Chief Medical Officer • **Patient Experience Annual Report** Report of the Chief Nurse	 Assurance Assurance Assurance Assurance Assurance	 Enclosure 9.1 Enclosure 9.2 Enclosure 9.3 Enclosure 9.4 Enclosure 9.5

	Time	Item	Status	Paper
10.	11.00	**Strategic Objective 2 – Empower and support our people to be the best they can be** • **Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual report** Report of the Chief Nurse • **Freedom to Speak Up** Report of the Freedom to Speak Up Guardian	Assurance Assurance	Enclosure 10.1 Enclosure 10.2
11.	11:10	**Strategic Objective 4 – Continuously learn and improve** • **Research Strategy – update** Report of the Head of Research and Innovation • **NHS Impact** Report of the Chief Medical Officer	Assurance Assurance	Enclosure 11.1 Enclosure 11.2
	11:10	**BREAK (10 mins)**		
	Operational			
12.	11:20	**Integrated Performance Report (IPR)** Report of the Executive Team • **NHS Oversight Framework (NOF) Q1 Update** Report of the Chief Operating Officer	Consider Assurance	Enclosure 12 Enclosure 12.1
13.	12:10	**Winter Plan** Report of the Chief Operating Officer	Approval	Enclosure 13
14.	12:20	**Self-Assessment: Minimum Standards of Patient Experience for Elective Care** Report of the Chief Operating Officer	Assurance	Enclosure 14
	Governance			
15.	12:30	**Board Assurance Framework (BAF)** Report of the Chief Executive	Review/ Approval	Enclosure 15
16.	12:40	**Assurance from Sub Committees** • **Finance & Performance Committee** Report of the Committee Chair (last meeting) o **Extraordinary Finance & Performance Committee** • **Quality Committee** Report of the Committee Chair (last meeting) • **Audit and Assurance Committee** Report of the Committee Chair (last meeting)	Assurance Assurance Assurance Assurance	Enclosure 16.1 Enclosure 16.2 Enclosure 16.3 Enclosure 16.4
17.	12:50	**Provider Board capability self-assessment** Report of Director of Corporate Affairs	Approval	Enclosure 17
18.	12:55	**Communications to wider organisation** (Chief Executive to confirm Board decisions requiring communication to Trust)	Agree	Verbal

	Time	Item	Status	Paper
19.	13:00	**Any Other Business**	-	-
20.	-	**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be: **3rd December 2026, Boardroom, King's Mill Hospital**		
21.	-	**Chair declares the meeting closed**		
22.	-	**Questions from members of the public present** (Pertaining to items specific to the agenda)		
23.	-	**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. 24	**Perinatal Safe Staffing**
Enc. 25	**Nursing Safe Staffing**
Enc. 26	**Regional Maternity Heatmap**
Enc. 27	**Significant Risks Report**
	Sub-committee's approved minutes
Enc. 28	• **Finance and Performance Committee**
Enc. 29	• **Audit and Assurance Committee**
Enc. 30	• **Extraordinary Audit and Assurance Committee**
Enc. 31	• **Partnership and Communities Committee**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ("THE TRUST")
UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS IN PUBLIC
ON THURSDAY 6TH AUGUST 2026 AT 09:00 IN THE BOARDROOM, KING'S MILL HOSPITAL

CHAIR:	Rukshana Kapasi	Trust Chair	RK
MEMBERS:	Steve Banks	Non-Executive Director	SB
	Neil McDonald	Non-Executive Director	NM
	Richard Cotton	Non-Executive Director	RC
	Manjeet Gill	Non-Executive Director	MG
	Jon Melbourne	Chief Executive	JM
	Rob Simcox	Chief People Officer	RS
	Simon Roe	Chief Medical Officer	SR
	Phil Bolton	Chief Nurse	PB
	Simon Illingworth	Chief Operating Officer	SI
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
IN ATTENDANCE:	Andrew Graham	Deputy Chief Financial Officer	AG
	Rich Brown	Head of Communications	RB
	Olivia Ward	Communications Officer	OW
	Deb Dowsing	Communications Officer	DD
	Laura Russell	Minute Secretary	LR
OBSERVERS:	One member of the public		
APOLOGIES:	Richard Mills	Chief Financial Officer	RM
	Barbara Brady	Non-Executive Director	BB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Jonathan Van Tam	Associate Non-Executive Director	JVT

Item No.	Item	Action	Date
26/129	**WELCOME AND APOLOGIES FOR ABSENCE** Quoracy Check; 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)		
Length of Discussion: 1 minute	The meeting was held in person and live-streamed to enable public access. The agenda and papers were published on the Trust website, and members of the public were able to submit questions via a live Q&A function. It was CONFIRMED that apologies for absence had been received from RM, BB, JVT and ARB. It was further NOTED that AG was in attendance on behalf of RM. The meeting being quorate, RK 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.		
26/130	**DECLARATIONS OF INTEREST**		
Length of Discussion: 1 minute	It was CONFIRMED that declarations of interest were requested in respect of items on the agenda.		
26/131	**INTRODUCTION**		
Length of Discussion: 5 minutes	RK introduced herself as Trust Chair and reflected on her connection to the local area, her commitment to the Trust's communities and her ambition for the organisation. RK highlighted the importance of balancing access, quality, safety, improvement, culture, workforce, equity and finance, and of operating as a unitary Board which listened to patients and staff, was inclusive, challenging and robust in its assurance. RK emphasised the importance of an open learning culture to support transformation, outstanding care and reducing health inequalities. RK thanked colleagues for their warm welcome and thanked JM for his leadership and communication during the recent Chair transition. The Board NOTED the Chair's introductory remarks.		
26/132	**PATIENT EXPERIENCE – WEBSITE ACCESSIBILITY**		
Length of Discussion: 15 minutes	RB presented the Patient Experience item, which focused on improvements made to the Trust's public-facing website. It was reported that the website, alongside the NHS App, formed part of the Trust's digital front door and was accessed by approximately 45,000 users each month. The Board NOTED that work had been undertaken to improve accessibility for patients, carers, staff and members of the public, particularly those living with disabilities or impairments which affected how they accessed digital information. RB advised the Board that the Trust had made significant progress, moving from 230th in a national accessibility ranking of NHS websites to the top 5, and achieving 99% compliance with the relevant technical accessibility standards. RB emphasised that the work was not solely		

	about technical compliance, but about improving independence, dignity and equal access to care for people who may otherwise experience barriers in accessing essential information online. The presentation included patient and staff perspectives which highlighted the impact of accessible digital information, including the importance of ensuring that website design was compatible with assistive technologies, clear navigation, appropriate colour contrast and mobile accessibility. The Board recognised that small changes in digital design could make a significant difference to patient experience and reduce the risk of health inequalities. In discussion, the Board welcomed the significant improvement in website accessibility and noted the impact demonstrated by the before-and-after comparison. PB and RK queried how the Trust would continue to build on this work, including capturing feedback, monitoring impact and considering wider opportunities to improve access and reduce inequalities for people with accessibility needs. RB advised that the website relaunch was the start of the work and that ongoing input from patients and disabled staff would continue to inform future improvements.		
26/133	**STAFF EXPERIENCE – ENHANCING OUR RESIDENT DOCTORS' EXPERIENCE**		
Length of Discussion: 17 minutes	SR introduced the Staff Experience item, which focused on enhancing the experience of resident doctors joining and working within the Trust. The Board was advised that August was a particularly significant period for postgraduate medical education, with 243 resident doctors joining the organisation, including Foundation Year 1 doctors starting their first NHS role, doctors entering registrar training and doctors approaching the end of their training. The Board NOTED the importance of effective induction, onboarding and support arrangements, recognising that resident doctors undertake key clinical responsibilities across the organisation, including emergency care, maternity, surgery, anaesthetics and responding to deteriorating patients. SR highlighted the importance of ensuring that new doctors felt welcomed, supported and able to contribute safely from the beginning of their placement. The presentation included reflections from resident doctors and colleagues involved in postgraduate medical education. The Board heard that improvements had included the development of the Doctors' Mess, wellbeing support, access to the Freedom to Speak Up Guardian, exception reporting, supervisor support and digital resources including the Eolas app. The Board recognised the importance of creating a positive first impression and sustaining support throughout the doctors' placements. In discussion, the Board welcomed the progress made and noted that the resident doctor experience had improved year on year. The Board recognised the contribution of teams across the organisation in supporting doctors during induction and handover, and noted the importance of preparing wider multidisciplinary teams to receive and support new doctors. The Board also acknowledged the positive role of charitable funding in supporting the Doctors' Mess.		

	The Board discussed the importance of ensuring effective feedback mechanisms for resident doctors, particularly following a challenging period including industrial action, and challenged whether feedback received was sufficiently balanced given the pressures experienced by resident doctors and the wider operational context. SR advised that feedback would be received and monitored through a range of routes, including informal feedback, formal channels, Freedom to Speak Up, exception reporting, Guardian reporting and reports to People Committee and Board. The Board emphasised the importance of identifying issues early, acting promptly on feedback and ensuring feedback loops were visible. The Board further discussed how resident doctors could be empowered to contribute to improvement and learning activity, including through audit and quality improvement projects. It was noted that work was being undertaken with the Improvement Faculty to support resident doctors to develop meaningful improvement projects, ensuring audit activity delivered tangible learning and service improvement. The Board was ASSURED by the update and AGREED that continued focus should be maintained on the resident doctor experience, including feedback pathways, wellbeing support, onboarding and opportunities for doctors to contribute to improvement and learning. RK suggested that future Board staff experience items could include hearing directly from resident doctors at different points in their journey. ***Action: Future staff experience items to include resident doctor perspectives of their journey at Sherwood.***	**SR**	**04/12/26**
26/134	**MINUTES OF THE MEETING HELD ON 4TH JUNE 2026**		
Length of Discussion: 1 minute	Following a review of the minutes of the Board of Directors held in Public on the 4th June 2026, the Board of Directors APPROVED the minutes as a true and accurate record.		
26/135	**ACTION TRACKER**		
Length of Discussion: 1 minute	The Board reviewed the action tracker and AGREED that actions **26/082, 26/087, and 26/094** are COMPLETE and could be REMOVED from the action tracker.		
26/136	**CHAIR'S REPORT**		
Length of Discussion: 4 minutes	RK presented the Chair's Report and highlighted her visits across the Trust during her first four weeks, including maternity, end of life care and theatres, noting that she had been impressed by the Trust's CARE values being lived by colleagues and by leadership demonstrated at all levels. RK recognised the work of volunteers, noting the significant contribution made during June and July, and highlighted charitable fundraising activity, including staff fundraising and the abseil event which had raised approximately £13,000 for the Trust charity.		

	RK also reported the outcome of the governor elections and welcomed newly elected and re-elected governors, noting the valuable assurance and insight provided by governors through their involvement in Trust committees. The Board NOTED the Chair's Report and expressed its sincere thanks to outgoing governors for their contribution and commitment to the Trust.		
26/137	**CHIEF EXECUTIVE'S REPORT**		
Length of Discussion: 5 minutes	JM presented the Chief Executive's Report and welcomed RK to the Trust. JM started his report by thanking colleagues for their continued commitment during a challenging period, including heatwave pressures, sterilisation challenges and significant demand across services. JM highlighted the Trust's recent CQC rating of Good across all domains, noting that colleagues should be proud of the outcome while recognising the need for continued improvement. JM also referred to national GIRFT visits, the opening and full operation of the Mansfield Community Diagnostic Centre, forthcoming developments including the new sterilisation unit, MRI facility at King's Mill and emergency department works, and the Trust's commitment to reviewing national maternity findings and applying relevant learning across services. JM welcomed the resident doctors joining the Trust and emphasised the importance of ensuring they felt supported, part of the team and able to contribute to Sherwood's continued improvement. The Board NOTED the Chief Executive's Report.		
26/138	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
Length of Discussion: 28 minutes	PB introduced the Perinatal Quality and Safety and Perinatal Safety Champions reports and reiterated the Trust's commitment to reviewing and learning from national maternity reports and applying relevant learning both within maternity services and across the wider organisation. The Board NOTED that the reports were now becoming more embedded and mature, with increased use of SPC charts and quality improvement methodology to support assurance and learning. PB advised of increased activity within maternity triage, with contacts rising significantly over recent months. PB also noted that the standalone triage unit and associated improvement work were supporting the response, although demand and unpredictability continued to create operational pressure. PB informed the Board of two stillbirths in the reporting period, with no immediate learning identified, and that there had been no external loss alerts or neonatal deaths. A peak in neonatal admissions had been seen in June and would continue to be monitored and reviewed. In discussion, the Board recognised that a number of national reports, action plans and requirements were being received at the same time, including the 10-point plan, CQC action plan, Ockenden, Amos and		

	maternity care bundle requirements. It was noted that the Perinatal Assurance Committee would have a key role in prioritising these requirements and ensuring that nothing fell through gaps. PB advised that the 10-point plan would provide the framework into which other requirements would be mapped. The Board NOTED that the Perinatal Assurance Committee would move to monthly meetings in recognition of the volume of work and level of focus required. Safety Champions activity remained active and visible, including forums and walkarounds, and the Board was advised that external visits and peer reviews had provided positive feedback on quality improvement, risk and learning processes. Work was also underway to review the Trust's position against the national 10-point plan and to consider learning from the Perinatal Equity and Anti-Discrimination Programme. In response to MG questions on maternity triage, PS explained that the Trust had worked back from RCOG guidance and national best practice, including staffing models, triage environment and use of patient and family feedback. The Board was advised that real-time data was now available to support monitoring of triage activity, including call volumes and waiting calls, and that delays were reviewed by the triage team. It was noted that an NHS England triage toolkit was expected, which would enable further benchmarking. SB queried the home birth figures, noting that the reported number reflected births that took place at home and did not include women who had laboured at home but transferred to hospital prior to birth. PS advised that the Trust had previously benchmarked the home birth service against national direction and had assurance regarding the robustness of the service, although future development would need to take account of demand, workforce models and national review outcomes. SB also discussed GIRFT and requested further clarity on how the approach should be interpreted in relation to maternity and wider Board assurance. PS explained that the maternity GIRFT work was an older framework and included areas such as third and fourth degree tears, haemorrhage and experience, with elements also woven into related improvement programmes. It was AGREED that consideration would be given to further Board development or education on GIRFT and how the metrics should be understood. ***Action: Consider future Board development on Maternity GIRFT metrics.*** In response to LM questions regarding staff wellbeing following the publication of national maternity reports, PB and PS advised that staff had been supported through forums, walkarounds and engagement sessions. The Board heard that some staff had found the reports difficult to read and that ongoing support was being provided. It was noted that staff were now focused on action, learning and moving forward, with the 10-point plan providing direction and prioritisation.	**PB**	**04/12/26**

	The Board discussed the importance of patient and family voice, including the role of the Maternity and Neonatal Voices Partnership and the Perinatal Services Oversight Group. PS highlighted the need to triangulate feedback from a range of sources, including patient and family feedback, 15 Steps, digital feedback and staff feedback routes, and noted that this qualitative insight would be used to inform future improvement activity. The Board emphasised the importance of ensuring that patient voice remained visible and effective, and that alternative routes within the Trust should be considered if external arrangements did not provide the required assurance. NM noted the importance of sharing positive feedback with staff as well as areas for improvement. PS described the use of Greatix to recognise and share examples of good practice, including feedback from women and families. The Board recognised that this was important in supporting staff morale, confidence and learning, particularly during a period of significant national scrutiny. The Board challenged whether the volume of national requirements and improvement activity could create resource or prioritisation pressures. PB advised that this may require Board-level consideration where decisions were needed about prioritisation, resource or deprioritisation of other work. RK summarised that the Board had received assurance from the reports and discussion, while recognising the need for continued oversight of the 10-point plan, GIRFT, patient voice, staff support and the potential resource and prioritisation implications associated with the volume of maternity improvement activity. ***Action: Assurance on gap analysis against the national 10-point plan to be presented at Board.*** The Board was ASSURED by the reports.	**PB**	**01/10/26**
26/139	**CQC REPORT OUTCOME**		
Length of Discussion: 17 minutes	PB presented the CQC Report Outcome and advised that the report related to the unannounced inspection undertaken on 9th and 10th March across the urgent and emergency care pathway, which had also followed patient pathways into several wider areas. The Board NOTED that the Trust had received a rating of Good across all domains. PB highlighted that this was a positive outcome and that colleagues should be proud of the result, particularly given the sustained operational pressures across services. The Board recognised the importance of celebrating the positive findings while also acknowledging areas for further improvement. PB noted that the CQC had identified issues which the Trust was already aware of, and that the ability of staff and leaders to describe the challenges, actions and improvement plans had contributed to the assurance received. The Board noted the positive findings in relation to committed teams, staff culture, teamwork and compassionate care.		

	In discussion, LM questioned how the Trust would move from Good to Outstanding and how teams would understand the difference between the two, and what needs to change to achieve this. PB and SR recognised that the Trust should be proud of the outcome but should not accept the current position as the limit of its ambition. The Board discussed the need to define what Outstanding would mean in practice, including continuing to improve access, patient flow, financial sustainability, patient experience and staff experience. The Board further discussed urgent and emergency care pressures and the extent to which external system factors affected the Trust's ability to deliver consistently outstanding care. JM noted the national increase in 12-hour waits since 2020 and advised that significant change was needed across urgent and emergency care pathways, including stronger links with neighbourhood care and system partners. The Board discussed whether the Trust had sufficient influence with external partners and how that influence could be converted into action. The Board also considered how learning from the inspection should be shared across the organisation in preparation for future inspections. PB advised that learning was being built into peer review and quality assurance processes, with a focus on ensuring that actions and learning were not confined to one area but were transferred across services. It was noted that teams had become more experienced in engaging openly with inspections and peer reviews, sharing both good practice and areas of challenge. The Board was ASSURED by the report and AGREED that the CQC action plan would continue to be monitored through the relevant governance routes, including Patient Safety Committee and Quality Committee, with Board oversight as required. ***Action: PB/SR to ensure CQC action plan monitoring continues through Patient Safety Committee and Quality Committee.*** The Board also noted the need for further discussion on the Trust's ambition to move from Good to Outstanding and the system conditions required to support sustained improvement. ***Action: Further Board discussion to consider the Trust's ambition and route from Good to Outstanding.***	**PB/SR** **SBS**	**01/10/26** **01/10/26**
26/140	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Length of Discussion: 91 minutes	JM introduced the Integrated Performance Report. In relation to quality, PB highlighted continued significant operational pressure across urgent and emergency care pathways, including attendances, waits, environment and the impact on colleagues and patients. PB apologised for the experience of those affected and advised that executive focus remained on areas requiring the greatest attention, including infection prevention and control, pressure ulcers, complaints and the continued need to maintain safe and effective care. A correction was noted within the narrative relating to stillbirth data. The reported rate should read 2 per 1,000 live births, rather than 6.7 per		

	1,000 live births. The Board noted improvement in some infection prevention indicators but recognised ongoing challenges in relation to gram-negative infections, antimicrobial stewardship, decant capacity, environmental pressures and patients being cared for in non-standard environments. SB sought assurance that the combined reporting of Duty of Candour and Patient Safety Incident Investigations was not masking underlying trends and that any increase in activity would be identified promptly. SR provided assurance that the Trust had a mature patient safety investigation framework, with regular review arrangements and improved capability following the recruitment and training of additional consultants to support investigation work. In relation to complaints, PB advised that the Trust had seen a 39% increase, consistent with a national trend, with common themes including communication, organisation, access to services and clinical care. The Board discussed the importance of considering complaints as a source of organisational learning and patient experience insight, rather than solely a process measure, alongside the need for timely, empathetic and factual communication across all patient touchpoints. RK emphasised the importance of revisiting this topic at a future Board Development Day. ***Action: Include a Board Development Day session on complaints as a source of organisational learning and patient experience insight.*** RS presented the people domain and advised that 7 of the 13 indicators were meeting or exceeding standard. Positive performance was noted in mandatory and statutory training, recruitment timelines, turnover, medical job plan compliance and use of off-framework agency. Areas requiring continued focus included vacancies, appraisal compliance, sickness absence and temporary staffing. RS advised that vacancy control arrangements had been strengthened, appraisal compliance remained above available benchmarking at 85%, despite being below the Trust target, and sickness absence stood at 5%, with stress and anxiety remaining the leading cause. The Board noted ongoing actions to embed the refreshed attendance management policy, support leaders and prepare for winter wellbeing and vaccination programmes. The Board discussed preparation for the staff survey, including the “Together We Will” approach, blended paper and electronic survey methods, and the importance of giving colleagues the best opportunity to share their views. RC emphasised the importance of enabling honest staff feedback and demonstrating how feedback had been acted upon, rather than focusing on a particular outcome. RS confirmed that engagement with divisions would continue throughout the survey period and that a blended approach had been adopted to maximise participation and ensure all colleagues had the opportunity to contribute. MG sought assurance that appraisal conversations appropriately recognised and utilised the experience of longer-serving colleagues. RS advised that the Trust's appraisal approach increasingly focused on enrichment and fulfilment, alongside development, and provided assurance that appraisal conversations were being reviewed to ensure	**PB**	**03/12/26**

	this was reflected consistently. LM sought assurance on lessons that could be learned from Outstanding organisations. RS advised that common features included consistent people management practices, reduced reliance on temporary staffing, investment in colleague wellbeing, and a strong focus on developing and retaining a substantive workforce. SI presented the operational performance update and reported an improving position in urgent and emergency care following the implementation of NerveCentre, with July performance showing improvement in both four-hour performance and 12-hour waits compared with June. The Board noted continued high demand, including high ambulance attendances, significant additional bed capacity and ongoing medically optimised patients awaiting discharge. SI advised that discharge improvement work, a system workshop in September and a mental health summit were being progressed. Elective performance was strong in Q1, although 52-week waits had deteriorated slightly and the CSSD challenges in July had affected theatre and outpatient activity; the Board noted that affected patients had largely been rebooked. LM raised a query whether current urgent and emergency care pressures should now be considered the ongoing norm rather than an exception, and how this should inform resilience, learning and future planning. SI advised that work was focused on streaming patients to the right place, reducing reliance on a single front door and improving pathways. In response to LM's question on mental health provision and wider system support, JM advised that national developments would be reviewed and that the Trust should be clear with system partners about the conditions required for a good winter. It was AGREED that the Trust should write to system partners setting out the conditions required to support delivery of the winter plan. ***Action: JM/SI to arrange a meeting with system partners setting out the conditions required to support winter planning.***	**JM/SI**	**01/10/26**
	SB sought assurance regarding the maturity of the NerveCentre implementation in ED and the implications of rolling the system out to other departments. SI provided assurance that the majority of benefits had now been realised, with further improvements expected as remaining elements were embedded. Learning from the ED implementation was already informing future phases of deployment, including elective services, to support a safe and effective rollout. RK sought assurance on delivery of the PC24 trajectory and the sustainability of the Type 3 service model. SI advised that the trajectory remained aligned to the Trust's recovery plan but noted that further progress in community services and discharge-to-assess pathways was required. SI also highlighted the need to consider the longer-term sustainability of the current Type 3 model in the context of increasing demand. AG presented the finance update and reported a year-to-date deficit of £8.0m at Q1, £4.3m adverse to plan. The principal drivers were under-delivery of elective activity, under-delivery of the efficiency programme and discrete pressures including industrial action, increased demand and		

	additional capacity. The Board noted that £4.8m of efficiencies had been delivered against a plan of £7.4m, resulting in a £2.6m shortfall, and that governance had been strengthened through the Financial Recovery Cabinet meetings, divisional review of schemes and learning from other providers. The Board also noted pressures relating to bank and agency expenditure, the cash position, working capital support and the need to continue prioritising supplier payments. AG highlighted an error in the report and confirmed that working capital support received totalled £4.3m, not £4.9m. The error related to a separate £4.9m funding application currently under consideration, with feedback expected shortly. The Trust continued to prioritise supplier payments and maintain engagement with local and national suppliers. MG queried the level of assurance that could be taken regarding delivery of the financial plan and a break-even position by year end. AG provided assurance that a comprehensive recovery programme remained in place, supported through the Financial Recovery Cabinet and overseen by the Finance Committee, with ongoing reporting to NHS England and continued development of efficiency schemes. The Board heard that divisions have been instructed to ensure all existing savings schemes are fully developed and costed, with increased scrutiny through weekly reviews of divisional trackers and more frequent performance reviews. Additional elective activity, detailed budget reviews and strengthened oversight of temporary staffing expenditure are expected to support improvement in the financial position. The Board discussed ongoing pressures relating to agency and temporary staffing costs. Whilst usage has reduced from previous levels, vacancies and service capacity requirements continue to drive expenditure. Further savings opportunities and workforce model reviews are being progressed with external support. The Board discussed the development of transformational opportunities and digital innovation to support long-term sustainability. Progress against key digital initiatives was noted, alongside the need to balance ambition with organisational capacity and delivery of immediate recovery priorities. Members highlighted the importance of developing transformational schemes to inform future financial planning and investment decisions and reflected on the need for greater strategic focus on long-term sustainability, transformation and income growth, including consideration of the underlying drivers of the Trust's financial challenges. JM emphasised the close relationship between urgent and emergency care performance and the financial position, noting that operational pressures, delayed discharges and additional bed capacity requirements remain key contributors to the Trust's financial challenges. The Board noted the report, acknowledged the risks associated with delivery of the financial plan, and received ASSURANCE on the strengthened governance, scrutiny and recovery actions in place.		

26/141	**FIT AND PROPER PERSON TEST COMPLIANCE**		
Length of Discussion: 4 minutes	SBS presented the Fit and Proper Person Test Compliance report and advised that this was the third annual update to the Board. The Board was ASSURED that the required annual checks had been completed and recorded within ESR in line with national requirements. SBS confirmed that the timing of the assessment had been aligned to the Chair transition, with the Senior Independent Director signing off the assessment for the Chair and the Chair signing off assessments for the Executive Team. The Board NOTED that the Trust continued to apply the regime to identified deputies to ensure appropriate checks were in place should they be required to step into relevant roles at short notice. SBS advised that actions arising from the national review of the Fit and Proper Person Test had been incorporated into the Trust's process, including checks in relation to disqualification and Charity Commission requirements. The annual sign-off had been submitted and acknowledged. The Board was ASSURED by the report.		
26/142	**ASSURANCE FROM SUB COMMITTEES**		
Length of Discussion: 16 minutes	The Board received assurance from the Sub Committees. **Finance Committee** RC reported that the Committee had focused on the year-to-date deficit of £8.0m and provided limited assurance on the financial trajectory, recognising the number of moving parts including delivery of the FIT programme and the maturity of financial recovery actions. The Committee noted the need for further development of detailed action plans and regular outputs from the Financial Recovery Cabinet. Positive assurance was received from a favourable internal audit report on financial management, and the Committee received an update on digital programmes, including the Shared Business Services implementation. **Quality Committee** LM presented the report. The Board received an update on the Committee's consideration of operational pressures and their impact on patient outcomes and experience. The Committee had discussed CSSD fragility and recovery arrangements, mental health system pressures, corridor care definitions and oversight, cancer 62-day performance and positive assurance in relation to planned care progress, improvement review actions, safeguarding assurance and dementia support. Principal Risks 1 and 5 had been reviewed and remained at their current scores, with further refinement of risk narrative required. **Audit and Assurance Committee** MG presented the report and advised that good progress had been made in addressing outstanding audit actions, with 82% of actions met compared with 73% at the same point the previous year. The Committee had reviewed the Board Assurance Framework and noted the need for committees to review principal risk judgements in light of current organisational circumstances. The Committee also considered the clinical audit programme and recommended that Quality Committee consider alignment of how audits were identified, actioned and prioritised, particularly in relation to patient impact and patient experience.		

	Action: Quality Committee to consider alignment of how clinical audits are identified, actioned and prioritised, with particular focus on patient impact and patient experience. **People Committee** SB presented the report. The Board noted that the Committee had reviewed its assurance approach, including reducing routine updates and increasing focus on assurance and strategic discussion. Divisional deep dives into people matters had commenced and would be reviewed. The Committee noted ongoing pressures in relation to absence and agency use and discussed new NHS staff standards and the NHS leadership and management framework. Assurance was also received in relation to Workforce Race Equality Standard and Workforce Disability Equality Standard reporting, while noting concern regarding increasing racially motivated aggression and harassment, which would require continued focus. ***Action: People Committee/RS to maintain focus on racially motivated aggression and harassment, including the Trust's zero tolerance approach and implications of the new NHS staff standards and leadership and management framework.*** **Charitable Funds Committee** SB reported that the Committee had received a positive update on the charity's financial position and activity. The Committee discussed progress with the charity lottery, noting that while income had been generated, momentum had reduced and further investment to support ticket sales may be brought to the Corporate Trustee in due course. The Board noted increasing legacies, greater use of charitable funds and examples of relatively small amounts of funding making a meaningful difference to staff, patients and services. It was also noted that there may be opportunities to amplify the charity's impact strategically through neighbourhood working. Thanks were expressed to the charity team, volunteers and fundraisers. The Board was ASSURED by the updates.	**LM** **RS**	**01/10/26** **01/10/26**
26/143	**DATA SECURITY PROTECTION TOOLKIT SUBMISSION**		
Length of Discussion: 1 minute	SBS provided a verbal update on the outcome of the Data Security Protection Toolkit submission. The Board was advised that the overall assurance position across the five objectives was positive, with no outcomes rated as not met. It was further noted that Internal Audit had reviewed a sample of the Trust's self-assessment and found it to be aligned with expected evidence requirements, resulting in a low level of findings and a high confidence rating in the Trust's self-assessment. The Board was ASSURED by the update.		
26/144	**COMMUNICATIONS TO WIDER ORGANISATION**		
Length of Discussion: 1 minute	JM advised that no decisions had been made during the meeting which required explicit communication across the wider organisation. The Board NOTED that discussion had taken place in relation to matters including the staff survey approach and winter planning, which would be		

	reflected through the usual communication routes as appropriate.		
26/145	**ANY OTHER BUSINESS**		
Length of Discussion: 1 minute	There were no items of Any Other Business raised		
26/146	**DATE OF NEXT MEETING**		
Length of Discussion: 1 minute	It was CONFIRMED that the next Board of Directors meeting in Public would be held on 1st October 2026 at 09:00. There being no further business the Chair declared the meeting closed at 12:40.		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. **Rukshana Kapasi OBE** **Chair** **Date**		
26/147	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
Length of Discussion: 1 minute	RK 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.		
26/148	**BOARD OF DIRECTOR'S RESOLUTION**		
Length of Discussion: 1 minute	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

ACTION TRACKER - Public Board Meeting | Thursday 6th June 2026

Version 3

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
26/012	05/02/2026	Target and tolerable levels of risk to be reviewed at a future Board of Directors workshop	Public Board of Directors	None	01/10/2026	J Melbourne		**Update 20/02/26** Added to Board workshop schedule for September 2026**.** **Update 23/09/26:** Further work during Bod away days to take place.	Amber
26/138.1	06/08/2026	Consider future Board development on Maternity GIRFT metrics.	Public Board of Directors	None	01/10/2026	P Bolton	P Bolton		Amber
26/139.1	06/08/2026	PB/SR to ensure CQC action plan monitoring continues through Patient Safety Committee and Quality Committee.	Public Board of Directors	None	01/10/2026	P Bolton / S Roe	P Bolton / S Roe		Amber
26/142.1	06/08/2026	Quality Committee to consider alignment of how clinical audits are identified, actioned and prioritised, with particular focus on patient impact and patient experience.	Public Board of Directors	Quality Committee	01/10/2026	R Kapasi	L Maclean	**Update 23/09/26:** Meeting with Phil B (QC pre-meet) on Friday at 09:00 to discuss. Update to follow.	Amber
26/140.2	06/08/2026	JM/SI to arrange a meeting with system partners setting out the conditions required to support winter planning.	Public Board of Directors	None	01/10/2026	J Melbourne	S Illingworth	**Update 23/09/26:** SI wrote to ICB and asked for a meeting along with NUH and NHC - Still pending a meeting date.	Amber
26/133	06/08/2026	Future staff experience items to include resident doctor perspectives of their journey at Sherwood.	Public Board of Directors	None	01/10/2026	S Roe	S Roe	**Update 24/09/26:** The CMO will work with executive colleagues to ensure resident doctor voices are heard within future staff experience videos. Resident doctor experience group feeds into regular reports into people committee. Action closed.	Green
26/142.2	06/08/2026	People Committee/RS to maintain focus on racially motivated aggression and harassment, including the Trust's zero tolerance approach and implications of the new NHS staff standards and leadership and management framework.	Public Board of Directors	People Committee	01/10/2026	R Simcox	R Simcox	**Update 04/09/26** Updates provided to People Committee (September 2026) and included as part of People Committee workcycle across 26/27. **Action Complete**	Green
26/014	05/02/2026	Penny Dash Report (Patient Safety across the Health and Care Landscape in England) to be a topic for a future Board of Directors workshop	Public Board of Directors	None	01/10/2026	P Bolton	P Bolton	**Update 20/02/26** Added to Board workshop schedule for September 2026 **Update12/08/26** Executive Team agreement to close action. **Action Complete.**	Green
26/138.2	06/08/2026	Assurance on gap analysis against the national 10-point plan to be presented at Board.	Public Board of Directors	None	01/10/2026	P Bolton	P Bolton	**Update 04/09/26** Scheduled on October's agenda.	Green
26/139.2	06/08/2026	Further Board discussion to consider the Trust's ambition and route from Good to Outstanding.	Public Board of Directors	None	01/10/2026	S Brook Shanahan	L Russell	**Update 04/09/26** Added to workshop forward planner.	Green

26/140.1	06/08/2026	Include a Board Development Day session on complaints as a source of organisational learning and patient experience insight.	Public Board of Directors	None	01/10/2026	P Bolton	L Russell	**Update 04/09/26** Added to workshop forward planner.	Green

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:**	24 September 2026
Prepared By:	Rich Brown, Head of Communications and Rukshana Kapasi OBE, Chair		
Approved By:	Rukshana Kapasi OBE, Chair		
Presented By:	Rukshana Kapasi OBE, Chair		

Purpose		
An update regarding some of the most noteworthy events and items from recent months from the Chair's perspective, covering August and September 2026.	**Approval**	
	Assurance	
	Update	**Y**
	Consider	

Recommendation

The Trust's Board of Directors is asked to NOTE the updates provided in this report.

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

BPH = Benign Prostatic Hyperplasia	OBE = Officer of the Order of the British Empire
CNH = Central Nottinghamshire Hospitals	PR = Principal Risk
HoLEP = Holmium Laser Enucleation of the Prostate	TOE = Transoesophageal Echocardiography
NED = Non-Executive Director	USB = Universal Serial Bus
NHS = National Health Service	VCSE = Voluntary, Community and Social Enterprise

Executive Summary

An update regarding some of the most noteworthy events and items from recent months from the Chair's perspective, covering August and September 2026.

Introduction

The sense of community I have experienced over the last couple of months at Sherwood has been uplifting. I have really enjoyed meeting all the Chairs of our staff networks and other forums, all our governors, talking to volunteers and visiting our services.

Key highlights for me have included:

- Chairing my first Council of Governors meeting and hearing about some of the great work that governors such as Cllr Angie Jackson are doing to highlight to local councils social care packages of care to support discharge of patients in our hospitals.

- Meeting all the Chairs of neighbouring trusts where I was able to stress that challenges faced by other NHS Trusts are a shared problem, as they often impact services and flow across the system so greater partnership working in solving complex issues is key.

- Learning about the breadth and depth of the work of our Patient Experience Team and attending the 'Coffee and Connect' session, where patients shared a range of experiences. The compassion, humility and leadership demonstrated by Emma Mutimer-Hallgarth and Natalie Bradbury during a session where there were difficult experiences was exemplary.

- My '15 Steps' visit to the Birthing Unit, where the person-centred leadership of Mandy Watson was heartwarming to hear. Mandy shared an example of a birthing partner that was in a wheelchair and the practical assessment and reasonable adjustments she put in place to ensure that they could share the birthing experience in full.

- The impressive neighbourhood work of Dan Smith, Respiratory Consultant and team shared at Quality Committee. At the Committee, he shared the better outcomes, better patient experience and better use of resources through secondary prevention work in the community, integrated community provision and the use of data to optimise care. He has also launched a respiratory network to recruit champions from across the area in primary care, community and (Voluntary, Community, and Social Enterprise) VCSE partners.

I just wanted to end by saying 'thank you' to Liv Worrall for inviting me to open the excellent 'Women in Leadership' conference she and the team facilitated, where we got to hear some powerful examples of leadership journeys and create an important space for us as an organisation to consider how to develop women in leadership.

I would also like to thank Richard Cotton, our outgoing Non-Executive Director, for his valuable contribution to the Board over the last year.

Recognising the difference made by our Trust Charity and Trust volunteers

Across August and September, 382 Trust volunteers generously gave more than 9,100 hours of their time, helping to make great patient care happen across 27 services.

During this period, the Community Involvement Team have worked with colleagues to facilitate service improvement initiatives and coordinate procurement and ordering processes to help improve patient care. These include:

- **Supporting Sherwood to begin offering pioneering HoLEP procedures**
  Supporting the Urology Team to enable Sherwood to become the first NHS trust in Nottinghamshire to offer Holmium Laser Enucleation of the Prostate (HoLEP), a minimally invasive, gold-standard treatment for benign prostatic hyperplasia (BPH), commonly known as an enlarged prostate.

  The Charity has supported the initiative with the procurement of equipment costing around £80,000.

The Trust's Urology team, who have become the first in the Midlands to begin offering pioneering HoLEP treatment

- **Assisting the Trust's Clinical Illustration Team to provide an improved sensitive and professionally-delivered maternity/paediatric bereavement photography service**
  Funds raised in The Daffodil Cafe have been utilised to provide photography equipment, mini printer, USB sticks and memory boxes which will provide families with high-quality memorial photos.

- **Working with the Orthoptics Team to obtain funding for four Thomson vision testing units which will significantly enhance the Orthoptic and Optometry care provided at King's Mill Hospital and Newark Hospital**
  The initiative will enable us to carry out a wider range of diagnostic and vision assessments on a single, modern system. The new technology will improve the patient experience, support more specialised testing for adults and children, including those with learning disabilities.

- **Supporting the purchase of two new Transoesophageal Echocardiography (TOE) probes for the Trust's cardiology service**
  TOE scans provide highly detailed images of the heart and are used to support the diagnosis and treatment of patients with complex cardiac conditions. The new equipment will enable patients to continue receiving specialist cardiac diagnostics closer to home, reducing the need for travel to other hospitals and helping people to get care more quickly.

  The purchase was made possible through a generous legacy gift left for Sherwood Forest Hospitals Charity by Jack Davies, which has helped to restore an important heart scanning service and protect it for the future.

During this period, the Community Involvement Team have also guided supporter stewardship and overseen a number of community fundraising events, including:

- Thanking Emily's Traditional Ice Creams, who have been based outside King's Mill Hospital over the summer, providing sweet refreshments to Trust patients and colleagues. The business has kindly donated 10% of their profits (£1,561.14) to the Sherwood Forest Hospitals Charity. Pictured right.

- Supporting six runners who took part in the Mansfield 10K, raising over £1,000 for the Sherwood Forest Hospitals Charity.

- Meeting colleagues from Skanska, Central Nottinghamshire Hospitals (CNH) and Medirest, who kindly arranged a tombola to raise funds for the charity which raised £1,020.61.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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

Subject:	Council of Governors meeting held in public	**Date:**	6 August 2026
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Rukshana Kapasi, Trust Chair		
Presented By:	Rukshana Kapasi, Trust Chair		
Purpose:			
To provide the Board of Directors with a summary of the key discussions, assurances, risks, decisions and actions arising from the Council of Governors meeting held on 6 August 2026.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Financial position: Month 3 showed an £8m year-to-date deficit, £4.3m adverse to plan, with a £15m gap against the £34.8m full-year efficiency requirement. Limited assurance was reported on the financial trajectory and cash remained a significant challenge. **Mental health pressures:** Patients with mental health vulnerabilities continued to wait in the Emergency Department, which was recognised as an unsuitable environment. The matter was being escalated across the system. **Corridor care and urgent care demand:** Sustained pressure at the front door continued to make reducing corridor care difficult. **CSSD fragility:** Sterilisation service resilience remained a key concern pending implementation of the new modular system, expected in September and October 2026. **Workforce safety and inclusion:** Racially motivated aggression and harassment had worsened, and the visibility and effectiveness of the No Hate campaign required renewed focus across all Trust sites.	• Financial Recovery Cabinet meeting more frequently; clearer projections, actions and accountability requested for Finance and Performance Committee. • Quality Committee to review how the clinical audit programme is prioritised against clinical risk and patient impact. • System summit agreed to address mental health pathway pressures and support access to the right care in the right place. • People Team to return with proposals to reinvigorate the No Hate campaign consistently across all sites. • AJ to write to the Head of Social Care at Nottinghamshire County Council and provide a written summary of delayed discharge work by 10 November 2026. • Governors to respond to PG on availability and involvement in the Meet Your Governor process by 10 November 2026. • GR to develop a process for governor nominations for 15 Steps visits from 2027. • SBS to progress recruitment for the NED vacancy through the appropriate governance route by 10 November 2026. • A discharge lounge update and digital transformation item to return to the next meeting.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
• Audit action completion improved to 82%, above the 80% target and up from 73% in the previous year. • The Trust received a positive CQC outcome, with services described as feeling joined up; a formal improvement process will address the remaining findings. • Improvements were reported in ED performance, four-hour waits and the cancer 62-day backlog. • The Mansfield Community Hospital Community Diagnostic Centre was fully operational and receiving positive feedback. • KPMG issued an unqualified opinion on the 2025/26 financial statements and identified no significant weakness in value-for-money arrangements. • Fit and Proper Person checks were completed with no adverse findings. • Fifteen Steps visits provided significant assurance, with teams consistently observed to be welcoming, compassionate and professional. • The Council received positive assurance on leadership, volunteering, staff commitment, the annual report and accounts, NED contributions and patient mealtime support.	• Approved the minutes of the Council of Governors meeting held on 19 May 2026 as a true and accurate record. • Approved the further re-appointment of Barbara Brady to 30 September 2027 and Manjeet Gill to 31 October 2027. • Approved recruitment at pace to fill the vacant specialist NED role, seeking professional finance/accountancy expertise and ideally transformation experience, with the intention that the appointee chair the Finance and Performance Committee. • Agreed in principle to appoint an Associate NED with transformation, partnerships and finance experience. • Agreed that the completed action relating to arrangements involving JS could move to green status. • No matters were escalated separately to the Board of Directors.

Comments on effectiveness of the meeting

The meeting was quorate and covered all scheduled business. There was sufficient time for discussion and to focus on assurance, challenge, risks and follow-up actions. Governors contributed constructively, drawing on engagement activity and patient experience.

Items recommended for consideration by other Committees

• Quality Committee: review assurance on prioritisation of the clinical audit programme, including clinical risks, patient impact and patient experience.
• People Committee: review proposals to reinvigorate the No Hate campaign and ensure consistent visibility and effectiveness across all Trust sites.

Progress with Actions

Number of actions considered at the meeting – 4
Number of actions closed at the meeting – 1
Number of actions carried forward – 3
Any concerns with progress of actions – Yes. Two actions remained amber pending definitive updates, and the digital transformation action was not recorded on the tracker but was confirmed for the next agenda.

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

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date:**	24 September 2026
Prepared By:	Rich Brown, Head of Communications and Jon Melbourne, Chief Executive		
Approved By:	Jon Melbourne, Chief Executive		
Presented By:	Jon Melbourne, Chief Executive		

Purpose

An update regarding some of the most noteworthy events and items from recent months from the Chief Executive's perspective, covering August and September 2026.	**Approval**	
	Assurance	
	Update	**Y**
	Consider	

Recommendation

The Trust's Board of Directors is asked to NOTE the updates provided in this report.

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

BAF = Board Assurance Framework
CQC = Care Quality Commission
ED = Emergency Department
NHS = National Health Service
NOF = National Oversight Framework
PR = Principal Risk

Executive Summary

An update regarding some of the most noteworthy events and items from recent months from the Chief Executive's perspective, covering August and September 2026.

Introduction

I am pleased to share this latest report, which reflects a significant period of progress across Sherwood Forest Hospitals during August and September.

Over these months, we have seen external recognition of the compassionate, high-quality care provided by our teams, taken important steps to improve our facilities and digital services, and celebrated the contribution of colleagues, volunteers and partners across the Trust.

The Care Quality Commission's rating of King's Mill Hospital as 'Good' – following Newark Hospital's 'Good' rating – was a particularly important moment. It recognised the professionalism, kindness and teamwork demonstrated by colleagues every day, while also giving us a strong foundation from which to continue improving. A line in the report said that people saw themselves as "one big team". I certainly feel that and it is something which we must cherish.

We have also progressed developments that will improve how patients access and experience care. These include the start of a £5million expansion of the Majors part of our Emergency Department at King's Mill Hospital and the continued driving of digital innovation across our hospitals.

These achievements have taken place against a challenging operational and financial backdrop. Many of you will have seen in the media that the NHS has faced record demand this summer – and this has certainly been felt at Sherwood Forest Hospitals.

Demand remains high and we know that some patients continue to wait longer than we would want. Our focus remains on providing safe, timely and effective care, and improving patient flow and productivity. This involves close partnership working – and today you will see our winter plan presented at Board.

I would like to put on record my continued thanks to colleagues for the care they are providing and the compassion which they show every day.

Trust updates

King's Mill Hospital rated 'Good' following latest CQC inspection

We were delighted that King's Mill Hospital was rated 'Good' overall in the Care Quality Commission report published on 15 July 2026. The hospital was rated 'Good' across all five assessed domains: Safe, Effective, Caring, Responsive and Well-led.

The inspection focused on Medical Care and Urgent and Emergency Care services. Inspectors highlighted that colleagues worked well together for the benefit of patients and their loved ones, and alongside other local NHS services to plan and deliver care. They also recognised the Trust's open and honest culture, person-centred approach and commitment to ensuring that patients feel safe, cared for, listened to and fully informed.

Patients and carers who spoke to inspectors were positive about colleagues and said they were treated with warmth and kindness and received effective care and treatment. This recognition reflects the dedication, professionalism and compassion shown by teams across the Trust.

We remain committed to learning from the inspection findings and using them to build on the progress already made. While we should be proud of this achievement, our focus remains on continuous improvement and ensuring that every patient consistently receives outstanding care.

Trust's National Oversight Framework (NOF) position updated

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

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

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

For us here at Sherwood, the league tables see us ranked 72nd place in the country in quarter one of 2026/2027. This places us in the third of the four segments, recognising that any trust working in financial deficit cannot climb any higher than segment three.

£5million investment to expand the Emergency Department at King's Mill Hospital

Patients across Nottinghamshire are set to benefit from a major £5million investment to expand the Emergency Department at King's Mill Hospital, thanks to funding provided by NHS England.

Subject to the necessary planning approvals, the development will add 14 treatment spaces to the Majors department, increasing capacity from 26 to 40 spaces for the sickest patients attending the Emergency Department. It will also provide additional patient toilets, a dedicated space for patients with mental health needs, a new 40-seat waiting area and four assessment rooms.

A further key feature will be the development of the ambulance handover area. This will support earlier assessment of patients' needs and help direct them to the most appropriate place for their care, while enabling quicker ambulance turnaround times.

Demand for Urgent and Emergency Care services at Sherwood continues to grow. This investment will provide additional capacity, improve patient flow and create a calmer environment for patients who need to spend longer in the department.

The first phase is expected to become operational by the end of 2026, with the overall project due to be completed by February 2028.

Other Trust updates

Celebrating colleagues' achievements at this year's Trust *Excellence Awards*

Rebecca Loveridge (centre) collects her 'Highly Commended' award in the Lifetime Achievement Award category

September provided an important opportunity to recognise the achievements of colleagues, teams, volunteers and partners at this year's annual Trust *Excellence Awards*.

The shortlist reflected the breadth of outstanding work taking place across Sherwood, recognising clinical and non-clinical teams and individuals, apprentices, rising stars and volunteers.

The People's Award also gave patients, families and members of the public the opportunity to recognise colleagues whose care, kindness and professionalism had made a meaningful difference.

The strength of the nominations demonstrated the compassion, innovation and commitment shown across the Trust. I would like to congratulate everyone who was nominated, shortlisted and won awards at this year's event, whose achievements reflect the contributions they make every day.

The event was only possible thanks to the support of our Trust sponsors, whose generous support and contributions meant that the event was run at no cost to the Trust.

Annual General Meeting and *Improving Lives* Showcase

The Trust held its Annual General Meeting, Annual Members' Meeting and *Improving Lives* Showcase event on Wednesday 23 September, where we welcomed members, governors, stakeholders, colleagues and the public to hear about the Trust's performance during 2025/26 – and our plans for the future.

The event supported our commitment to openness and accountability, enabling attendees to learn more about the Trust's Annual Report and Accounts and to ask questions about our services and priorities.

The *Improving Lives* Showcase also provided an opportunity to highlight examples of innovation and improvement from across the organisation and to recognise the work colleagues are doing to improve patient care, experience and outcomes.

Welcoming and developing our people

During the summer, we welcomed a new cohort of 143 resident doctors to Sherwood Forest Hospitals.

Welcoming new colleagues is an important opportunity to reinforce the culture we want to create: one in which people feel supported, included and able to provide high-quality care. The contribution of our resident doctors is vital across our services, and we are committed to ensuring that they receive the support, education and development they need.

This work sits alongside our wider focus on workforce wellbeing, leadership development, recruitment and retention, and creating an organisation where colleagues can be at their best.

Preparing for winter through the vaccination programme

The NHS has begun offering flu vaccinations to children and pregnant women from the beginning of September as preparations for winter gathered pace, with King's Mill Hospital one of the first sites in the country to begin offering this vital protection as we approach winter.

Supporting vaccination remains an important part of protecting patients, colleagues and local communities and reducing avoidable pressure on health services. The Trust continues to work with partners to encourage eligible people to take up the vaccinations available to them.

Our wider winter planning is also focused on maintaining patient flow, supporting timely discharge and ensuring that patients receive the right care, in the right place, at the right time.

The Trust's annual staff flu vaccination campaign is due to begin in early October.

Trust risk ratings reviewed

The Risk Committee reviewed and updated Board Assurance Framework (BAF) Principal Risk 7, 'A major disruptive incident', for which it is the lead assurance committee in September. Committee members discussed the risk scores and assurance ratings but decided that they should remain unchanged.

The full updated Board Assurance Framework (BAF) is presented to the Trust's Board of Directors every four months and will next be presented at the Public Meeting of the Board of Directors in October.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet and report

Subject:	Perinatal Quality and Safety - July and August 2026 data	**Date:**	1 October 2026
Prepared By:	Sarah Ayre, Divisional Director of Perinatal and Women's Health Services (Interim), and Lisa Butler, Deputy Head of Perinatal Services		
Approved By:	Paula Shore, Director of Nursing and Midwifery/Deputy Chief Nurse; Philip Bolton, Executive Chief Nurse; Simon Roe, Chief Medical Officer; Neil McDonald, Non-Executive Director		
Presented By:	Lisa Butler, Deputy Head of Perinatal Services		

Purpose		
This report provides an integrated update on maternity and neonatal quality, safety and assurance for 1 July–31 August 2026, aligned to NHS England's Perinatal Quality Oversight Model (PQOM). It brings together locally and nationally agreed measures to inform the ICB Board and Trust Board of current performance, existing and emerging safety concerns, and actions being taken to improve care. Reporting is being tailored to explicitly map to the Regional Perinatal Quality Group (RPQG) domains, providing a clear and consistent structure for presenting evidence, identifying gaps and tracking improvement. The report supports two-way 'ward to board' oversight, ensuring that insight from the multidisciplinary, multiprofessional perinatal team informs Board assurance and that priorities and required actions are communicated back to services.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Recommendation
The Board of Directors are asked to: • Review the July and August evidence and determine the level of assurance it provides. • Consider identified safety concerns, operational pressures and gaps in assurance. • Agree any further actions, named owners, timescales and escalation required.

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

Committees/groups where this item has been presented before

Senior Management Team
Perinatal Quality Surveillance Group (LMNS)
Perinatal Governance Meeting

Acronyms

- Perinatal Assurance Committee (PAC)
- National Health Service England (NHSE)
- Perinatal Quality Oversight Model (PQOM)
- Statistical Process Control (SPC)
- Maternity and Newborn Safety Investigations Programme (MNSI)
- NHS Resolution (NHSR)
- Perinatal Mortality Review Tool (PMRT)
- Patient Safety Incident Investigation (PSII)
- Maternity Outcomes Signal System (MOSS)
- Reduced fetal movements (RFM)
- Intra Uterine Fetal Death (IUFD)
- Maternity and Neonatal Voices Partnership (MNVP)

Executive Summary

This report provides the Board of Directors with an integrated overview of maternity and neonatal quality, safety and performance during July and August 2026.

Birth activity remained broadly stable across the preceding 12 months; however, rising maternity ward occupancy indicates increasing inpatient demand and reinforces that birth numbers alone do not fully represent service complexity or operational pressure.

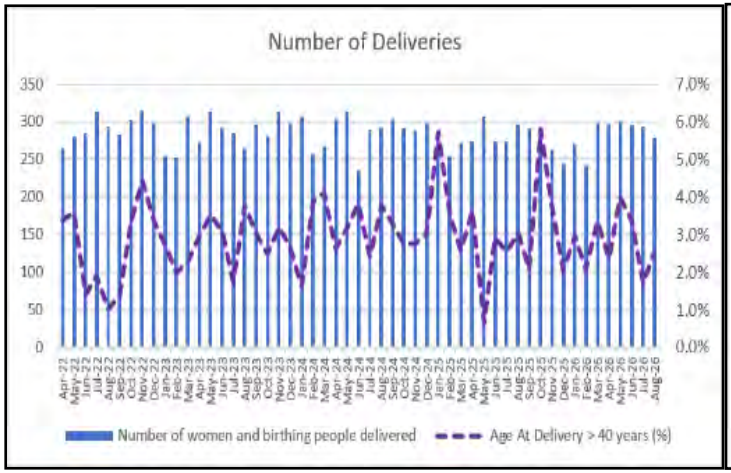
There are several areas of positive assurance. The overall caesarean birth rate reduced from 45.2% in July to 41.2% in August, while term neonatal admission rates reduced from 4.71% to 3.8%. Following a significant increase in obstetric haemorrhage in July, the rate reduced substantially in August. This improvement coincided with the introduction of the BadgerNet postpartum haemorrhage prevention assessment and colour-coded risk indicators, alongside continued progress through the Position for Progress programme.

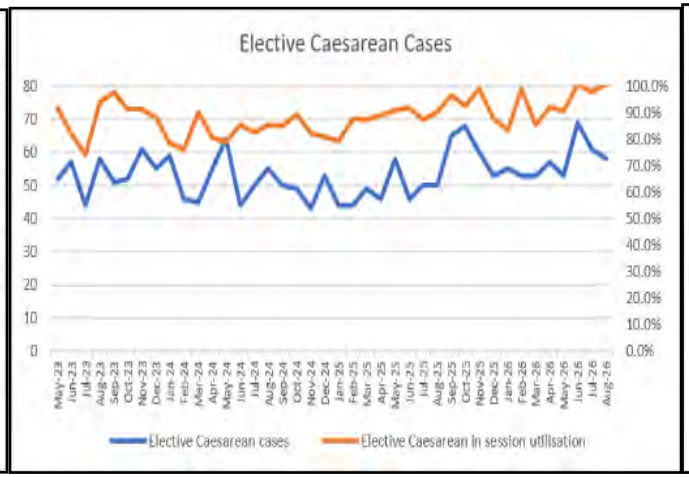
External validation also confirmed 91% implementation of the Saving Babies' Lives Care Bundle version 3.2, with three elements fully implemented. There were no Maternity Outcomes Signal System signals, Regulation 28 reports or outstanding HM Coroner reports during the reporting period. Perinatal losses were reviewed through established multidisciplinary and formal review processes, with bereavement and staff support provided. Areas requiring continued oversight include incomplete reporting against the specified National Maternity and Perinatal Audit indicators, particularly unplanned maternal readmissions and small-for-gestational-age births.

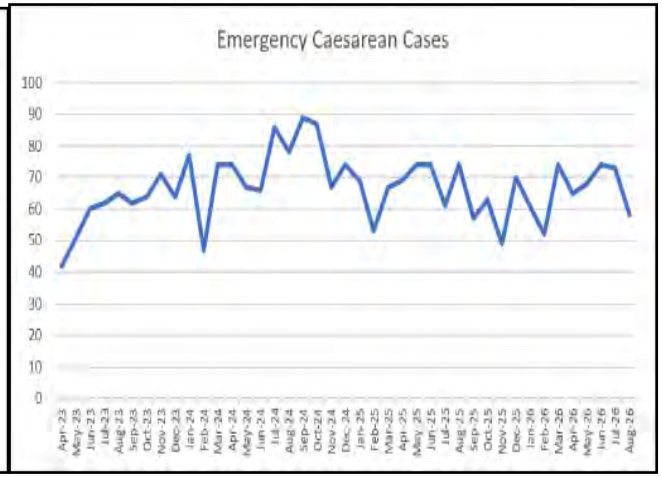
Two risks remain scored at 12 relating to neonatal airway competence and maternity ward security, with active mitigations and further improvement plans in place. One maternity diversion occurred in July, and none in August, with no reported harm; development of the Maternity Operational Silver pilot will further strengthen out-of-hours senior midwifery support and escalation. Overall, the report demonstrates active identification and management of key safety concerns, with positive improvement evident alongside defined gaps requiring sustained monitoring and PAC oversight.

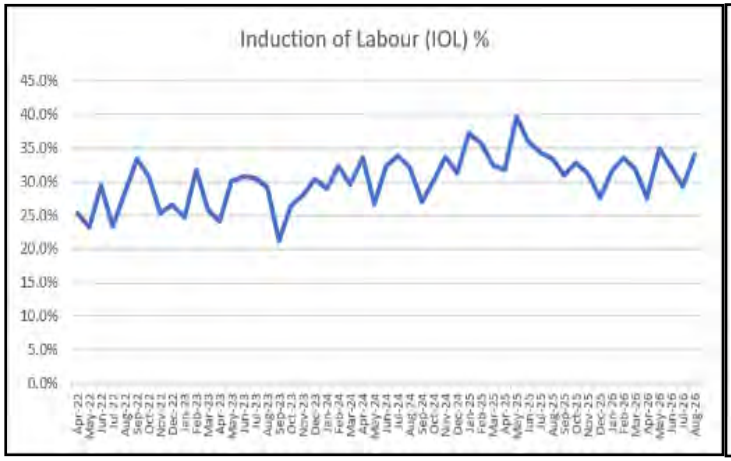
1.0 Statistical process control (SPC) data

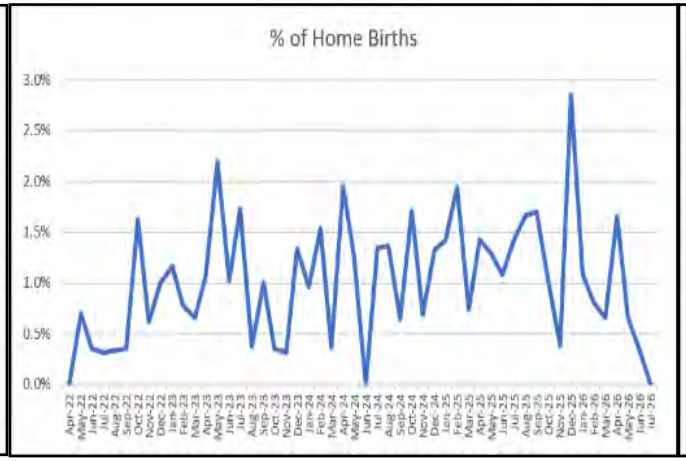
This PQOM report uses SPC to provide robust, consistent and meaningful interpretation of maternity and neonatal safety data. SPC enables the Trust to distinguish between expected variation and true change in performance, supporting early identification of emerging risk and timely, proportionate escalation.

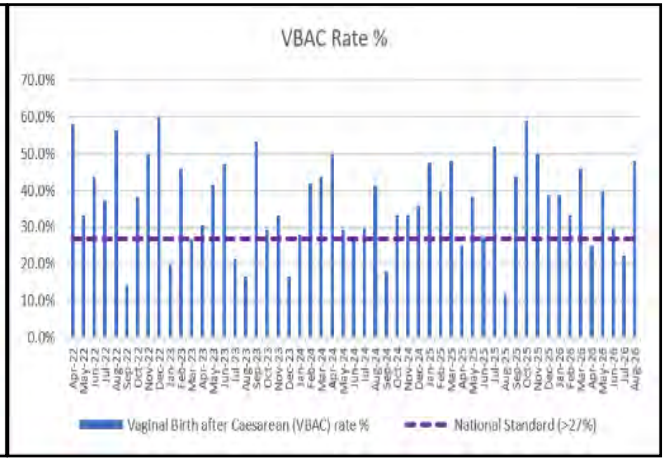












1.1 – August 2025 to August 2026

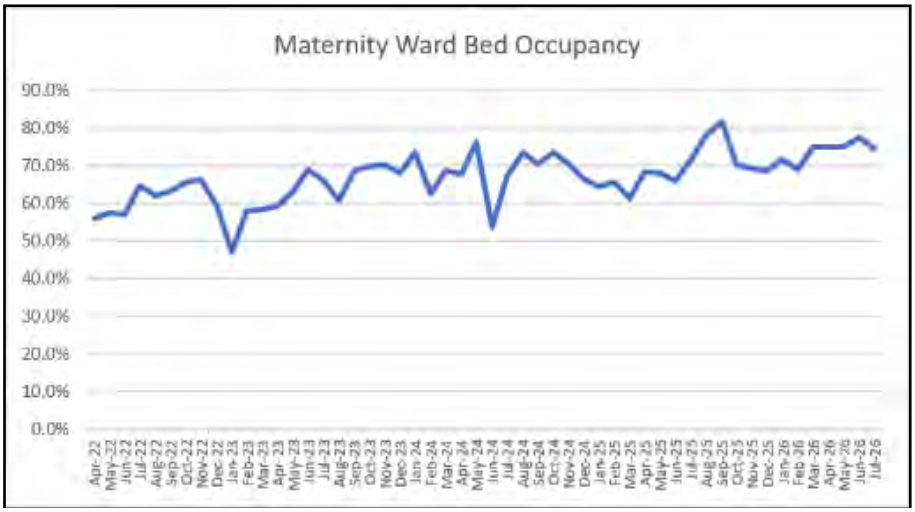
Over the 12 months from September 2025 to August 2026, monthly birth activity averaged approximately 280 deliveries, ranging from around 240 to 300. Activity was lower during parts of the winter period before returning to approximately 300 deliveries per month during spring and early summer. The overall pattern shows fluctuating demand rather than a sustained reduction in birth activity.

Caesarean birth remained a substantial component of the birthing profile. Elective caesarean activity generally ranged from approximately 50 to 70 cases per month, with emergency caesareans ranging from around 50 to 75. Both showed monthly variation, without a consistent downward trajectory across the year. These figures demonstrate the continuing demand for planned and emergency obstetric theatre capacity.

Induction of labour accounted for approximately 28–35% of births throughout the period, remaining close to one-third of deliveries. This represents a consistent component of maternity activity, with implications for pathway capacity, staffing and flow across the service.

The vaginal birth after caesarean (VBAC) rate varied considerably, ranging from approximately 22% to 59%. Performance was above the dashboard's 27% reference line in most months; however, intermittent reductions mean that sustained improvement cannot yet be confirmed. Interpretation should take account of the number of women attempting VBAC and their clinical circumstances.

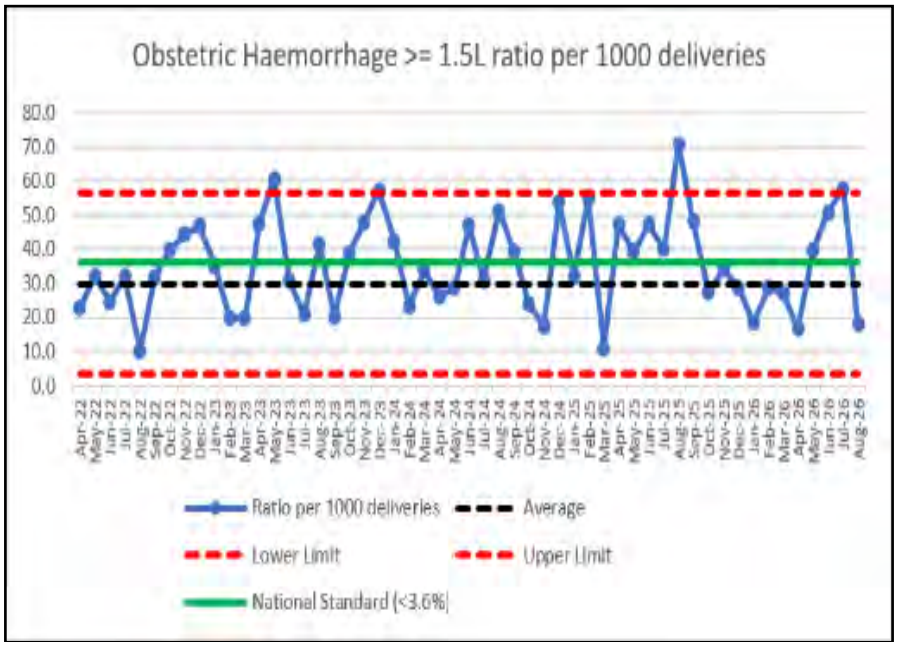
Home births remained a small and variable proportion of overall activity, generally below 2%, with an isolated peak approaching 3%. The available data show a decline towards the end of the reporting period, reaching zero in July 2026. August data are required to complete the annual picture, and the recent reduction warrants consideration alongside women's preferences, eligibility and service availability.



Despite broadly stable birth volumes, maternity ward bed occupancy demonstrates an overall upward pattern between April 2022 and July 2026. Occupancy increased from approximately 56% at the start of the period to around 75% in July 2026, with a peak of approximately 82% in August 2025.

Although monthly variation remains evident, recent occupancy has generally been higher than in the earlier reporting period. Assuming a consistent available bed base, this indicates increased demand for inpatient maternity care and reinforces that delivery numbers alone are an insufficient measure of service workload.

1.2 Obstetric Haemorrhage



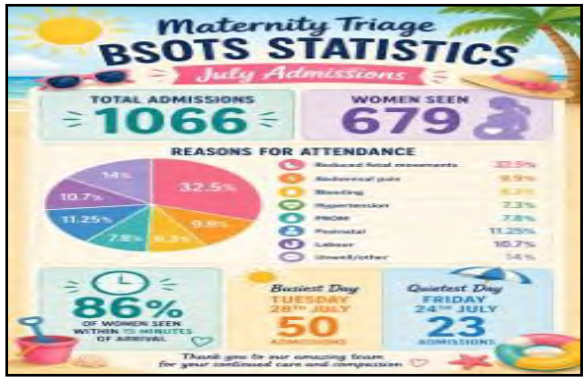
The SPC chart demonstrates considerable monthly variation in obstetric haemorrhage ≥1,500 ml. Over the latest 12 months, September 2025–August 2026, there were 112 cases across 3,366 deliveries (3.3%), below the dashboard benchmark of 3.6%. However, individual months exceeded this benchmark. July 2026's rate was 57.8 per 1,000 deliveries (5.8%; 17 cases), above the chart's upper control limit, reducing to 17.9 per 1,000 (1.8%; five cases) in August. The August position is consistent with the early findings reported by Consultant Midwife Sam Todd following the introduction of the BadgerNet PPH Prevention Assessment on 15 July and colour-coded risk indicators on 22 July.

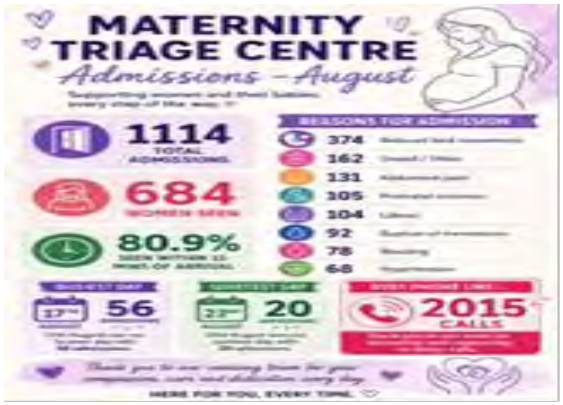
Intrapartum assessment completion increased from 5.8% to 50% within two weeks. These changes support earlier risk recognition, clearer multidisciplinary communication and preparation. ST's early August review also identified fewer severe haemorrhages, suggesting that the combined prevention measures may be contributing to improved outcomes.

Alongside this, Position for Progress is supporting changes in labour and birth practice. Among unassisted vaginal births, sacrum-free positioning increased from approximately 15% in February to 22% in August, while lithotomy reduced from approximately 17% to 14%. Staff feedback describes benefits for comfort, fetal rotation and labour progress. Positioning may contribute to improved birth outcomes, but its specific effect on haemorrhage has not been demonstrated locally. The strongest current assurance is improved prevention processes and an encouraging August outcome. Continued monitoring of PPH severity, assessment completion, birth position, mode of birth and blood-product use will help establish whether these changes produce sustained benefit

1.3 SFH Perinatal Services Monthly Dashboard – accessed via [Maternity Portal]

1.4 Monthly Triage Stats poster generated by Triage Team for staff awareness





2.0 National Maternity and Perinatal Audit (NMPA), Outlier Status (RPQG 14):

The National Maternity and Perinatal Audit (NMPA) evaluates NHS maternity care across England, Scotland and Wales, using data on care processes and outcomes to identify good practice and opportunities for improvement. Commissioned by the Healthcare Quality Improvement Partnership (HQIP), it is led by the Royal College of Obstetricians and Gynaecologists (RCOG) in partnership with the Royal College of Midwives (RCM), the Royal College of Paediatrics and Child Health (RCPCH), and the London School of Hygiene and Tropical Medicine. Women, birthing individuals and families help shape the audit's priorities and accessible reporting, with all reports and results publicly available.

The latest data for SFH is displayed below:

State of the Nation - Audit results by provider 2024

	Year	Indicator	Unadjusted rate	Adjusted rate	GB mean	Limits 95%	Limits 99.8%	Adjusted rate in relation to 99.8% Limits
1	2024	Babies receiving breast milk (Overall at first feed)	62.50%	64.40%	71.90%	70.4 - 73.5	69.6 - 74.3	Below
2	2024	Caesarean birth (In Robson Group 1, overall)	24.40%	24.50%	19.90%	16.7 - 23	15.1 - 24.6	Within
3	2024	Caesarean birth (In Robson Group 2, overall)	66%	67.90%	60.50%	57 - 64	55.1 - 65.8	Above
4	2024	Caesarean birth (In Robson Group 5, overall)	84.10%	83.10%	83.10%	79.5 - 86.7	77.6 - 88.7	Within
5	2024	Caesarean birth (Overall)	42.70%	45.70%	42.70%	41 - 44.4	40.2 - 45.3	Above
6	2024	Episiotomy (Overall)	19.30%	20.70%	24.70%	22.8 - 26.7	21.7 - 27.7	Below
7	2024	Induction of labour (Overall)	30.90%	29.50%	32.50%	30.9 - 34.2	30 - 35.1	Below
8	2024	Late antenatal booking (Overall)	17.40%	20%	24.40%	22.9 - 25.8	22.1 - 26.6	Below
9	2024	Postpartum haemorrhage (Haemorrhage of 1500ml or more (overall))	3.30%	3.30%	3.50%	2.9 - 4.1	2.5 - 4.5	Within
10	2024	Preterm birth rate (Overall)	5.70%	5.90%	6.20%	5.4 - 7	5 - 7.5	Within
11	2024	Skin to skin contact (Overall (34+0 to 42+6 weeks))	76.50%	75.60%	73.20%	71.7 - 74.7	70.9 - 75.5	Above
12	2024	Small for gestational age babies born at or after 40 weeks	41.70%	43%	41.40%	33.9 - 49	29.9 - 53	Within
13	2024	Term babies with a 5-minutes Apgar score of less than 7	1.80%	1.90%	1.50%	1.1 - 2	0.9 - 2.2	Within
14	2024	Third and fourth degree tears (Overall)	4.40%	4.70%	3.50%	2.7 - 4.3	2.2 - 4.8	Within
15	2024	Unplanned maternal readmission within 42 days	3.30%	3.40%	3.40%	2.7 - 4	2.3 - 4.4	Within
16	2024	Vaginal birth after primary caesarean section	13.50%	13.90%	13.70%	9.6 - 17.7	7.4 - 19.9	Within
17	2024	Vaginal birth, with or without the use of instruments (Overall)	57.30%	54.60%	57.30%	55.6 - 59	54.7 - 59.8	Below

2.1 NMPA Outlier Monitoring and Assurance (RPQG 14)

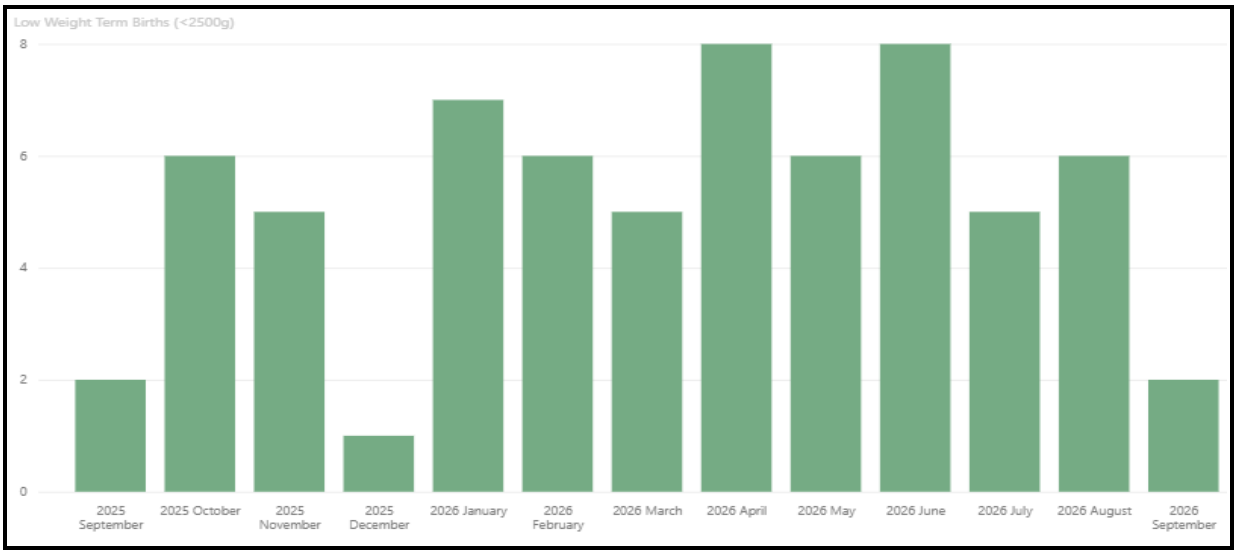
The Regional Perinatal Quality Group (RPQG) requires monthly reporting and rating of outlier status, currently to include unplanned maternal readmissions, small-for-gestational-age babies and caesarean birth rates.

Metric	Indicator	July 2026	August 2026
1	Unplanned maternal readmissions	Not collected	Not collected
2	Small-for-gestational-age indicator (reported as low birth weight < 2500 g)	1.7% (5/294)	2.15% (6/279)
3	Caesarean births, all categories	45.2% (133/294)	41.2% (115/279)

Metric 1: Data on unplanned maternal readmissions are not currently collected in line with the specified indicator. Work is underway with the Digital and Business Intelligence teams to establish the required data capture and incorporate this measure into the maternity dashboard, enabling routine monitoring and reporting. Until this is available, assurance against this metric remains limited.

Metric 2: Small-for-gestational-age indicator (reported as low birth weight < 2500 g)

Current reporting captures low birth weight at term, which is not equivalent to small-for-gestational-age, as this is assessed using birthweight centiles. We will work with the Digital and Business Intelligence teams to refine data capture and update the maternity dashboard to report against the specified small-for-gestational-age indicator, strengthening future monitoring and assurance.



Between September 2025 and August 2026, the number of term babies born weighing less than 2,500 g varied from one to eight per month, with 65 recorded across the 12 months. There were five cases in July and six in August, below the peaks of eight in April and June. For the financial year to date, April–August 2026, 33 cases were recorded. The chart shows monthly fluctuation without a clear sustained upward or downward pattern; September 2026 is incomplete and should be excluded from comparison.

Metric 3: The overall caesarean birth rate reduced from 45.2% in July to 41.2% in August 2026, a reduction of 4.0 percentage points. This reflected fewer emergency caesareans, which fell from 75 (25.5% of deliveries) to 57 (20.4%). Elective caesareans remained unchanged at 58 each month, although the proportion increased slightly from 19.7% to 20.8% because total deliveries decreased. For the financial year to date, April–August 2026, there were 633 caesarean births across 1,466 deliveries, giving an overall rate of 43.2%. This comprised 289

elective caesareans (19.7%) and 344 emergency caesareans (23.5%). The overall rate was slightly higher than the equivalent period in 2025, at 42.1% (601/1,426). Monthly rates ranged from 40.2% in May to 48.5% in June, before reducing in July and August.

3.0 Perinatal mortality and review

3.1 July and August summary

Cases of Stillbirths and Late fetal losses			
Ref No.	**Incident Category**	**Outcome**	**Immediate actions**
July 2026			
104608	IUFD	Booked for care at SFH. Attended for routine antenatal contact with CMW at 37+5, unable to auscultate FH, escalated via triage. IUFD sadly confirmed on USS. Birthed 38+1. Ongoing bereavement support. PMRT Review ongoing.	Discussed in Triggers MDT. Learning discussions held with staff for support and reflection. Identified excellent counselling conversations, positive feedback to staff.
August 2026			
105061	ENND x1 IUFD x2	Booked for care at SFH whilst receiving OOA community care. Identified DCTA pregnancy. Shortening of the cervix identified at 20+2 on scan. Had contact arranged for review following week and was prescribed progesterone, encouraged bed rest and enoxaparin prescribed. Sadly, laboured following day 20+3. Triplet 1 born with signs of life (ENND). Triplets 2 & 3 born with no signs of life (IUFD x2). RIP. This case was referred to PMRT via SPEN but was rejected on the grounds of gestation prior to 24/40.	Discussed at Maternity Triggers and no learning/actions identified.
105162	IUFD	Unbooked pregnancy, call received via EMAS, transfer in during second stage. Presented to unit with half-delivered breech. Difficult delivery requiring craniotomy due to head entrapment. Infant born with no signs of life, RIP. Maternal view of approx. 22 weeks gestation based on LMP but examination by neonatologists determined 29/40 gestation. Case reported via SPEN and PMRT review.	Case discussed in Triggers MDT and no learning/actions identified. Identified excellent MDT working, positive feedback to staff. Ongoing pastoral support for staff.

Cases of Neonatal and Postnatal Death			
Ref No.	**Incident Category**	**Outcome**	**Immediate actions**
July			
No NNDs in July			
August 2026			
105061	Please see above table for information.		

3.2 Learning from PMRT reviews

Issue		Action	By Whom	By When
Historical learning: 2025/26 Q3 – recorded as completed in the previous paper				
Q3	Learning update disseminated to ED and SBU staff regarding the CDOP and reporting process.	CDRT to provide learning on annual training regarding usual CDOP processes and correct reporting process.	CDRT Lead Midwife	January 2026
	Reminder to junior Dr's during teaching regarding exploring other avenues with UTI symptoms	Teaching update	Consultant Obstetrician	January 2026
	Update required regarding need for repeat bloods.	Plan to contact patient and repeat bloods as required if consents.	Consultant Obstetrician	January 2026
	Incomplete plans regarding fetal monitoring	Shared learning through an after action review.	Clinical governance midwife	March 2026
	Declined GTT - No HBA1c offered	To discuss Diabetic Specialist MW to clarify if a patient is declining GTT, if any investigations should occur in place.	Clinical governance midwife	December 2025 Discussed – currently unable to offer an alternative – Gold standard is GTT – as per NICE
	Deranged urinalysis not actioned	Individual discussions with MW and Reg	Clinical governance midwife	December 2025

Issue		Action	By Whom	By When
		regarding management		
Historical learning: 2025/26 Q4 – recorded as completed in the previous paper				
Q4	Lack of documentation	Discussed with MW at the time of the incident – Retrospective account completed.	Clinical governance midwife	February 2026
	Prescribed Iron BD instead of iron infusion	Learning to staff regarding iron dosage and iron infusion	Clinical governance midwife	March 2026
	No Mifepristone given to commence regime	For discussion with consultant – shared learning.	Consultant Obstetrician	March 2026
	Poor documentation around decision for birth	Individual discussions with staff	Consultant Obstetrician	March 2026
	Incorrect VTE assessment	Individual feedback to Community Midwife	Quality and Safety Lead	March 2026
	UtAD on USS not performed.	Review of CRIS shows that the UtAD was booked however the patient DNAd	Consultant Obstetrician	March 2026
2026/27 Q1				
Q1	Missed FGR risk	S2S completed as patient receiving OOA CMW care	RDH	July 2026
Q2	Missed AN CMW contacts 28-35/40	Discussion with individual staff member to unpick.	Community Midwifery Team Leader	July 2026
	Clarification of decision for estimated gestation placed on Badgernet, no documentation of examination	Individual discussions with staff	SBU Ward Leader	August 2026

Issue		Action	By Whom	By When
	Choice of 1st line medication for active 3rd stage	Ongoing dissemination of learning within PPH QI workstream	Consultant Midwife	September 2026

4.0 Maternity and Newborn Safety Investigations (MNSI) (RPQG 20)

4.1 Investigation progress update

Date	MNSI reference	MNSI - Date Reported	ENS - Reported	ENS - Date Accepted	DoC - Verbal	Draft Report Received	Final Report Received
17/01/2025	MI-039331	22/01/2025	ENS-002-24	17/02/25	17/01/2025	23/06/25	24/06/25 Closed
08/02/2025	MI-039722	11/02/2025	N/A	N/A	14/02/2025	Case rejected by MNSI – lack of consent	
11/04/2025	MI-041409	16/04/2025	N/A	N/A	23/04/2025	Case rejected by MNSI – lack of consent	
01/05/2025	MI-041785	02/05/2025	N/A	N/A	02/05/2025	16/09/25	08/10/25
22/07/2025	MI-044576	23/07/2025	N/A	N/A	23/07/2025	26/11/25	19/12/25
13/07/2025	MI-044904	01/08/2025	N/A	N/A	04/08/2025	Case rejected by MNSI – lack of consent	
12/08/2025	MI-045323	15/08/2025	N/A	N/A	15/08/2025	Case rejected by MNSI – lack of consent	
30/08/2025	MI-045821	01/09/2025	N/A	N/A	01/09/2025	12/02/2026	27/02/26
31/08/2025	MI-046096	05/09/2025	ENS-25-001	Not accepted	05/09/2025	29/01/2026	23/02/26
30/09/2025	MI-047287	02/10/2025	N/A	N/A	02/10/2025	19/01/2026	23/02/26
05/02/2026	MI-052986	09/02/2026	09/02/2026	No	06/02/2026	07/07/2026	18/08/2026
17/03/2026	MI-055636	20/03/2026	CLM1909001	03/04/26	20/03/2026	19/08/2026	
03/08/2026	MI-064879	03/08/2026	10/09/2026	Not accepted	03/08/2026		

4.2 Learning from MNSI reviews

Theme	Actions	Responsible role	By when
Actions carried forward – confirm completion and evidence at 31 August 2026			
Guidance variation	Review of guidance on use of Aspirin in pregnancy	Governance team	March 2026
Communication	Ensure communication process is clear when changes to infrastructure	Senior leadership team	March 2026
Triage	Ensure a designated quiet space for telephone triage, protected from interruptions	Matron – Perinatal Services	March 2026
Escalation	Clarify and reinforce escalation pathways within SOPs, including consultant advice	Matron – Perinatal Services	March 2026
Latent phase of labour pathway	Review the Latent phase of Labour guidance to ensure the correct process and a holistic assessment	Consultant Midwife	April 2026
Triage	Review the Latent phase of Labour guidance to ensure there is a clearly defined pathway of care regarding pain management in Triage	Consultant Midwife	April 2026
Communication	Review of the electronic patient record system to support with transfer of information.	Digital Lead Midwife	May 2026
Guidance	Review the use of medicine in neonatal emergencies and develop staff safety prompt.	Neonatal Practice development Matron	August 2026
Identification of a deteriorating patient	Audit to evaluate care determine issues, trends or themes in relation to the appropriate use, documentation, escalation, and response	Audit Lead Midwife	August 2026

4.3 Maternity Patient Safety Incident Investigation (PSII) (RPQG 21)

Ref No.	Incident category	Summary/ Update
DW222256	HIE	Previous position (June 2026): the investigation report had been shared with the family; addressing outstanding queries was being led by Consultant Midwife Sam Todd. UPDATE July–August: awaiting Neonatal input to enable a full review of all questions raised by the family

4.4 Investigation tracker – position at month end (August)

Period/service	STEIS	PSII	MNSI	Thematic review	Rapid review	AAR	SHOT	Total
Maternity	3	1	3	0	2	2	0	11

5.0 Safety Reporting

5.1 Outstanding HM inquests/reports (RPQG 22)

Reference	Date listed / due	Summary / current position
Nothing to report		

5.2 Regulation 28 report issued

Identifier	Action required	Progress	Responsible role	By when
Nothing to report				

6.0 Review of NHS Resolution Scorecard

April 25 – March 26 Data will be available on 26 September so will be shared at next meeting

Historical claim's themes Source scorecard covered incident dates 1 April 2024–31 March 2025
Failure to monitor second stage of labour
Failure to monitor first stage of labour
Failure to respond to an abnormal fetal heart rate
Failure to monitor the dose/ rate of syntocinon

7.0 Maternity Outcomes Signal System (MOSS) (RPQG 19)

7.1 Signal History

Period	Signals/action taken
Q1	No signal received in this Quarter

Period	Signals/action taken
Q2	No signal received as of the end of August

7.2 MOSS Critical Safety Check (Annex 9) drill

8.0 Performance Metrics

8.1 Maternity Service Diversions

The diversion review presented to July PAC identified the need to strengthen out-of-hours senior midwifery support and ensure consistent application of escalation arrangements. A six-month Maternity Operational Silver (Senior Midwife On-Call) pilot is under development to support Trust Silver with senior clinical advice and decision-making during periods of escalation and potential diversion.

The maternity dashboard records one diversion in July and none in August 2026. No patient harm was reported in relation to the July diversion. However, the absence of reported harm does not fully reflect the potential impact on women, birthing individuals and their families, including anxiety, disruption to planned care and additional travel. Assessment of the quality and safety of diversion arrangements must therefore consider service-user experience, communication and continuity of care alongside clinical outcomes.

8.2 Term admission to NICU (Avoiding Term Admission into the Neonatal Unit, ATAIN)

Avoiding Term Admissions into Neonatal Units (ATAIN) remains a key measure of the maternity and neonatal pathway, including the use of Transitional Care.

Measure	July 2026	August 2026	Total Apr–Aug
Term admissions to neonatal unit (n)	13	10	71
Term births (N)	276	263	1393
Term admission rate (n/N × 100)	4.71%	3.8%	3.6%
Cases reviewed / total admissions	Due to unforeseen circumstances, there has been a delay in the scheduled ATAIN meetings. A recovery plan has been agreed and is being implemented; however, a backlog of case reviews remains from April 2026. Full recovery is anticipated by December 2026.		

9.0 Training compliance – maternity and neonatal staff

Training August 2026	Midwives	Obstetricians (Consultant)	MSWs	Anaesthetists	Neonatologists (consultants)	Neonatal nurses / ANNPs
Saving Babies Lives Care Bundle	82%	91%	88%	N/A	N/A	N/A

Training August 2026	Midwives	Obstetricians (Consultant)	MSWs	Anaesthetists	Neonatologists (consultants)	Neonatal nurses / ANNPs
Fetal monitoring and surveillance	98%	100%	N/A	N/A	N/A	N/A
Maternity Emergencies and multi-professional training	92%	92%	82%	78%	N/A	N/A
Equality/ equity and personalised care (3-Year programme)	82%	91%	88%	N/A	N/A	N/A
Care during labour and immediate postnatal period (3-Year programme)	92%	92%	82%	78%	N/A	N/A
Neonatal Life Support training	92%	N/A	N/A	N/A	93%	95%
Mandatory and statutory training	92%	89%	93%	87%	91%	93%
Qualified in specialty	N/A	N/A	N/A	N/A	N/A	

10.0 Saving Babies' Lives – compliance update (RPQG 9)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	90%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	85%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	92%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	93%	Partially implemented	91%

The Saving Babies' Lives Care Bundle version (SBLCBV3) 3.2 report received LMNS validation confirming that 91% of interventions are fully implemented, compared with the Trust's self-assessment of 93%.

Three elements are fully implemented: reduced fetal movements, fetal monitoring during labour and diabetes in pregnancy.

Smoking in pregnancy, fetal growth restriction and preterm birth are partially implemented, with validated implementation levels of 90%, 85% and 92% respectively. This demonstrates broad implementation across the bundle, while recognising specific gaps requiring further improvement.

Six interventions remain partially implemented. Priorities include clarifying smoking-related compliance data, strengthening assurance around fetal growth surveillance and detection reporting, and demonstrating consistent achievement of preterm birth intervention standards.

The review identifies missing or conflicting evidence in some areas, highlighting the need to improve data quality alongside clinical compliance.

PAC oversight should therefore focus on delivery of the outstanding actions, reconciliation of reporting discrepancies and evidence of sustained improvement, while maintaining assurance across the fully implemented elements.

11.0 NHS Resolution Maternity Incentive Scheme – Year 8 (RPQG 10)

A focused paper was shared at the September PAC meeting.

12.0 Risk Register Assurance

12.1 Risks scored 12 or above

Risk ID	Risk / Description	Score	Current Position / Assurance	Lead
3081	Delay in securing neonatal airway in emergencies, increasing risk of hypoxic injury, morbidity or mortality	12	Airway competence is supported by competency checks and balanced rostering to provide airway competence on every shift. A consultant training compliance plan is in place. Due review 06/11/26	Alison Davies
1481	Abduction from the Maternity ward	12	Ongoing: improve oversight of the ward entrance; baby-tagging business case (action 7346); review reception cover. Due review 25/09/26	Sarah Ayre

12.2 Emerging Risks

Emerging Risk	Current Position	Status
Maternity Pharmacy Provision	Previous position: Business case and supporting risk assessment in development to ensure sustainable pharmacy support for Perinatal Services.	ongoing
National Epidural Supply	Previous position: Risk assessment completed and scheduled for review through Perinatal Governance to support local contingency planning.	ongoing

13.0 Board of Directors Assurance

The report assures that key safety concerns are being identified and that improvement activity is directed towards recognised clinical and operational priorities. External validation of Saving Babies' Lives implementation and improvements in prevention processes provide positive evidence of progress.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet and report

Subject:	Perinatal Safety Champions Update Reporting period: July–August 2026	**Date:**	1 October 2026
Prepared By:	Sarah Ayre, Divisional Director of Perinatal and Women's Health Services (Interim)		
Approved By:	Paula Shore, Director of Nursing and Midwifery/Deputy Chief Nurse; Philip Bolton, Executive Chief Nurse; Simon Roe, Chief Medical Officer; Neil McDonald, Non-Executive Director		
Presented By:	Sarah Ayre, Divisional Director of Perinatal and Women's Health Services (Interim)		

Purpose		
To provide the Board of Directors with a balanced assessment of the safety, quality and delivery of maternity and neonatal services at Sherwood Forest Hospitals (SFH) NHS Foundation Trust. The report aligns with the Perinatal Quality Oversight Model (PQOM) and relevant regional perinatal quality surveillance areas, distinguishing progress, evidence limitations, outstanding risks and actions requiring oversight.	**Approval**	**X**
	Assurance	**X**
	Update	**X**
	Consider	

Recommendation

The Board of Directors asked to:

- Consider the assurance provided recognising evidence limitations and outstanding risks.
- Note progress in research, PPH prevention, staff engagement and preparations for national programmes during July and August 2026.
- Review workforce, neonatal and operational risks through the relevant supporting reports and agree any additional mitigation or escalation required.
- Note the outcome of the separate Silver On-Call review and approve the recommended model, subject to the detailed paper presented

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	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Senior Management Team

Perinatal Quality Surveillance Group (LMNS)

Perinatal Governance Meeting

Acronyms

- Perinatal Assurance Committee (PAC)
- Perinatal Quality Oversight Model (PQOM)
- Maternal Care Bundle (MCB)
- Maternity Incentive Scheme (MIS)
- Multidisciplinary Team (MDT)
- Perinatal Services Forum (PSF)
- Postpartum Haemorrhage (PPH)
- Perinatal Equity and Anti-Discrimination Programme (PEADP)
- Maternity and Neonatal Voices Partnership (MNVP)
- Maternity Services Data Set (MSDS)
- Sherwood Birthing Unit (SBU)
- Neonatal Intensive Care Unit (NICU)
- Enhanced Midwifery Continuity of Carer (EMCoC)
- Avoiding Brain Injury in Childbirth (ABC)
- Maternity Early Warning Score (MEWS)
- Modified Early Obstetric Warning Score (MEOWS)
- Neonatal Oral Antibiotics at Home (NOAH)
- East Midlands Neonatal Operational Delivery Network (EMNODN)
- Whole-Time Equivalent (WTE)
- Royal College of Midwives (RCM)
- Maternity and Newborn Safety Investigations (MNSI)
- Friends and Family Test (FFT)
- Perinatal Services Oversight Group (PSOG)

Executive Summary

This report provides the Board of Directors with an overview of the safety, quality and delivery of maternity, neonatal and transitional care (Perinatal) services during July and August 2026. It demonstrates continued leadership visibility, multidisciplinary engagement and clinically led improvement across the perinatal pathway. Positive developments include the recruitment of 12 newly qualified midwives, equivalent to 9.6 whole-time equivalent (WTE) posts; sustained neonatal audit performance; the implementation of strengthened Transitional Care pathways; expansion of research activity; and progress across postpartum haemorrhage prevention, simulation, staff recognition and leadership development. The report provides reasonable assurance that appropriate governance and improvement arrangements are in place. However, assurance remains qualified in several areas where implementation is incomplete, outcome evidence is preliminary or further action is required. These include completion and evaluation of the postpartum haemorrhage assessment, readiness for National Maternity Early Warning Score (MEWS) implementation across different digital systems, replacement of ageing neonatal incubators, low neonatal family-feedback response rates and the impact of changes to Maternity and Neonatal Voices Partnership arrangements. Equalities data also identify differences in access, deprivation and preterm birth outcomes, alongside gaps in ethnicity recording, which require further validation and focused review. Preparations continue for the Maternal Care Bundle (MCB), Maternity Incentive Scheme (MIS) Year 8, the national 10-Point Plan submission and the Perinatal Equity and Anti-Discrimination Programme (PEADP). The next phase should focus on translating this activity into measurable and sustained improvements, supported by named leads, delivery dates and outcome measures.

1.0 Perinatal Services Safety Champions (RPQG 15)

Safety Champion walkarounds provide a route for staff and service-user concerns to reach senior leaders. Assurance depends on the resulting actions, timely escalation and evidence that feedback has been addressed.

July and August findings should be considered alongside the action log, with outstanding concerns carried forward until closure is evidenced.

1.1 July walkaround – July 2026

The July walkaround included discussions with staff around the Independent Maternity Review (IMR) and the Amos Report. Staff overall shared their concerns around the impact of additional women and birthing individuals attending the Unit, following the concerns shared in the press around care provided by neighbouring Trusts.

1.2 August walkaround – 6 August 2026

The August walkaround covered the Maternity Ward and Sherwood Birthing Unit, with discussions focused on recent service changes and staff preparedness for the anticipated busier period. Staff reported that the changes were largely working well, while highlighting complexities associated with the multidisciplinary team (MDT) room. The discussion identified a need to revisit and clarify previous communications to ensure a shared understanding of the room's intended use and arrangements.

1.3 15 Steps Feedback

It has been agreed that feedback from the 15 Steps initiative will be shared and reported through PAC from October 2026, enabling triangulation with other safety and quality evidence and informing SMART action plans with clear ownership and timescales.

2.0 Perinatal Services Forum (RPQG 8)

The Perinatal Services Forum (PSF) brings frontline colleagues and senior leaders together to discuss service delivery, concerns and improvement opportunities. The reporting emphasis is on what was heard, what changed and what remains outstanding.

2.1 July PSF – chaired by the Deputy Chief Nurse/Director of Midwifery

The Perinatal Services Forum held on 9 July 2026 was chaired by Deputy Chief Nurse/Director of Midwifery Paula Shore (PS) and attended by Chief Executive Jon Melbourne (JM), our new Trust Chair Rukshana Kapasi (RK), and Non-Executive Director Neil MacDonald (NM), alongside multidisciplinary staff from across the full perinatal pathway. The strong senior leadership presence enabled open discussion of the recently published national maternity and neonatal reports, including their impact on staff and families. The Trust's response through the national 10-Point Plan was outlined, alongside a commitment to visible leadership, psychological support, open communication and ensuring staff understand how to raise concerns through Freedom to Speak Up arrangements.

Positive workforce assurance was provided, with recruitment reflecting the revised establishments. Preceptorship has been extended to two years, supported by regular reflective learning sessions. Community services also reported more than 90% continuity of antenatal and postnatal care, with most families seeing no more than three midwives.

The Forum heard encouraging updates on research, innovation and digital improvement. These included reducing lithotomy positioning for unassisted vaginal births from 18% to 9%, research into access and support during early labour, and a funded project to improve assessment of babies from Global Majority backgrounds.

Effective multidisciplinary working also maintained emergency and elective obstetric services during a business continuity incident, while plans to relocate evening antenatal education to the Mansfield Community Diagnostic Centre aimed to improve accessibility and reduce inequalities.

Overall, the Forum provided positive assurance regarding workforce, innovation, continuity of care and operational resilience, alongside continued focus on responding openly and compassionately to national maternity and neonatal concerns.

2.2 August PSF – chaired by the Chief Nurse and attended by new Trust Chair

The Perinatal Services Forum held on 13 August 2026 was chaired by the Chief Nurse Phil Bolton (PB) and attended by the Trust's new Chair, Rukshana Kapasi (RK). This provided staff with an important opportunity to engage directly with senior Trust leadership. The discussion demonstrated positive progress across workforce, quality improvement and staff experience. This included the successful recruitment of 12 newly qualified midwives, equating to 9.6 WTE, supported by a structured induction, supernumerary and preceptorship programme. Recruitment to the Band 8 governance post and neonatal Band 6 roles was also confirmed, with no current neonatal nursing vacancies.

Quality and safety updates were shared with staff who attended and included ongoing improvement work relating to birthing positions, peanut-ball use, postpartum haemorrhage, venous thromboembolism and diabetic ketoacidosis, with encouraging early outcomes. Quarter-one Saving Babies' Lives data had been submitted, and preparations continued for Maternity Incentive Scheme Year 8, the national 10-Point Plan and the next MNSI Quality Review Meeting. Vaccination uptake had also improved, with pertussis uptake exceeding 60% and RSV uptake increasing from 23% to 42%.

The Forum also considered seasonal workforce planning, staff wellbeing and culture. Plans included enhanced support for newly appointed and returning staff, strengthened escalation arrangements, regular leadership walkarounds and the relaunch of the staff-led Perinatal Staff Council. The introduction of *Monday Matters* and a divisional staff survey ahead of the national survey would further strengthen communication and demonstrate how staff feedback informs improvement.

Overall, the Forum provided positive assurance regarding workforce recovery, quality-improvement activity and visible leadership, while maintaining a clear focus on staff engagement, wellbeing and safe service delivery.

3.0 Key Strategic Developments

3.1 Maternal Care Bundle (RPQG 12)

Implementation planning for the NHS England Maternal Care Bundle continues. The national implementation deadline is March 2027. PAC members were asked to consider the separate report from Consultant Midwife Sam Todd for the current position against each element, delivery milestones and dependencies, agenda item 12 of the agenda for the PAC meeting held on 18 September 2026.

3.2 Postnatal Care toolkit (RPQG 13)

The NHS England toolkit covers listening to women, birthing individuals and families; addressing inequalities; workforce, training and education; and a public health approach. The proposed next step is to benchmark current pathways, feedback, outcomes and evidence against these domains. This will identify strengths, gaps and variation and inform a prioritised plan with leads, timescales, resource requirements and outcome measures.

Stakeholders will include maternity and neonatal teams, primary care, health visiting, infant feeding, perinatal mental health, pelvic health, public health, commissioners, service-user representatives and voluntary-sector partners. The assessment will distinguish local actions from those requiring system support. A progress update is planned for PAC in November 2026.

3.3 Perinatal Equity and Anti-Discrimination Programme (RPQG 11)

NHS England, in partnership with the NHS Race and Health Observatory, is introducing the Perinatal Equity and Anti-Discrimination Programme (PEADP) to address the poorer experiences and outcomes associated with racism, discrimination and deprivation. Building on the Perinatal Culture and Leadership Programme, it will support maternity and neonatal teams to provide care free from racism and discrimination and create an equitable working environment for staff. The programme will be delivered to all consultant-led obstetric units and their neonatal services through phased regional intakes over 18 months. The programme will focus on understanding and tackling racism and discrimination; identifying local inequalities with Maternity and Neonatal Voices Partnership involvement; strengthening executive and perinatal leadership; equipping multidisciplinary clinical leaders to challenge inappropriate behaviours and manage difficult conversations; and embedding sustainable cultural change. Trust leadership and Board Safety Champions are expected to provide visible support, maintain strong links with frontline teams and enable identified staff to participate. SFH is part of the third national cohort of the PEADP, commencing in September 2026. Local leads have been identified, and preparatory work is underway. A detailed update is planned for November 2026.

3.4 Maternity Incentive Scheme Year 8 (RPQG 10)

PAC members considered the dedicated NHS Resolution Maternity Incentive Scheme (MIS) Year 8 Action Plan which was shared as part of the agenda of the September meeting.

3.5 10-Point-Plan Assurance Tool Submission – September and December 2026

Following Trust Board approval, the completed 10-Point Plan Evidence Log and maternity triage benchmarking assessment have been submitted to the regional team for review ahead of the first national submission deadline of 25 September 2026. The submission sets out the Trust's current position, supporting evidence and areas requiring further improvement. Regional feedback will inform any final amendments, with Trust Board having delegated approval of these changes to the executive-led Perinatal Assurance Committee (PAC). Review at PAC will provide a further opportunity to scrutinise the evidence, confirm outstanding actions and strengthen assurance ahead of national submission (by 25th September) as needed.

3.6 National MEWS Implementation Position Update

Maternity-specific MEOWS remains in use across the Trust, supported digitally through Nervecentre for antenatal and postnatal care and BadgerNet for intrapartum care and initial triage assessment. Paper MEOWS charts are used outside maternity services. This ensures that maternity-specific observation systems are in place, although National MEWS has not yet been implemented. BadgerNet is expected to transition to National MEWS in November 2026, creating a potential risk if equivalent functionality is not available within Nervecentre at the same time. Different systems operating concurrently could affect consistency of assessment, escalation and continuity of care. A business case has been developed to extend maternity-specific electronic observations to non-maternity areas, with implementation planned during 2026/27. Regional and national clarification has been requested to support a coordinated transition ahead of the stated 31 March 2027 deadline. Assurance on implementation therefore remains dependent on confirmation of system readiness, aligned transition arrangements, staff training and governance oversight.

Risk 2786 highlights the fragility of 2 maternity systems in use and scores a 6. However, this was in relation to Badgernet and Orion from 2023; we have continued the risk as we recognise there are now additional considerations such as Nervecentre and ICE. The risk will be updated to reflect this.

2786	Sarah Ayre	Women and Children's Division	2 parallel Maternity electronic systems currently in use	26/06/2023	Patient harm	Service level risk	Tolerate - take no further action to improve control of the risk	6	30/07/2027

3.7 Maternity Triage Benchmarking Tool – national submission and next steps.

The triage benchmarking work distinguishes requirements fully in place, partially in place and not applicable, with evidence and actions for each gap. PAC will be presented with visibility of assessment timeliness, delays, staffing, access, experience and any resource or estates dependencies at October's committee.

4.0 Research and Innovation

Consultant Midwife-led work is supporting access to research and the use of published evidence in practice. Participation and evidence sharing are positive developments; local changes in care and outcomes require separate evaluation before clinical benefit can be attributed to this activity.

SFH is currently supporting 12 research studies, covering smoking and vaping, maternal anaemia, diabetes, epilepsy, stillbirth prevention, perinatal mental health and staff experiences. For four studies, SFH acts as a Participant Identification Centre, identifying eligible participants and, with consent, referring or signposting them to external research teams. This broadens access to research opportunities with limited additional demands on clinical teams. The multidisciplinary team has been encouraged to raise awareness of relevant studies, support informed discussions about participation and embed research into everyday maternity care. This activity supports an inclusive research culture and opportunities to inform future improvements in care.

- **Position for Progress:** Learning from the BUMPES trial has been shared with staff. Among women giving birth for the first time with a low-dose epidural, the trial reported more spontaneous vaginal births in the lying-down group than the upright group (41.1% versus 35.2%). Lying down included left- or right-side lying. This supports informed, individualised discussion of positioning; it is not evidence that local birth outcomes have improved. Exploration of positioning aids, including peanut balls, is a separate local activity.
- **PANDA Study**: During July 2026, the PANDA study received 30 referrals, its second-highest monthly total, compared with 21 in June. Referrals were received from Sherwood (14), Ashfield (10) and Newark (6), with none from Mansfield. The contribution from Ashfield represents positive progress in extending research opportunities across community services. One participant was recruited during July, compared with two in June. The study has been extended until the end of September 2026. Team leaders have been asked to continue research discussions and referrals, with eligibility screening and follow-up undertaken by the Research Team. Priorities are to understand variation between teams, particularly the absence of Mansfield referrals, and review the participant pathway from referral to recruitment. Monthly referrals and recruitments may concern different individuals and should not be treated as a same-month conversion rate.

5.0 Quality Improvement

5.1 Avoiding Brain Injury in Childbirth – intrapartum fetal deterioration

Implementation planning has commenced for the intrapartum fetal deterioration component of the Avoiding Brain Injury in Childbirth (ABC) programme. Initial discussions with Health Innovation East Midlands have considered digital capability, fetal monitoring practice, workforce preparedness and governance. PAC should receive an update on readiness, identified gaps and the implementation plan at November's Committee.

5.2 Postpartum haemorrhage prevention

Consultant Midwife-led PPH prevention work progressed during July and August through improved risk assessment and multidisciplinary communication:

- **Implementation:** An updated BadgerNet PPH Prevention Assessment launched on 15 July, providing risk categorisation and recommended management plans. Colour-coded risk indicators were introduced on the SBU handover board on 22 July to support MDT awareness and preparation.
- **Practice improvement:** Intrapartum assessment completion increased from 5.8% to 50% within two weeks, demonstrating improved uptake, although consistent completion remains a priority.
- **Early outcomes:** Overall PPH rates remained broadly comparable with previous months. PPH ≥1,500ml varied from 5.8% before implementation to 10.0% during the first week, then 2.1% during 22–31 July. No blood losses ≥2,000ml were reported in that final period.
- **Assurance and next steps:** These are encouraging early observations, but small numbers and short follow-up mean a sustained reduction or causal link cannot yet be established. Continued monitoring will assess completion and assessment quality, monthly PPH outcomes and blood component usage to determine whether changes in practice translate into measurable clinical benefit.

The remaining implementation gap is important: at the reported assessment point, completion was 50%. Proposed follow-up is to agree a completion target and trajectory, audit assessment quality and monitor monthly outcomes using case numbers and denominators. This will distinguish improved documentation from sustained clinical benefit.

5.3 In-situ multidisciplinary simulation

The simulation approach described in Appendix A focuses on short scenarios in the clinical environment across the entire perinatal service, testing teamwork, escalation, equipment, and processes. The supporting material makes clinical safety and operational capacity the basis for deciding whether to proceed. Assurance should be based on sessions delivered, MDT participation, identified safety issues and evidence that resulting actions have been completed.

5.4 CQC Maternity Survey (RPQG 1)

For 2025, our results and action plan were presented at PAC in July and regionally at Perinatal Quality Surveillance Group (PQSG) at the end of August.

The survey received 102 responses, representing a response rate of 34.2%. Respondents included women and birthing individuals from a range of age groups, ethnic backgrounds and clinical circumstances.

Half of the respondents were first-time parents, and over one-fifth reported their baby had received neonatal care, providing feedback across a broad range of perinatal experiences. The survey also captured the views of women and birthing individuals with long-term health conditions, pregnancy-related health conditions and additional communication needs, supporting a diverse representation of service user experience. The targeted actions were presented to in a dedicated report to PAC in July and build upon existing improvement programmes. An update will come to October PAC.

The 2026 Maternity Survey was successfully submitted by IQVIA ahead of the final deadline of 24 July 2026, with all required validation checks completed and no further action required from the Trust. SFH achieved a final response rate of 38%, equal to the overall average across participating IQVIA Trusts and within the 35–39% range achieved by 11 organisations. Initial detailed results were released on 5 August 2026, with the full management report due on 9 September 2026; the findings will be reviewed to identify areas of positive practice and priorities for service improvement.

The 2026 survey findings will be considered alongside complaints, compliments, local feedback and the regional experience data and will form part of the Perinatal Services Oversight Group (PSOG) Report and improvement plan led by Lead Advocate Sarah Seddon (SS), supported by Consultant Midwife Sam Todd (ST)

5.5 East Midlands Perinatal Deterioration Summit

A multidisciplinary team from Perinatal Services is due to attend the East Midlands Perinatal Deterioration Summit on 8 September 2026. This provides an opportunity to identify regional learning relevant to local recognition and response to deterioration. Following attendance, key learning will be shared through governance, and any identified gaps will be translated into clear improvement actions.

6.0 Neonatal and Transitional Care overview – July and August 2026

NICU quality assurance remains positive, with metric audit compliance sustained within the green category for three consecutive months, achieving 90.4% in July and 90.0% in August. Environmental audit compliance also remained strong at 92.2% and 91.7%, respectively. Senior clinical oversight has been strengthened through the introduction of weekday consultant “hot week” cover.

Clinical improvements include the launch of Neonatal Oral Antibiotics at Home (NOAH), supporting earlier discharge and reducing avoidable inpatient bed use for eligible babies. A new CFAM monitor has enhanced neurological monitoring, while staff training has commenced through the EMNODN palliative care programme. Transitional Care pathways and dedicated nursing and medical checklists have been implemented, providing greater clarity regarding admission criteria, professional responsibilities, documentation and discharge processes across maternity and neonatal services.

A dedicated cannulation trolley on Sherwood Birthing Unit now enables eligible babies to receive screening and treatment alongside their parents, helping to reduce unnecessary separation.

A dedicated laptop and live handover process support contemporaneous bedside documentation, continuity and timely transfer of clinical information. The discharge medication process has also been strengthened through new guidance and parent information, supporting the safe provision of vitamins and medicines following discharge. A Transitional Care Padlet provides families with improved access to information, education and support.

Following audit findings and recognition of the high number of babies receiving intravenous antibiotics, a Neonatal Early Onset Sepsis Bundle Booklet has been developed and is awaiting governance approval. This will standardise assessment, investigations, documentation, treatment planning, communication and discharge, while supporting implementation of the NOAH pathway. Work also continues to implement Martha's Rule and strengthen family feedback and escalation arrangements.

The parent and staff environment has improved through refurbished family accommodation, additional sleeper and recliner chairs, and height-adjustable chairs that allow staff to document at the bedside. Workforce developments include the appointment of the permanent NICU Ward Sister, Infant Feeding Specialist and Family Integrated Care Lead, alongside two internal Band 6 appointments.

There are no current Transitional Care risks requiring escalation. However, an emerging NICU risk relates to six incubators that are over ten years old and overdue for replacement. This is being assessed for inclusion on the NICU risk register, with appropriate mitigation and escalation arrangements being developed. A focused paper will be presented at October PAC, which will include the work already underway Divisionally on medical devices.

Friends and Family Test (FFT) response rates remain below the required standard. Improvement actions include checking that QR codes work reliably, Wednesday walkabouts and Friday family feedback sessions. Progress will be monitored through regular review and reported via Perinatal Services Oversight Group (PSOG).

The Trust is also updating its FFT provider. As part of this work, greater attention is being given to health inequalities. A question aligned with Core20PLUS5 will be explored to assess whether it can provide useful data for identifying local priorities. Further questions will focus on the lowest-scoring areas and align with the National Survey. Together, these changes should strengthen the assurance we provide to PAC about the safety and quality of care, particularly for service users most affected by health inequalities.

7.0 Maternity and Neonatal Equalities Dashboard

NHS England's Maternity and Neonatal Equalities Dashboard supports analysis of access, care and outcomes by ethnicity and deprivation. The figures reproduced here were captured in August 2026 and cover a rolling 12–24-month period ending December 2025; they are not current monthly performance.

Missing demographic information, small numbers, case mix and statistical uncertainty limit interpretation. Therefore, data will be validated against current local information and service-user feedback before conclusions are drawn about causes or care quality.

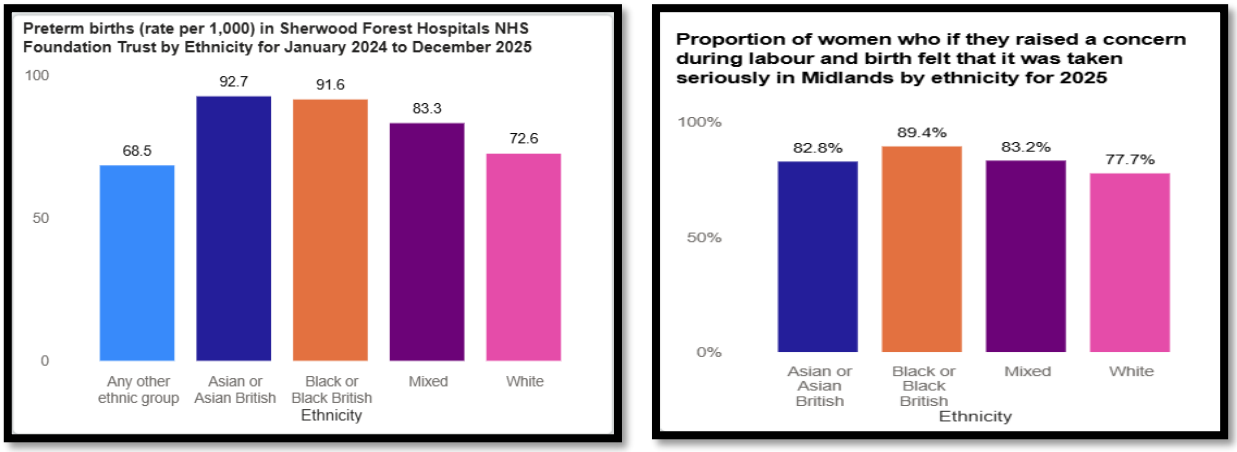


Figure 1. Left: SFH preterm births per 1,000, January 2024–December 2025. Right: Midlands experience data, 2025; not SFH-level assurance. Source: dashboard extract in the supplied draft.

7.1 Key findings

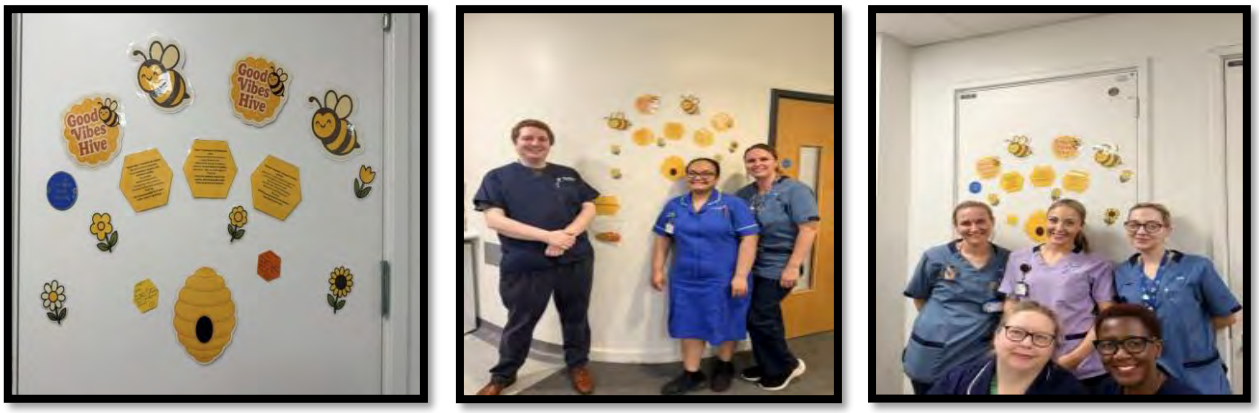
- **Early access:** Booking by 10 weeks was 65.4% versus 64.8% nationally, a difference of 0.6 percentage points.
- **Preterm birth:** Rates per 1,000 were 92.7 for Asian, 91.6 for Black and 83.3 for Mixed ethnic groups, compared with 72.6 for White women.
- **Deprivation:** 30.3% of the booking population was in the most deprived quintile, versus 24.9% nationally.
- **Data quality:** Ethnicity was unknown for 10.3% at booking, versus 3.8% nationally.
- **Service-user experience:** The experience findings represent the Midlands, not SFH.

7.2 Next Steps

The proposed next steps are to validate the local data; undertake a more detailed review of early booking and preterm birth by ethnicity and deprivation; improve the completeness of demographic information; and work with service-user representatives to better understand barriers to access, experience and outcomes. The findings will inform priorities within the Perinatal Equity and Anti-Discrimination Programme (PEADP) and Enhanced Midwifery Continuity of Carer (EMCoC) work. PAC members were asked to note this focused review and that further analysis will be presented through Sam Todd's inequalities paper, aligned with the planned PEADP update in November 2026.

8.0 Culture, Staff Voice and Leadership (RPQG 8)

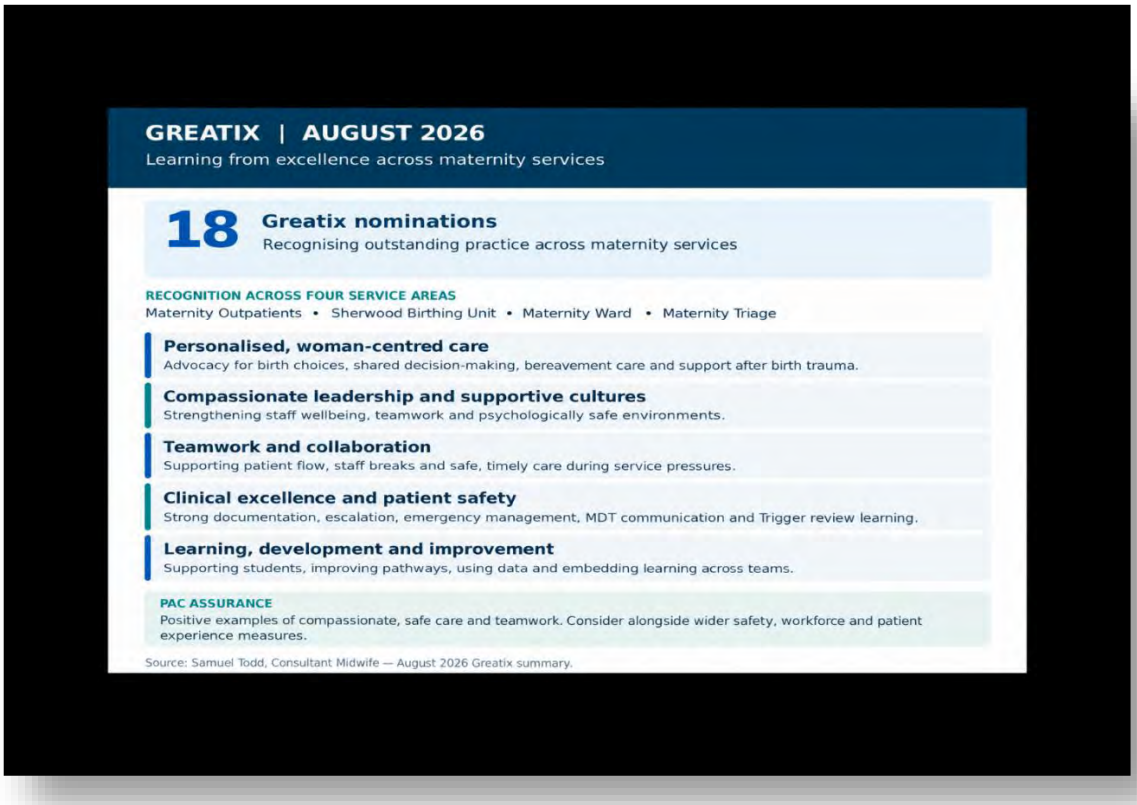
8.1 Staff recognition and wellbeing



Picture 1: staff recognition activity.

Recognition activity includes the NICU PositiviTree, launched in May, the maternity ward's Good Vibes Hive, launched in July, and the August Positivitea Trolley. These provide opportunities to recognise colleagues and hear feedback.

8.2 Learning from excellence – Greatix



8.3 Perinatal Services Staff Council

The Perinatal Staff Council continues to progress its programme of work, although activity has been moderated by sustained clinical pressures and annual leave during the summer period. Current priorities include proposed improvements within the Maternity Triage Centre, including baby-changing facilities and staff refreshment provision, alongside development of a dedicated noticeboard featuring a “Meet Your Council” section and staff suggestion box. Recruitment activity is ongoing to strengthen representation from Neonatal Intensive Care and Transitional Care colleagues, although no expressions of interest have been received to date. The Council is also developing a business case for a programme of structured staff wellbeing and team-development days, supported by the Professional Midwifery Advocate team, with delivery anticipated during the next financial year to maximise staff access while maintaining safe service provision

8.4 Leadership development

The July leadership development update records seven awarded places: three on the RCM EIDOS programme, two on the Florence Nightingale Foundation Established Leaders programme and two on the Emerging Leaders programme. A reflective account from Matron Melanie Johnson describes learning in compassionate leadership and team development. These demonstrate investment and reported learning; see Appendix B.

8.5 Chief Midwifery Officer’s Silver Award – August 2026

Lisa Butler received the Chief Midwifery Officer’s Silver Award during the August visit, recognising her commitment and leadership across Perinatal Services. The award provides an opportunity to celebrate her contribution and share learning from her leadership practice.

9.0 Divisional Planning Priorities

The June divisional planning event identified three priorities. An update demonstrating delivery since the event will be presented to the October Committee.

- **Priority 1 - Outpatient transformation:** improve access, triage, advice and guidance, appointment use and follow-up pathways.
- **Priority 2 - Being a great place to work:** support wellbeing, development, training and wider experience
- **Priority 3 - Workforce transformation:** develop skills, digital capability, ways of working and data-led planning.

10.0 The Board of Directors are asked to:

1. National MEWS readiness (section 3.6): Seek assurance that there is a coordinated implementation plan for National MEWS across BadgerNet, Nervecentre and non-maternity clinical areas, including confirmed system functionality, staff training, governance oversight

and escalation of any unresolved digital dependencies. Members are also asked to note that Risk 2786 will be updated to reflect the current digital position.

2. Neonatal equipment (section 6): Note the emerging risk relating to six incubators that are more than ten years old and overdue for replacement. Board members are asked to seek assurance regarding interim safety controls, inclusion on the NICU risk register, the proposed replacement programme, funding route and delivery timescale.

3. Postpartum haemorrhage prevention (section 5.2): Note the improvement in completion of the PPH Prevention Assessment from 5.8% to 50%, while recognising that compliance remains below the required level.

4. Equalities (section 7): Support the focused review of early booking, preterm birth, deprivation and demographic data completeness, including engagement with service-user representatives to understand barriers to access, experience and outcomes. Further analysis will be presented alongside the PEADP update in November 2026.

5. Neonatal family feedback (section 6): Note that neonatal Family and Friends response rates remain below the required standard and request a measurable improvement plan that includes a responsible lead, delivery timescale and evidence of how feedback is being used to improve services.

11.0 Conclusion and Overall Assurance

This report provides reasonable but qualified assurance regarding the safety, quality and delivery of Perinatal Services during July and August 2026. Positive assurance is supported by visible senior leadership, multidisciplinary engagement, workforce recruitment, sustained neonatal audit performance, expanded research activity and continued clinically led improvement across maternity, neonatal and transitional care pathways.

Assurance remains limited where implementation is incomplete, outcome evidence is preliminary or identified risks require further mitigation. This includes National MEWS readiness across multiple digital systems, replacement of ageing neonatal incubators, completion and evaluation of the PPH Prevention Assessment, neonatal family-feedback response rates, Maternity and Neonatal Voices Partnership capacity and the further investigation of inequalities in access and outcomes.

The Board of Directors are asked to consider the evidence alongside the accompanying specialist reports, approve the recommendations identified in Section 10 and maintain oversight of the outstanding risks and actions.

Further assurance will return through subsequent PAC reports, including updates on maternity triage and the CQC Maternity Survey, the Postnatal Care Toolkit, PEADP and equalities analysis, National MEWS readiness, neonatal equipment and feedback, and the impact of ongoing quality-improvement programmes.

Source

1. NHS England – The Maternal Care Bundle
2. NHS England – Improving postnatal care: a toolkit for ICBs, partners and providers
3. NHS Resolution – Maternity Incentive Scheme
4. BUMPES trial – BMJ 2017;359:j4471
5. NHS England – Maternity and Neonatal Equalities Dashboard

Appendix A – In-situ simulation approach

Supporting material from the source draft. Implementation evidence and action closure are to be reported in section 5.4.

Appendix B1 – Leadership development opportunities

July 2026 programme update. Participation and impact evaluation are addressed in section 8.4.

Appendix B2 – Leadership reflection

Reflective account from Matron Melanie Johnson; qualitative learning, not a service-level outcome evaluation.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board- Cover Sheet

Subject:	Thirlwall Inquiry Report- Sherwood Forest Hospitals Trust proposed approach	**Date:**	18/09/2026
Prepared By:	Paula Shore, Deputy Chief Nurse/ Director of Midwifery		
Approved By:	Phillip Bolton, Chief Nurse & Simon Roe Chief Medical Officer		
Presented By:	Paula Shore, Deputy Chief Nurse/ Director of Midwifery		

Purpose

The publication of the Thirlwall Inquiry is a significant moment for the NHS. The purpose of this paper is to outlines the key findings and recommendations which then reflects the proposed approach taken by SFH and requires consideration and approval.	**Approval**	**X**
	Assurance	
	Update	
	Consider	**x**

Recommendation

That Board members note the content of the paper and support a decision around the Senior Responsible Officer and Chair to establish a task force to address the initial ask from the national team and any subsequent recommendations.

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	**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

- Perinatal Assurance Committee 18/09/2026

Acronyms

- NHS- National Health Service
- CQC- Care Quality Commission
- SFHT- Sherwood Forest Hospitals Trust
- SUDIC- Sudden and Unexpected Death In Children

Executive Summary

The publication of the Thirlwall Inquiry is a significant moment for the National Health Service (NHS). Whilst the findings arise from events at another organisation, the lessons are relevant to every Board and provider. The report reinforces the importance of a culture in which staff feel safe to speak up, concerns are acted upon promptly, families are listened to, and patient safety remains the overriding priority. We will undertake a detailed review of the recommendations and

assess our current position against the inquiry findings to ensure Sherwood Forest Hospitals Trust (SFHT) continues to provide safe, compassionate and high-quality care.
A letter received from NHSE on the 21st of September outlines the next for Trusts, with the details and actions being provided in this paper.

Thirlwall Inquiry Report

1. Purpose of the Inquiry

The inquiry was established to examine how concerns regarding neonatal deaths and collapses were managed, why opportunities to intervene were missed, and what lessons the NHS must learn to strengthen patient safety, safeguarding and organisational accountability.

2. Key Findings

Profound Failures of Leadership and Governance

The report identifies significant failures across management, governance and safeguarding arrangements. Concerns raised by clinicians were not acted upon promptly, and organisational processes failed to protect babies, families and staff.

Failure to Escalate and Act on Safety Concerns

Repeated concerns from clinicians were not escalated effectively or investigated with sufficient urgency. Opportunities to recognise patterns, respond to risk and take preventative action were missed.

Culture and Psychological Safety

The inquiry highlights concerns regarding organisational culture, including barriers to speaking up and shortcomings in how concerns raised by clinicians were managed. Strengthening psychological safety and effective Freedom to Speak Up arrangements is a major theme.

Duty of Candour and Family Engagement

The report emphasises the importance of openness, transparency and meaningful engagement with families following incidents, investigations and adverse outcomes.

Safeguarding and Patient Safety Systems

The inquiry found weaknesses in safeguarding processes, recognition of risk indicators, mortality review processes and organisational responses to emerging concerns.

NHS-Wide System Learning

The report concludes that lessons extend beyond a single organisation and require action across the NHS, regulators, boards, professional bodies and healthcare leaders.

3. Key Recommendation Themes

The report provides 17 recommendations, which are:

1. CCTV and Monitoring
2. Insulin
3. Bereavement Care
4. Safeguarding and contracts of employment
5. Operating Systems (interoperability)
6. Monitoring Deaths in Hospitals
7. Data Reporting
8. Sudden Unexpected Death in Infancy and Childhood (SUDIC)
9. Suspicion of Deliberate Harm Protocol and Guidance
10. Panel of Experts
11. Medical Examiners
12. Paediatric and Perinatal Pathologists
13. Accountability and Regulation of Managers
14. Care Quality Commission (CQC)
15. Assessment of the Performance of the CQC
16. Parliamentary and Health Service Ombudsman
17. Implementation of the Recommendations

4. National Letter

Received on the 21st of September 2026, the Thirlwall Inquiry report and recommendations letter from NHSE outlines the findings from the enquiry and details actions that are needed now, these include:

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.

  Action- paper agenda for discussion at Public Board 1st of October 2026.

- Sudden and Unexpected Death In Children (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no preexisting medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out

above. This must be completed by no later than Monday 28 September 2026. It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

Action- SFH SUDIC protocol shared with teams working with Children and Neonates.

- National Bereavement Care Pathway for stillbirth and neonatal death: ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

  Action- National Bereavement Care Pathway is already in place within Perinatal Service. Bereavement teams to review and provide an update through the perinatal Assurance Committee.

- Insulin: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

  Action- Insulin will become a workstream of the internal task force to deliver the ask for 31st of March 2027.

- Safeguarding: Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required. In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

  Action- Safeguarding will become a workstream of the internal task force to review current position and action as necessary.

- Health and wellbeing
  We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.
  We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

  Action- Maternity and Neonatal Safety Champions to review the current provision, focused work with the Perinatal teams and feedback from the Maternity and Neonatal Voice Partnership. This will be achieve through walk rounds and forums, providing the Perinatal Assurance Committee with the findings and action accordingly.

5. Proposed Approach at Sherwood Forest Hospitals Trust

Given the breadth of the recommendations and the service lines involved the proposal would be to approach the report with a internal task force to review the actions required now and any subsequent ask from the national team.

The proposal for an internal task force would include:

SRO and Chair:

- Executive TBC

Membership:

- Neonatal- Nursing and Medical Representative
- Chief Medical Office representative
- Chief Nursing Office representative
- Safeguarding and Child Death representative
- People representative
- Corporate Governance representative
- Digital Representative
- Pharmacy Representative

Responsible Reporting Committee:

- Quality Committee.

6. Recommendations

That Board members note the content of the paper and support a decision around the SRO and chair to establish an internal trust wide task force to address the actions required now outlined within the NHSE letter and any subsequent recommendations.

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report is a sobering moment for all of us working in the NHS. From the devasting failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children** (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death**.** This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin**: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow**.** It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,

Duncan Burton

Chief Nursing Officer for England

Sarah-Jane Marsh

NHS England Chief Operating Officer

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Learning from Deaths (LfD)	**Date:**	01/10/2026
Prepared By:	Dr Nigel Marshall (Chair- Learning from Deaths Group)		
Approved By:	Dr Simon Roe (Chief Medical Officer)		
Presented By:	Dr Simon Roe		

Purpose

To provide an update summary of mortality intelligence reviewed by the Learning from Deaths group and advise of ongoing work to respond to findings and improve organisational and wider learning.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Recommendation

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Learning from Death Highlight Report is presented at Patient Safety Committee (PSC) quarterly

Acronyms

- **SFH(T) -** Sherwood Forest Hospitals (Trust)
- **SHMI -** Summary Hospital-Level Mortality Indicator
- **HSMR (+) -** Hospital Standardised Mortality Ratio (Plus)
- **HED –** Healthcare Evaluation Data
- **VLAD-** Variable Life Adjusted Display (charts)
- **CUSUM -** Cumulative Sum
- **SJR-** Structured Judgement Review
- **LfD –** Learning from Deaths (Committee)
- **SPC-** Specialist Palliative Care
- **CDOP-** Child Death Overview Panel
- **EOL-** End of Life
- **ReSPECT -** Recommended Summary Plan for Emergency Care and Treatment
- **PSIRF-** Patient Safety Incident Response Framework
- **ICB/S-** Integrated Care Board / System
- **LD / LeDeR** Learning Disabilities / Learning Disabilities Mortality Review
- **ICB / ICS-** Integrated Care Board / System

Executive Summary

This report provides an overview of mortality intelligence reviewed by the Learning from Deaths Group for Q1 and Q2 of 2026-27. It seeks assurance on current performance (and process) alongside outlining future intentions and priorities for the group and wider trust.

Benchmarking Values as of 17.09.2026

- **SHMI (**Summary Hospital-Level Mortality Indicator) NHS Digital: **1.0669 ("As Expected")**
  - SHMI is the key mortality metric referenced in the "NHS performance framework".
  - Previous reporting (Q3-4 25/6) = 1.0423 / (Q1-2 25/26) = 1.0686
- **HSMR** (Hospital Standardised Mortality Ratio) - HED (excl. SPC adjustment): **101.55**
  - Formal tracking stopped, as of October 2025, but the value continues to be considered as part of wider triangulation.

Over the period Q1-2 2026-27, the Trust's Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remained within expected ranges. Peer benchmarking places the Trust within the middle of national and HED funnel-plot distributions.

The learning from Deaths group continues to triangulate headline measures using these values alongside use of other intelligence, including Variable Life Adjusted Display (VLAD) chart and Cumulative Sum (CUSUM) signals, Medical Examiner intelligence / reporting, Clinical Coding, Structured Judgement Reviews (SJRs), Coronial findings, and Divisional / Speciality reporting.

Statistical signals and highlighted areas were subject to discussion, monitoring and coding (or clinical) review; areas included pneumonia, acute cerebrovascular disease and fluid and electrolyte disorders. Fractured neck of femur and secondary malignancies remain under observation, with particular focus on the influence of community deaths on the reported position. Assurance was supported by stable headline metrics, reporting of accurate coding in the sampled acute cerebrovascular disease and pneumonia cases and continued scrutiny of deaths by the Medical Examiner Service.

During Q1 2026-27, the Medical Examiner (ME) and Bereavement Centre (BC) reported 408 acute deaths reviewed and 26 SJR requests raised. Despite ME vacancies, for which recruitment has now been successful, the service continued to work hard towards scrutinising all deaths with family engagement remaining high throughout at just under 99%.

Governance has strengthened through revision of the Mortality Management Policy, clearer divisional and speciality accountability, mandatory reviewer training and ongoing development of both the Trust DATIX IQ platform and Power BI Dashboard. 82 SJRs remained open beyond 45 days at latest extract (increasing from 67 in June SJR report), and delays in completion, recording, specialty response and divisional sign-off remain an assurance gap and area of continued focus.

Recurring improvement and learning themes include communication, clinical documentation, ReSPECT conversations, timely specialist review, flagging of learning disability and reasonable adjustments, alongside the need for evidence that actions have been implemented and sustained. Three PSIIs were commissioned between 1 April and 16 September 2026 concerning potential contribution to death; all were escalated through the coronial process.

Operational pressures, delayed specialty responses, outstanding SJRs, reduced specialist palliative care provision and the continued absence of a funded paediatric bereavement nurse remain areas requiring monitoring for progress and improvement.

The Board is asked to note:

- SHMI and HSMR remained within expected ranges during the reporting period
- Improvements to triangulation, governance and scrutiny through:

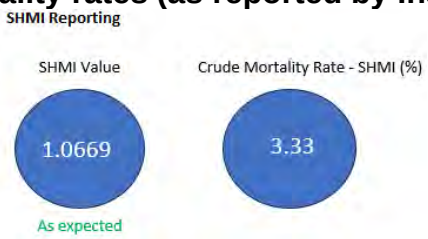
    - continuing review of identified mortality signals via coding, case-note review and clinical governance
    - increasing use of HED benchmarking tool by the Trust and a drive to further embed this within divisional and service-lines to support intelligence and learning
    - focus on divisional and speciality-level ownership of data, governance (including SJR oversight and completion) and reported learning
    - revision of Mortality Management Policy and Datix IQ processes
- Recurring learning themes and the priorities set out in this report.
- Use of quarterly thematic review to help demonstrate and support measurable and sustained improvement.

Mortality Surveillance

Headline Position:

- Latest SHMI reporting values were released on 10th September 2026, for the reporting period May 2025 - April 2026- (NHS Digital and HED (Healthcare Evaluation Data)).
- **SHMI** was reported to be **1.0669** and the **Crude Mortality Rate (SHMI spells) 3.33%**
- SHMI has been consistently in **Band 2 ("as expected")** over the reporting period.
- SHMI and HSMR (excl. palliative care adjustment) have remained within the expected range throughout the formal reporting period.
- HED analysis showed that in-hospital SHMI is reasonably aligned with HSMR; however, differences between in-hospital and out-of-hospital mortality continue to be monitored.
- Mortality intelligence review uses a suite of metrics and intelligence reporting rather than reliance on a single measure, including SHMI, HSMR, VLAD, CUSUM, HED, Medical Examiner information, coding review and divisional evidence.

SHMI - Crude and adjusted mortality rates (as reported by Insights team)



Although official reporting is taken from national metrics, the HED portal allows visualisation of SHMI and HED data 1 month earlier than national publication; this, in theory, provides earlier visibility of unexpected variation and potential future alerts.

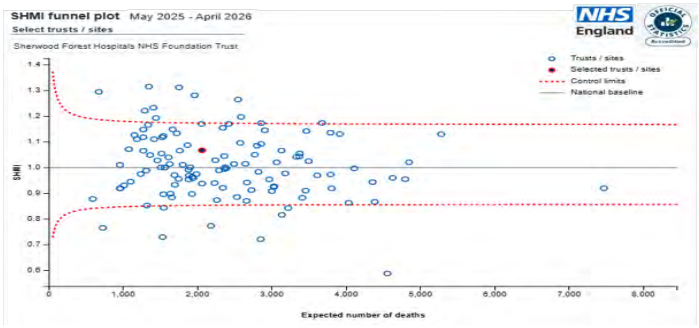
Provision of accurate and relevant data remains the foundation for meaningful evaluation and reporting; this requires clear documentation and includes the comprehensive recording of co-morbidities, a consistent approach to coding, and timely, accurate diagnosis. These factors help towards reflecting patient complexity alongside providing a more reliable picture of activity.

The evolution of Nerve-centre within the Trust will be a key aspect of supporting the above. This, together with further development, roll-out, and use of the Trust internal power BI dashboard is intended to create accessible data, delivery at a speciality level and support effective reporting and assurance around patient quality and safety metrics. Divisional and speciality ownership, especially led by clinical colleagues and teams, is pivotal to this improvement work.

Peer comparison (last 12 months)

Peer analysis information, provided to LfD group monthly, continues to show SFHT within the middle of funnel-plot distributions for both SHMI (National and HED) and HSMR (excluding palliative care adjustment- HED)

SHMI- National (NHSE) Interactive Portal-

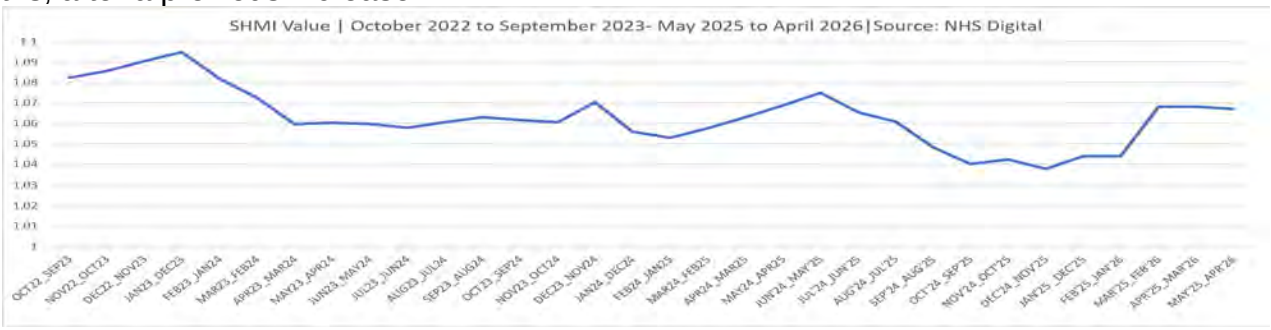


SHMI- (HED Extract)-

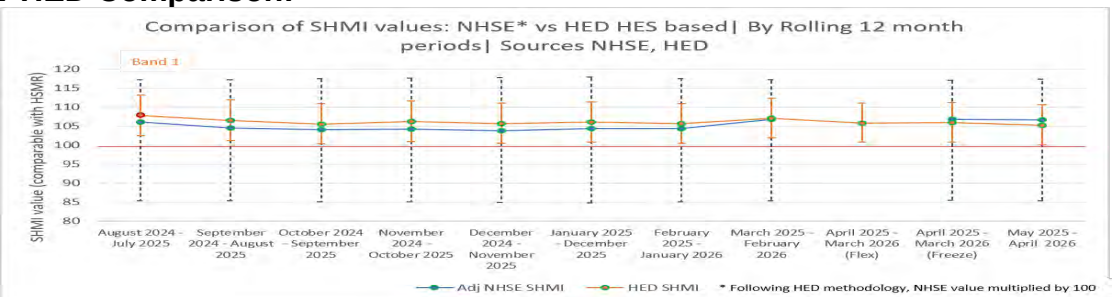
HSMR (without palliative care adjustment) (HED Extract)

SHMI Value

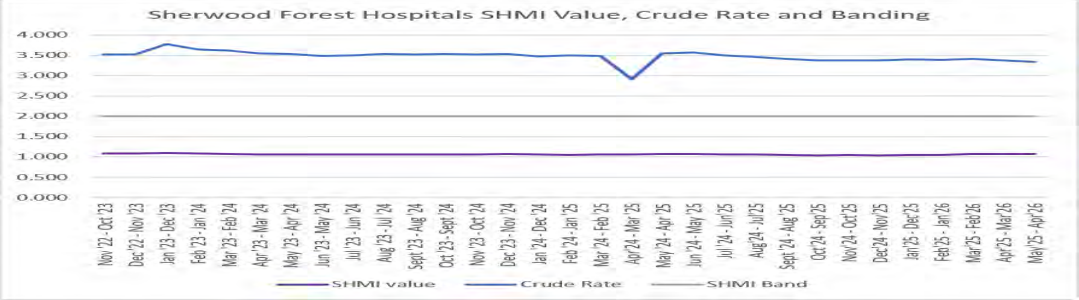
SHMI continues to report “as expected”; the value appears to have stabilised over the past 3 months, after a previous increase.



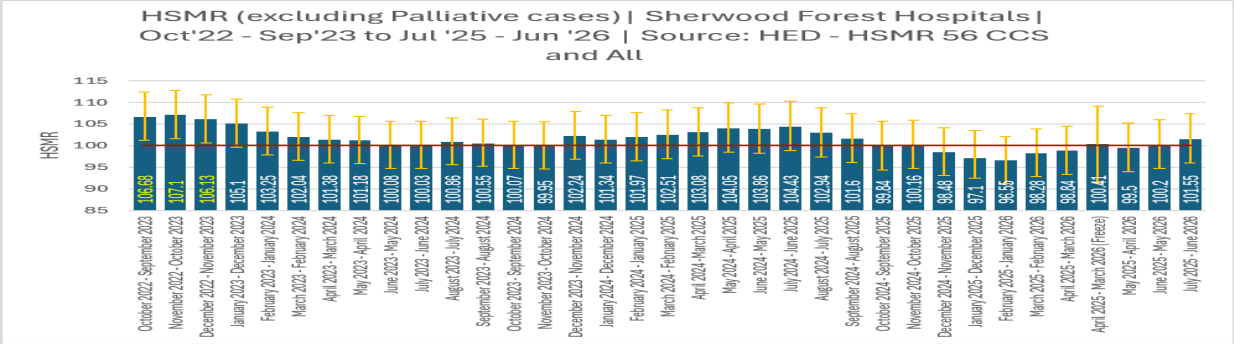
National v HED Comparison:



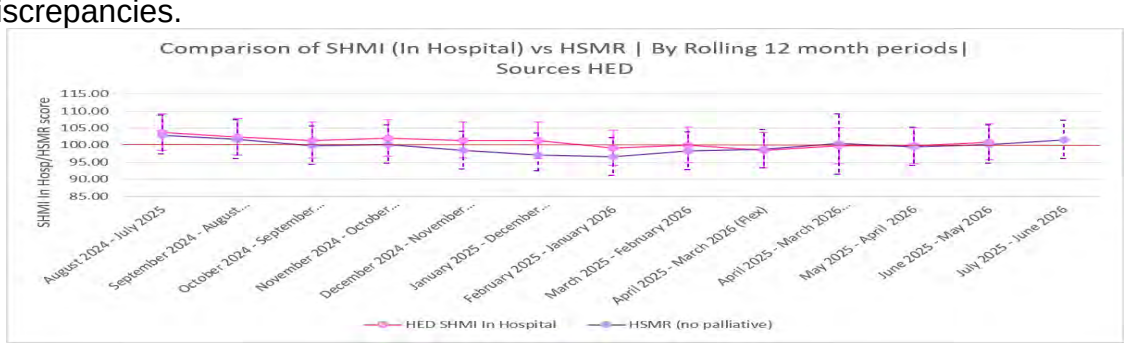
SHMI Crude Rate and SHMI Banding
The SHMI crude rate remains stable and SHMI remains in reporting Band 2 (“as Expected”)



HSMR Trend (HED Data)
HSMR (excluding palliative care adjustment) is monitored, in the background, to support triangulation (and assurance) of data. This has continued to report “as expected”.



HED SHMI (in hospital) v HSMR Comparison (Source- HED)
Further review and comparison of HED metrics for both SHMI and HSMR help to support and identify discrepancies.



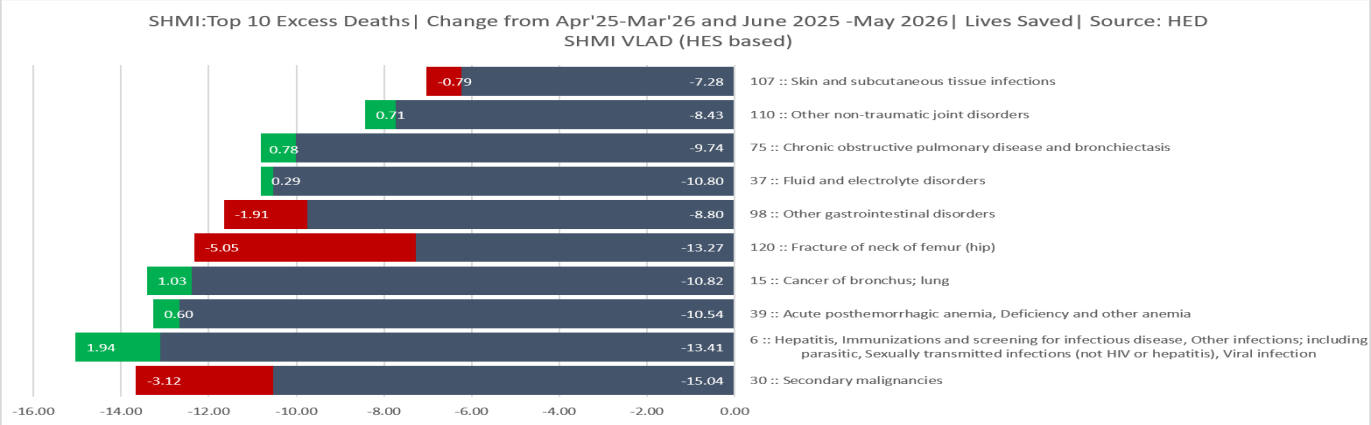
Outlier monitoring and review:
Monitoring during the period appeared to suggest a number of statistical signals rather than one consistent outlier profile.

Pneumonia, acute cerebrovascular disease and fluid and electrolyte disorders were selected for focused review. Coding reviews of sampled acute cerebrovascular disease and pneumonia cases found coding to be accurate with review of fluid and electrolyte disorder cases ongoing.

Other surveillance has included septicaemia, aspiration pneumonia, gastrointestinal conditions, fractured neck of femur, secondary malignancies, diabetes and peripheral/visceral arterial disease.

Coding analysis with potential for onward case note review has been agreed for areas where specific triggers have raised concern, triangulation warrants further evaluation, or areas remain as persistent “outliers”.

Focus on VLAD top 10 excess deaths



In the 7 months of using HED, there are 5 conditions that have persisted in the top 10 excess deaths. 4 of the 5 have reported a reduced number of excess deaths in the last 2 months (Hepatitis; Acute post-haemorrhagic anaemia (deficiency and other anaemia), Fluid & electrolyte disorders, Cancer of bronchus/lung).

Secondary Malignancies is thought to be driven by deaths in the Community, with a similar picture potentially being seen with Fracture Neck of Femur; these remain under review.

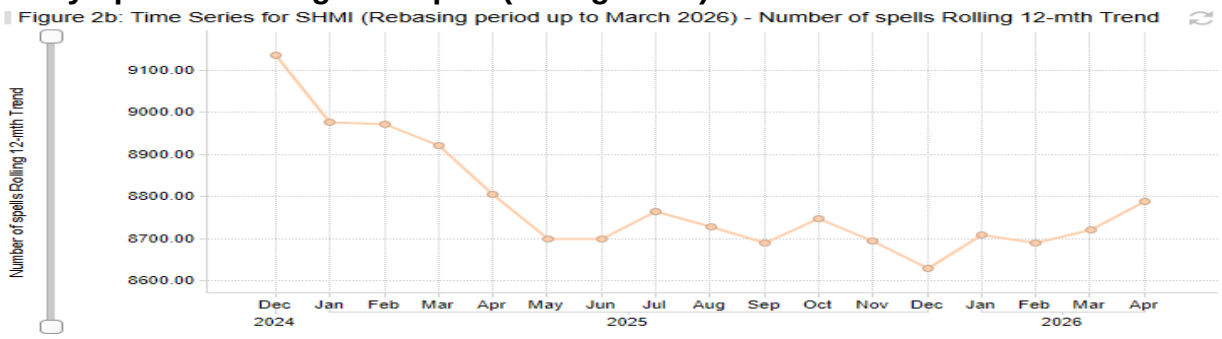
Other gastrointestinal disorders and skin and infectious tissue infections each appeared in the top 10 but no more than three times. Together, they accounted for 2.5% of deaths in June 25 - May 26 and 2.4% in May 25 - April 26.

Clinical Coding

The coding team works alongside analytics and other intelligence to support speciality areas, clinical teams and other forums with understanding and quality improvement. Provision and use of more relevant and informative data aligns with the Trust direction of improving overall reporting, strengthening governance, and working towards a more meaningful basis for learning.

“Depth of coding” continues to be monitored and is seen as an important factor in supporting explanation of gaps between observed and expected rates; an improving (reducing) picture for symptoms and signs coding appears to correlate with accurate capture of diagnoses and co-morbidities.

Spells in symptoms and signs chapter (rolling trend)= HED extract



Divisional reporting

Divisions and Specialty leads report into Learning from Deaths on a quarterly basis; this approach includes a standardised template, in addition to any verbal update, whereby further discussion and actions can be evaluated. A new addition to the rolling calendar is a quarterly thematic review meeting (“wash up”), where reflection of themes, actions (and progress), alongside any learning can be discussed and shared.

Examples of highlights and themes from divisional reports:

Urgent and Emergency Care (ED):

Recurring themes were communication, documentation, senior clinical oversight, impact of patient flow and overcrowding. Earlier specialty involvement and changes to front-door processes require monitoring for impact and sustained improvement.

Acute medicine:

Two reported cases from SJR reviews identified suboptimal care with both being progressed through Coroner and PSII processes. Reported learning included sepsis screening, infection-source identification, antibiotic prescribing, telemetry, patient flow and consideration of reversible causes of reduced consciousness.

Medicine:

Reports highlighted outstanding SJRs, particularly in Diabetes and Endocrinology, and reviews completed outside Datix IQ or awaiting formal sign-off. Specialties were asked to complete and record reviews as a matter of priority. Learning included timely specialist review, communication and handover, ReSPECT documentation, and specific focus related to ECG/long QT recognition and compliance with DVLA guidance.

Critical Care:

Reviews reported no avoidable deaths from a Critical Care perspective. Positive findings included multidisciplinary working, specialty input, responsive care and communication with families. Specific learning related to impact from delayed admissions or theatre access, vigilance after difficult central line insertion and family access at end of life. Delayed feedback from referred specialties continued to limit aspects of SJR progress and learning, this being highlighted in the Learning from Death meeting.

Planned Care and Surgery:

Four SJRs reported in May identified no suboptimal care or avoidable deaths. Positive themes included communication, documentation, appropriate care environments, early recognition of end-of-life needs and palliative care involvement. Fracture and frailty mortality was subject to focused report and discussion; time to theatre remains under governance oversight, with additional attention to pre-optimisation and appropriate non-operative management.

Women, Children and Paediatrics:

CDOP reporting covered expected and unexpected child deaths, recurring modifiable factors and gaps in bereavement support. Learning included housing and home conditions, smoking and substance use, unsafe sleeping, road and water safety, joint agency responses, information sharing, post-death care, escalation of ED pre-alerts, visibility of alerts for children with complex needs, and communication between primary and secondary care.

Increased visibility and oversight of maternity and neonatal deaths is supported through Perinatal Assurance Committee (PAC) and Maternity Outcomes Signal System (MOSS) tracking.

A funded bereavement nurse and a gynaecology mortality lead remain outstanding.

Reported further learning included epilepsy, challenge of identifying focal seizures in histories, RCPH stroke guidance and availability of neurological support.

End-of-Life and Specialist Palliative Care:

The Newark CQC inspection rated end-of-life care “Good” overall and “Outstanding” for care, with positive findings on partnership, compassion, leadership and specialist support. Improvement work continues on ReSPECT, mental capacity, recognition of dying and communication.

Quarterly reporting identified variable quality and timeliness of ReSPECT documentation and the need for earlier supported conversations. Challenges around reduced specialist palliative care provision were escalated to the Alliance Board and monitored whilst a clear message remained for referrals to continue as usual. Positive evidence included compassionate care, early recognition of end-of-life needs, multidisciplinary working and re-emphasised the improved CQC findings for end-of-life care at Newark.

Learning was reported to be already widely disseminated through a range of established mechanisms, including formal reporting, governance processes and specific learning events.

Learning Disability and LeDeR:
Quarterly report for Q1 highlighted 4 deaths, with 2 SJRs being undertaken and 1 case of potential sub-optimal care, which was going through the PSII process.
Key themes included communication with families and carers, ReSPECT completion, advocacy, unsafe discharge, ward documentation, flagging on clinical systems, pain relief, staff attitudes and limited SJR detail.
Positive family feedback was received for the dialysis and intensive care teams with regard to a patient's care and support during end-of-life. A learning event linked to the EOL toolkit was shared.
The national LeDeR report highlighted continuing inequalities and informed priorities on dysphagia, aspiration, hydration, oral health, deterioration, seizure management, reasonable adjustments and training. Local review of aspiration pneumonia and compliance with national learning disability training standards were proposed. Summary of the LeDeR annual report 2024- highlighted priorities of earlier recognition, faster escalation, safer pathways, consistent reasonable adjustments and stronger accountability for outcomes.

Coroner and Legal:
Q1 (2026/27) report to Learning from Deaths highlighted the following:

- Total of 37 coronial matters- (41 for Q1 2025/26).
- 15 inquests and 22 investigations; 15 investigations closed without inquest.
- Inquest conclusions included: narrative, natural causes, open, road traffic collision (RTC) and suicide.
- 1 Regulation 28 notification received, relating to a RTC and, alongside other healthcare providers, focused on no documentation for having informed / advised not to drive (DVLA).
- Learning areas included urgent inpatient biopsy access and tracking, documentation of DVLA driving advice, safety-netting for rib-fracture discharge, telemetry transfer following bed moves, access to MRI for patients with pacemakers, resuscitation practice and consideration of penicillin allergy de-labelling. Actions were progressed through relevant governance routes; some cases remain under review with awaited outcome.
- A Safety Alert with regard to DVLA guidance on Fitness to Drive was sent out to Divisions for wider sharing and learning. (See appendix)
- Actions and sharing learning sits with divisions, governance groups and the Governance Support Unit rather than the legal team.
- Positive working relationships and engagement with specialities and divisions.

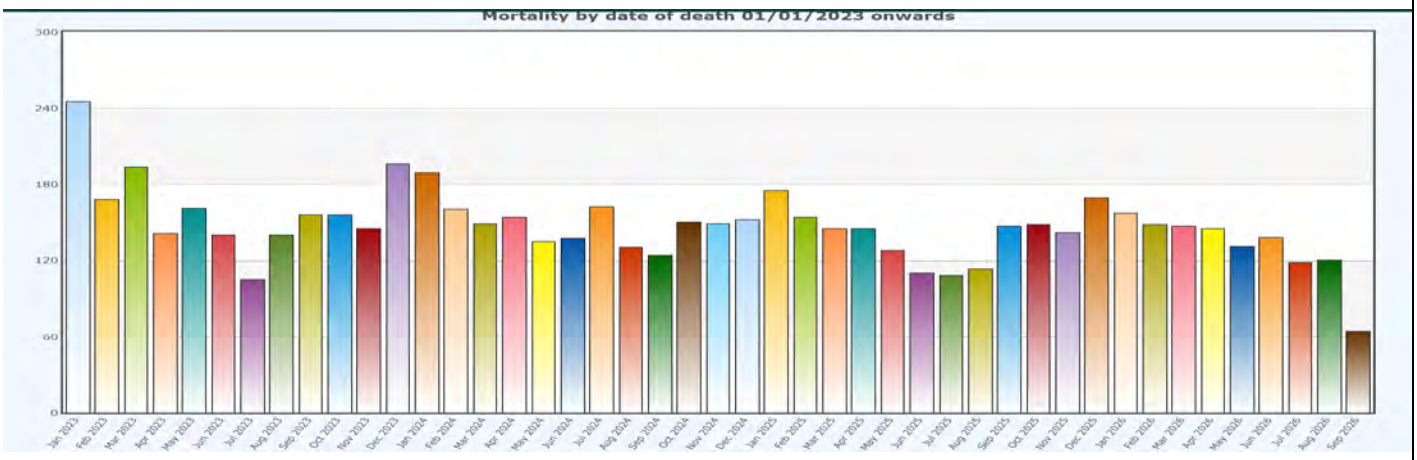
Organisational Learning:
Recurring themes identified across divisional / speciality mortality reviews, Medical Examiner scrutiny, LeDeR reviews and coronial learning included:

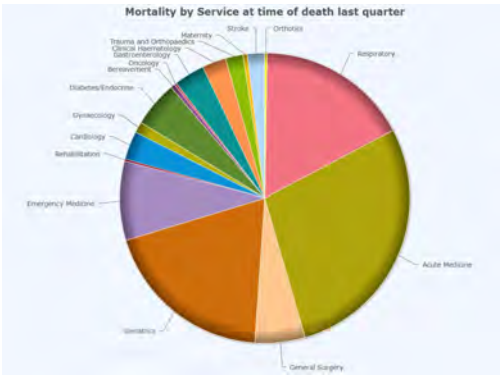
- Communication with patients, families and carers.
- Quality of clinical documentation.
- ReSPECT completion and end-of-life conversations.
- Earlier recognition and escalation of deterioration.
- Timely specialist review and multidisciplinary working.
- Safety-netting and handover arrangements.
- Learning disability flagging, advocacy and reasonable adjustments.
- Evidence that identified actions have been completed and embedded.

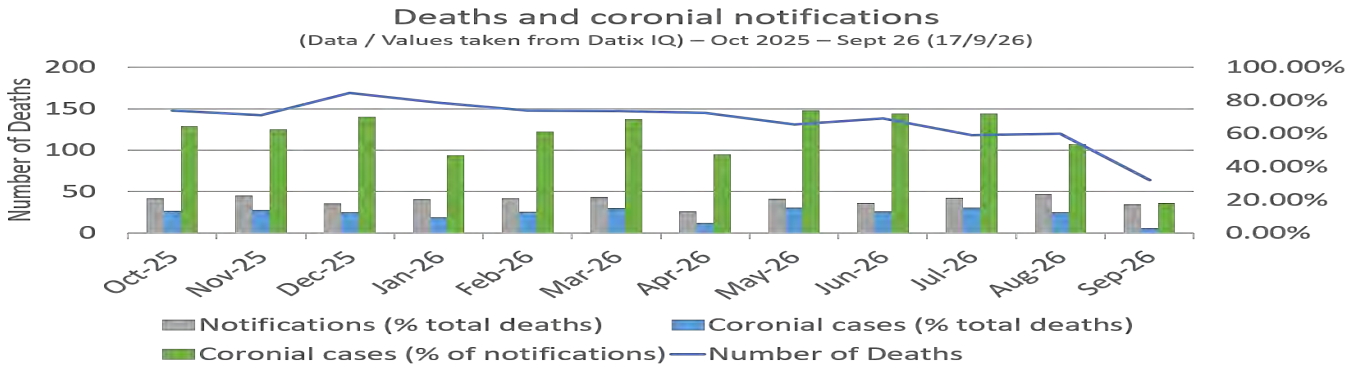
Examples of positive practice included compassionate end-of-life care, effective multidisciplinary working, family engagement, specialist palliative care involvement and examples of appropriate non-operative management. Reports from Critical Care and Planned Care and Surgery did not highlight any avoidable deaths from the reviewing specialties' perspectives.

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

Data from the Medical Examiner Service and LfD Dashboards (Datix-IQ 17.09.26):







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

Medical Examiner and Bereavement Centre (Q1 reporting summary):
Total number of acute deaths processed- 408

- 405 Adult deaths- 334 MCCD issued; 71 referred to coroner of which 46 cases taken over
  - 25 CN1A issued, 32 postmortem, 14 inquest / investigation
- 3 Child deaths- 1 MCCD issued, 2 taken for postmortem
- 26 SJRs raised during Q1, including 6 mandatory Learning Disability / Mental Health cases

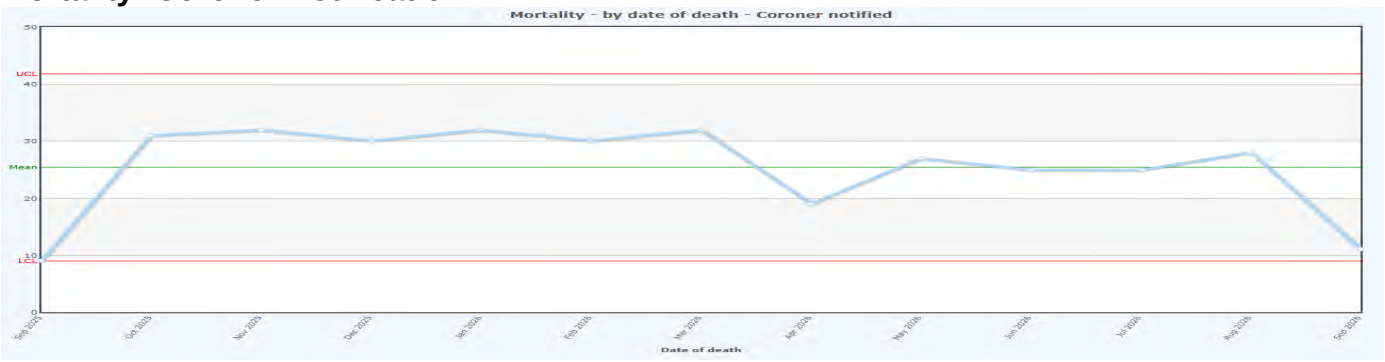
The service continued to review all deaths and maintained family engagement at just under 99% (only 5 cases without, of which 4 related to no NOK and 1 case where no direct family contact received).
There was 1 reported case of early release, managed appropriately with nil delay for family.
Improvement in timeliness of processing acute cases, with median timeframe for death to registration reducing from 6 to 4 calendar days and referral to registration from 4 to 2 days.

Vacancies in the Medical Examiner Service added to the challenge in meeting targets and maintaining performance; however, the team continued to focus on all cases being scrutinised and delivering a high-quality service to families. Successful recruitment has now taken place, with posts intended to commence October 2026; induction and training will be required before full benefit realisation.

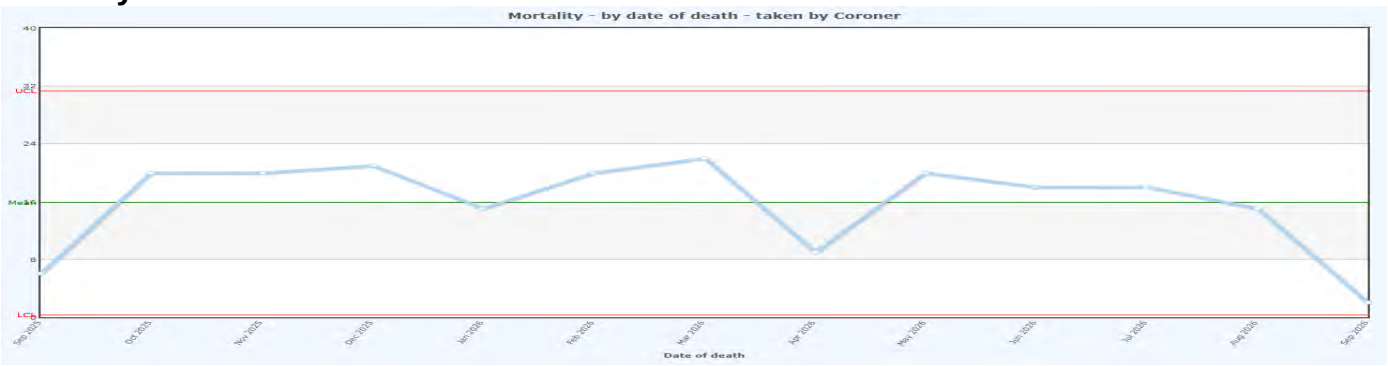
Community deaths are recorded and captured by the Bereavement Centre and Medical Examiner Service; the Learning from Deaths group has requested this forms part of future reporting to enable a shared understanding of wider performance, greater understanding of quality-of-service delivery and potential learning.

.

Mortality- Coroner Notification:



Mortality- Coroner Taken



Structured Judgement Reviews:

The DATIX-IQ mortality review tool provides data on internal trust related deaths; mortality reviews are managed using this platform which has capacity to capture Structured Judgement Reviews (SJRs), avoidability assessments and other learning outcomes.
The Power BI dashboard, which includes SJR data and the functionality to be “tailored” to divisional / speciality views for a suite of metrics, continues to undergo improvement.

Mortality processes have been a key element of the Mortality Management Policy revision, aligning with external auditor requirements. To help with consistency and quality, users (including clinical teams and governance leads) are required to undergo training in use of the DATIX-IQ platform and SJR methodology prior to access.

Emphasis has been placed on timely completion of SJR reviews and divisional / speciality ownership, with mortality leads being responsible for oversight and submission of reviews.
It is believed this provides clarity around process and expectations for Speciality and Divisional teams whilst forming a key part of the journey towards strengthening governance, assurance processes and supporting ongoing organisational learning.

The Power BI dashboard is able to show SJR “overall phases of care” within its reporting functionality; the current predominant rating is that of “Good”. Where poor care is identified, the escalation process includes review through Divisional Governance meetings and Patient Safety Incident Review Group (PSIRG). This supports identification of cases requiring a Patient Safety Incident Investigation (PSII) under the Patient Safety Incident Response Framework (PSIRF) where it is believed a problem in care has more than likely contributed to a death.

The quarterly SJR update provided a summary of updates to the mortality review process administered through the DATIX-IQ platform and Power BI Dashboard. This included reminders for escalations of poor care, process for approval of submissions, divisional sign off (including avoidability assessment) and information on overdue reviews. In addition, the agreed standard procedure for review of adult deaths (decision flow for SJRs and PSII) was presented.

SJR quarterly reporting to LfD – DATIX IQ outputs (June 2026 report) and template:

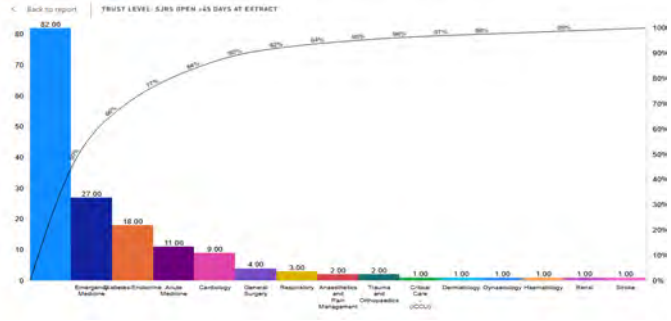
- 190 SJRs requested on the new system, with monthly requests not appearing to show any clear special cause variation.
- 94.7% SJRs had been raised by / via the Medical Examiner Service
- SJRs open >45 days at extract (June 2026) = 67
- Focus on SJRs still awaiting completion and sign off / closure, and importance of reducing “blank fields” to allow more complete reporting.
- Template summary report:
    - Changes to digital workflow to reflect external audit requirements and feeding into revision of Mortality Management Policy
    - Increased review and accountability at Divisional level; approved job descriptions for Divisional and Speciality-level Mortality and Governance Leads with intention to provide clarity and sufficient job-planned time to undertake governance activities.
    - Dashboard developments with focus on “timeliness”

Latest Outputs from DATIX-IQ / Power BI Dashboard (17/9/26 - Extract Sept 2026)
SJR activity:

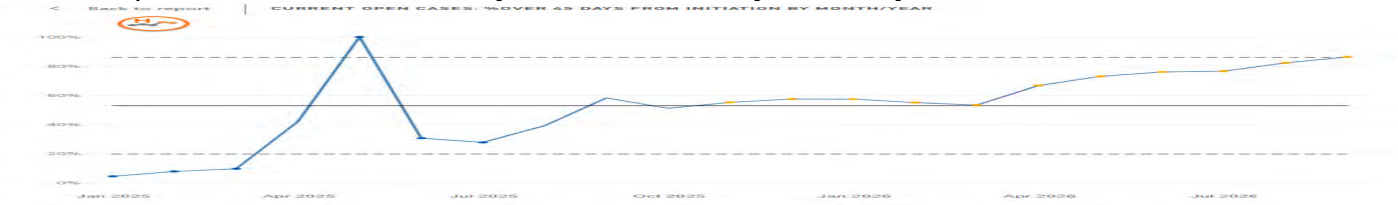
Back to report | ACTIVITY OVER TIME

Division	FY2024-25	FY2025-26	FY2026-27	Total
Trust Level	**58**	**118**	**46**	**222**
Total	**58**	**118**	**46**	**222**

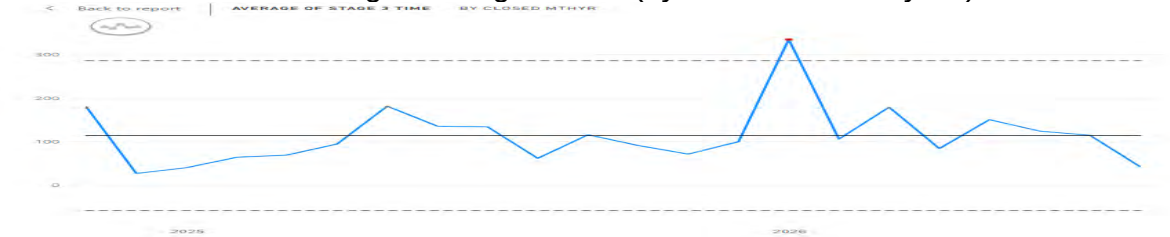
Trust level: SJRs open >45 days at extract (n=82)- September 2026



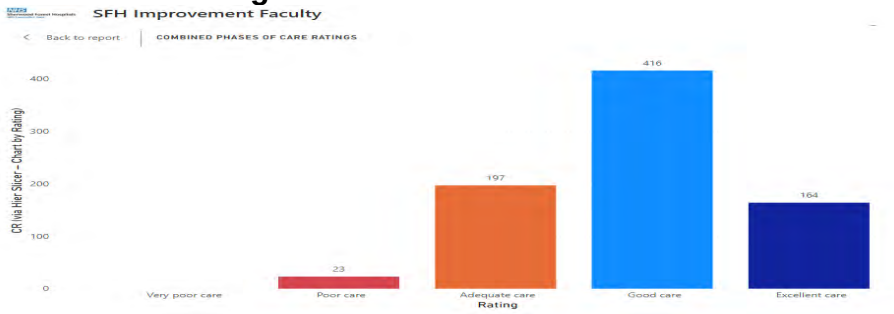
Current open cases : % over 45 days from initiation by month / year



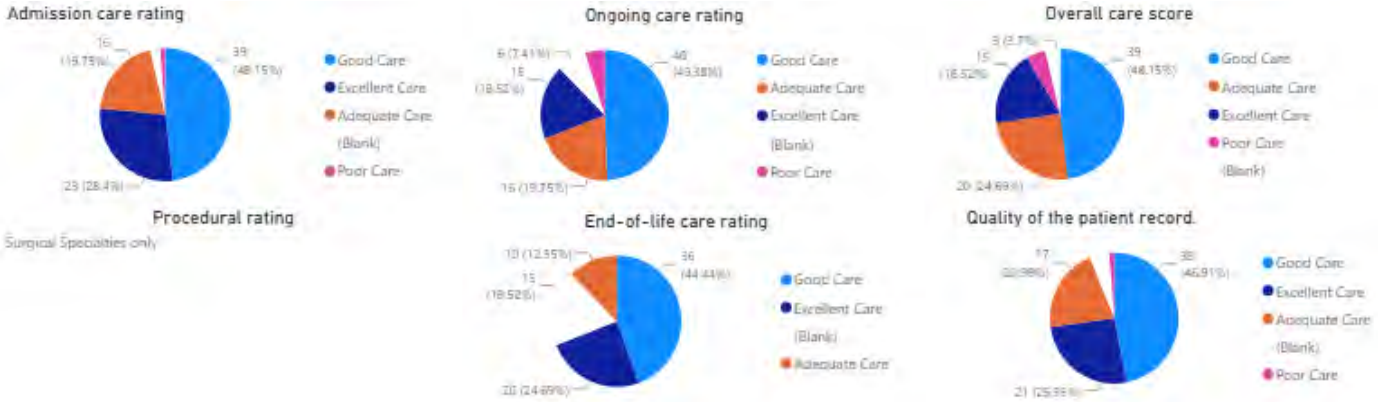
Process measures- Average of Stage 3 time (by closed month / year)



Trust Level Phases of Care Rating:



Individual Phases of Care breakdown:



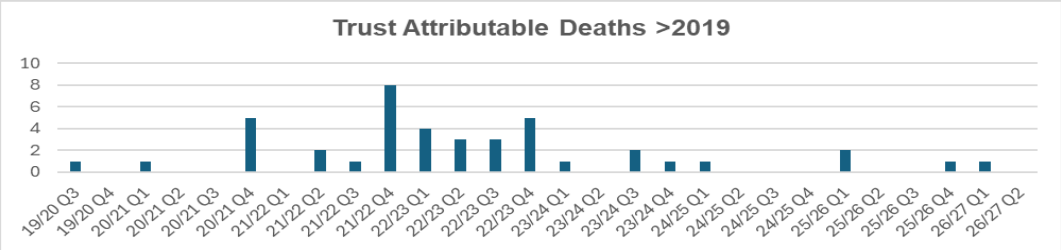
DATIX IQ reporting (Acute Deaths) Q1-2 2026/27 (19/9/26)

2025 / 26	TOTAL 2025/26 Q1-4 (to 21.3.26)	Q1 2026/27	Q2 2026/27 (to 17.9.26)	Total Q1-2 2026/27
Mortality by Date	1614	414	311	725
Coroner Notified	341	71	65	136
Taken by Coroner	213	47	36	83
ME Requested SJR	118	26	22	48
SJR Quarter (%)	**7.3**	**6.3**	**7.1**	**6.6**

SJRs are requested and captured through DATIX-IQ. Requests include statutory cases (e.g. LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People) and patients detained under the Mental Health Act) alongside cases where concerns or issues have been raised during patient management, family contact and as part of the ME scrutiny process.

For SFHT, SJR requests for Q1-2 2026/27 (to 19/9/26) represent approximately 6.6% of total deaths (reference 2025/26 = 7.3%). The previous Board report referenced the National Medical Examiner Report 2024 (published Sept 2025) which indicated Medical Examiners in England referred around 7 to 8% of deaths in acute trusts for case record review or equivalent, and 5 to 6% of all deaths for some form of clinical governance review.

Feedback and Serious Incident Investigations from Coroner:
There is a requirement to report to Trust Board an estimate of deaths where a problem in care has been felt to contribute to a death. PSII's are felt to provide insight into these cases, with these being regularly taken for coronial investigation. Investigations and inquests can take months to conclude and report; however, learning will be reported as becomes available.
It is understood that between 01/04/2026 and 16/09/2026 3 PSII's were commissioned in relation to potential contribution to patient death. As of 17/09/2026 one case (Q1 2026) has been identified as pertaining to potential catastrophic harm. All 3 cases have been escalated through the coronial process.



LfD Meetings Reflection
Meetings continue monthly and provide a forum for standardised reporting, active discussion and general review of themes arising as a result of divisional highlights, data and other areas.
Trust-wide multi-disciplinary engagement has been essential to enabling meaningful discussion, outcomes and learning.
HED has become more embedded and, alongside further development of the power BI dashboard, is hoped to provide a means for greater speciality and divisional access to data, enabling more consistent and pro-active ownership and responsibility.
Mortality Management Policy revision has strengthened governance and clarity around process. The reporting template is routinely used and provides a clear and consistent summary of highlights and themes, alongside a template for further discussion and escalation. The BIG-5 communication is sent to triumvirates, on a quarterly basis, to share some of the key themes.
Patient Safety Committee continues to receive a quarterly highlight report accompanied by a dashboard of high-level metrics and performance data; this committee feeds into the Quality Committee.

Wider accountability
The regional/ICB Learning from Deaths forum provides an opportunity to share information and identify wider learning across the system.
Areas of discussion have included:

- Developments within the Primary Care / Community Medical Examiner process, including SJR triggers and escalation protocols for concerns.
- Learning from deaths related to:
  - Mental Health patients requiring physical health care
  - Alcohol mortality
- Collaborative opportunities for regional PFD (Prevention of Future Deaths)
- Formalisation of process for how issues identified through LfD, PFDs, and related thematic work are escalated into the appropriate system governance structures.

Summary and Reflections of Learning:

Care and Improvement:

- Divisional / speciality areas are encouraged to report using an agreed template, which highlights SJRs and cases where sub-optimal care may have been identified.
- Reports highlighted positive multi-disciplinary working, compassionate communication, and

improvements with EOL recognition and Specialist Palliative Care involvement (where required).
- The Medical Examiner Service continued scrutiny of all deaths with associated strong and consistent family engagement.

Governance and Assurance:
- The Mortality Management Policy was comprehensively revised following 360 Assurance review. Both the policy and Learning from Deaths Terms of Reference were agreed.
- In connection with this, a focused piece of work has taken place to refine Governance roles (Divisional and Speciality) and ensure clear responsibilities with owners.
- Datix IQ was further developed to align mortality review processes with external audit requirements.
- System access and training for Governance teams / leads, and requirement for new SJR reviewers to complete appropriate training.
- SJRs are required to be reviewed through divisional governance before closure and sign-off. Outstanding reviews, incomplete Datix IQ entries, and delays in specialty responses remain areas for improvement. Work is ongoing to alert Governance leads when SJRs are raised in addition to supporting visibility of reviews approaching key timeframes.
- The power BI dashboard is continually under development to aid divisions, specialities and individuals (including Governance leads) in taking ownership of their data alongside responsibilities for reporting, actions and opportunities for learning.
- The Learning from Death meeting reporting cycle has recently been revised on a proof-of-concept basis to include dedicated quarterly reflection on themes, actions, impact and whether improvement has been sustained.
- The LfD dashboard, flash report and “Big 5” communication continue to support concise reporting, primarily into Patient Safety Committee, and wider sharing of priorities.
- Q1 ME Service performance improved; average time from death to registration reduced from six to four days and referral-to-review time reduced from four to two days.
- Successful recruitment to Medical Examiner vacancies; posts intended to commence October 2026 with induction and training required before full benefit would be realised.
- Invitation of the new Trust Risk Manager to regular Learning from Deaths meetings was acknowledged to present an opportunity to strengthen the triangulation of safety, effectiveness and risk.

Principal Risks and Assurance Gaps:

1. Timeliness and Closure of Mortality Reviews

Although visibility and accountability have improved, delays remain in:
- Completion of SJRs.
- Datix IQ recording and closure.
- Inter-specialty responses to SJR requests and support.
- Divisional governance sign-off.

2. Workforce and Service Capacity

Ongoing concerns relate to:
- Medical Examiner workforce sustainability during recruitment and induction.
- Specialist palliative care provision compared to regional and national benchmarks.
- Lack of an agreed and funded Paediatric Bereavement Nurse post.

3. Learning Disability and Vulnerable Patient Pathways

Reviews continue to identify risks relating to:
- Reasonable adjustments.
- Recognition of deterioration.
- System flagging and advocacy.
- Learning disability training compliance.
- Specific awareness with regard to clinical scenarios of Aspiration pneumonia, Dysphagia and hydration.

4. Demonstrating Impact
While recurring themes are consistently identified, evidence that actions have led to measurable, sustainable improvement is not yet consistently demonstrated and requires further focus.

Future Intentions and Priorities

- Continue routine surveillance and case-note review of mortality signals, completing the fluid and electrolyte disorder review, and monitoring the conditions identified through HED, VLAD and CUSUM.
- Embed the revised Mortality Management Policy and consistent divisional governance of SJRs, including timely completion, Datix IQ recording, sign-off, escalation and evidence of resulting action.
- Use quarterly thematic review to confirm whether identified learning has produced measurable and sustained improvement.
- Strengthen divisional ownership of mortality data and use of the Power BI dashboard and HED.
- Maintain focus on communication, documentation, ReSPECT, safety-netting, timely specialist review and palliative care referral pathways.
- Improve learning disability and autism training compliance, system flagging, reasonable adjustments and involvement of the Learning Disability Team; consider local review of aspiration pneumonia in people with learning disabilities.
- Monitor and support Medical Examiner service as new staff are recruited and trained.
- Progress Women and Children governance arrangements for the Maternity Outcomes Signal System and continue escalation of the paediatric bereavement nurse gap.
- Monitor the impact of reduced specialist palliative care provision and update on developments.

Conclusion:
The reporting period provides assurance that headline mortality measures remained within expected ranges and that the Trust continues to review mortality through multiple sources of evidence.
A key focus of work within Learning from Deaths has been that of strengthening governance and oversight controls, including thorough revision of the Mortality Management policy, clarity of governance roles and further development of data / information platforms. These are intended to equip divisions, specialities, and leads to take ownership of their data and provide clear and consistent reporting.
The drive for continued improvement focuses on areas of timeliness (including diagnosis), documentation, specialty feedback, end-of-life processes, learning disability support and service capacity. Priorities are therefore focused on completing reviews, strengthening accountability and, through effective channels for reporting, demonstrate learning has led to sustained improvement.

<u>The Board is asked to note:</u>

- SHMI and HSMR remained within expected ranges during the reporting period;
- Improvements to triangulation, governance and scrutiny through:
    - continuing review of identified mortality signals via coding, case-note review and clinical governance
    - increasing use of HED benchmarking tool by the Trust and a drive to further embed this within divisional and service-lines to support intelligence and learning
    - focus on divisional and speciality-level ownership of data, governance (including SJR oversight) and reported learning
    - revision of Mortality Management Policy and Datix IQ processes
- Recurring learning themes and the priorities set out in this report.
- Use of quarterly thematic review to help demonstrate and support measurable and sustained improvement.

Appendix-

- **Safety Alert- DVLA**

Please share this safety alert with your staff and colleagues as appropriate. Consider forwarding this e-mail, reading this alert out at briefings and handovers, printing a copy of for staff rooms and offices or displaying it on notice boards.

What happened?

A patient was assessed on multiple occasions across primary care and secondary care services for symptoms consistent with cough-related syncope (transient loss of consciousness associated with coughing). Despite repeated clinical contact, there was no documented evidence that the patient was advised not to drive, or to notify the DVLA of a relevant change in health status. Following the patient's death in a road traffic collision, the Coroner issued a **Prevent Future Deaths (PFD)** report. The PFD highlighted a **significant missed opportunity** to provide clear advice about driving restriction and DVLA notification, raising concern that similar omissions could place other patients — and the public — at risk.

What should have happened?

Where a patient presents with symptoms that may impair consciousness (e.g. syncope or pre-syncope):
Clinicians should:

- Consider **fitness to drive** as part of the clinical assessment
- Provide **clear verbal advice** about driving restrictions where indicated.
- Ensure this advice is **documented in medical records** and included in correspondence to primary care and the patient

Patients should be advised to notify the DVLA in line with national guidance when required. Patients should be advised to **notify the DVLA** in line with national guidance when required.

What can be learned?

Fitness to drive is a routine clinical consideration and applies to a wide range of conditions and treatments that may affect consciousness, cognition, vision, or physical function. Clinicians should actively consider driving implications during assessment and provide **clear, timely advice** on driving restriction and DVLA notification where relevant. **Advice must be documented** — if it is not recorded, it cannot be assumed to have occurred. Clinicians should **not assume** that another service has already discussed fitness-to-drive with the patient. Treating fitness-to-drive as **a shared responsibility across the patient pathway** helps reduce risk to patients and others.

What are we doing to stop this from happening again?

We are reminding clinicians that **considering fitness to drive is part of routine clinical assessment** where conditions, symptoms, or treatments may affect safe driving. We ask clinicians to **familiarise themselves** with the DVLA Assessing fitness to drive guidance, which was updated in 2025, and applies across a wide range of conditions and specialties. We ask colleagues to ensure fitness-to-drive conversations take place with patients, that advice is clearly documented, and that we do not assume another clinician or service has already had this discussion. **Assessing fitness to drive – a guide for medical professionals.**

- **Template- Divisional reporting – SFHT Learning from Deaths**

Learning from Deaths – Divisional Summary Report (2026/27)			Sherwood Forest Hospitals NHS NHS Foundation Trust	
REPORTING PERIOD		Standard Quarterly LfD Report		
DIVISION		Targeted Review (Diagnosis Group)		
DIVISION LEAD		Other		
SUMMARY OVERVIEW				
Total Deaths in period		Number of cases with potential sub-optimal care		
SJRs Undertaken		Please confirm ALL /any cases with highlighted issues or themes felt contributory to (or to have had any impact on) death have been escalated / managed appropriately		
Coroner referrals				
KEY THEMES AND LEARNING (Summarise recurring / pertinent themes- e.g. communication, documentation, pathways.....)				
1:				
2:				
3:				
AREAS / EXAMPLES OF GOOD CARE:		AREAS OF SUB-OPTIMAL CARE / EXAMPLES FOR IMPROVEMENT:		
1:		1:		
2:		2:		
ACTIONS IDENTIFIED:		RESPONSIBILITY	DUE DATE	PROGRESS
1.				
2.				
3.				
IMPACT OF LEARNING (Measurable outcomes / changes)		FEEDBACK (How has learning been shared?)		
1:		1:		
2:		2:		
OTHER INFORMATION (for reporting / sharing):				

- **Big 5 Communication- Example- Q1 2026**

Learning from Deaths – "The BIG 5"

Learning Themes for Q1 2026

NHS Sherwood Forest Hospitals NHS Foundation Trust

- **1 Mortality Metrics:**
  - **SHMI (Summary Hospital-Level Mortality Indicator)** remains "**as expected**" (Band 2)
  - **HED (Healthcare Evaluation Data) –** we want to encourage wider and more informed use of the HED benchmarking tool and mortality data; please contact the improvement faculty for training opportunities
    - ***Reminder-*** *accurate and timely documentation is vital in ensuring our coding is reflective of activity and management.*
- **2 Communication:**
  - Recurrent learning themes relate to the quality of clinical documentation, communication with patients/families, and timely, well-recorded ReSPECT conversations. Please ensure clear and accurate documentation in clinical notes and effective communication, including between teams.
    - ***Development-*** *Sage and Thyme communication workshops continue throughout 2026- please contact the EOL team for further details*
- **3 Governance and SJRs-**
  - The Trust Mortality Management Policy has now been signed off and provides important information around responsibilities and mortality processes, including SJRs.
  - Delays in SJR completion and specialty responses remain important governance risks requiring stronger oversight and divisional ownership.
    - **Request-** Please ensure timely response in completing SJRs and responding to speciality requests.
  - The Trust Power BI dashboard can support you and your teams to look at your own speciality data, including SJR monitoring.
    - ***Development-*** Familiarise yourself with the SJR processes and make use of both SJR and DATIX IQ training (training must be undertaken to have access) – *please contact the Trust Patient Safety Specialist and SJR Lead Dr John Tansley.*
    - *The LfD Group want to prioritise meaningful learning, feel free to suggest improvements for sharing of information and communication.*
- **4. Learning Disabilities-**
  - Please ensure patients with learning disabilities are correctly flagged on systems and highlight any alerts to the team
  - For support with LD related queries, whether in relation to patient management or other processes (including SJRs), please contact the team.
- **5 Clinical pathways and escalation (themes)-**
  - Highlighted risks include timely specialist review, delayed admission, theatre/endoscopy access, ED overcrowding, and escalation of deteriorating patients.
    - **Reminder-** Please pay particular focus to these areas in your day-to-day working alongside discussions and reflections with colleagues.
  - Specialist Palliative Care / End of Life- Continue to refer to services and highlight any delays or issues to response or provision.

Dedicated to Outstanding care

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet

Subject:	Patient Experience Annual Report.	**Date:**	1 October 2026
Prepared By:	Emma Mutimer-Hallgarth, Head of Patient Experience		
Approved By:	Sally Whittlestone, Deputy Director of Quality and Governance.		
Presented By:	Emma Mutimer-Hallgarth, Head of Patient Experience		

Purpose		
This report provides the Board of Directors with an annual update on patient experience, including complaints, compliments and concerns, together with an overview of emerging themes and trends.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Recommendation
The Board of Directors are asked to take assurance from this paper

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

Principal Risk		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**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
Patient Experience Committee Nursing Midwifery and AHP Committee

Acronyms
PET - Patient Experience Team CQC - Care Quality Commission

Executive Summary
This report provides a comprehensive update on patient experience for the 2025/2026 period, focusing on key areas such as complaints, concerns, compliments, Parliamentary and Health Service Ombudsman (PHSO) cases, and patient feedback mechanisms—including the Friends and Family Test and the National Survey Programmes. Additionally, it examines patient, family, carer, and external partner engagement, aligning these aspects with divisional quality assurance visits conducted during both in and out-of-hours periods. The report evaluates complaint activity, tracking the volume of complaints, concerns, and compliments received compared to the previous year. It presents a breakdown of total submissions by division and identifies emerging themes and trends. Moving forward, these insights will be aligned with the implementation of the Patient Safety Incident Response

Framework to enhance monitoring and responsiveness.

Patient engagement and involvement are further examined through various feedback methods, including national survey programmes and the Friends and Family Test, Patient Stories, 15 Steps, Coffee and Connect Engagement Forum and the Patient Safety Partner role.

The report outlines strategic aims for improvement throughout 2025/26, ensuring that divisional quality assurance visits support these initiatives.

By triangulating emerging themes and trends, this report highlights continuous efforts to refine patient care and enhance overall patient experience.

Patient Experience and Engagement Report 2025/26

The Trust is dedicated to addressing concerns as swiftly as possible, often through direct discussions between the patient, relative, or carer and the relevant team. For those who may feel uncomfortable raising their concerns within the department or service, or if issues remain unresolved, the Patient Experience Team (PET) offers confidential advice and support. The PET works to resolve concerns efficiently and informally.

SFH operates a centralised complaints service to ensure a patient-focused approach in managing complaints. Each complaint is thoroughly investigated, with responses provided within a timescale of 25 to 60 working days, depending on complexity.

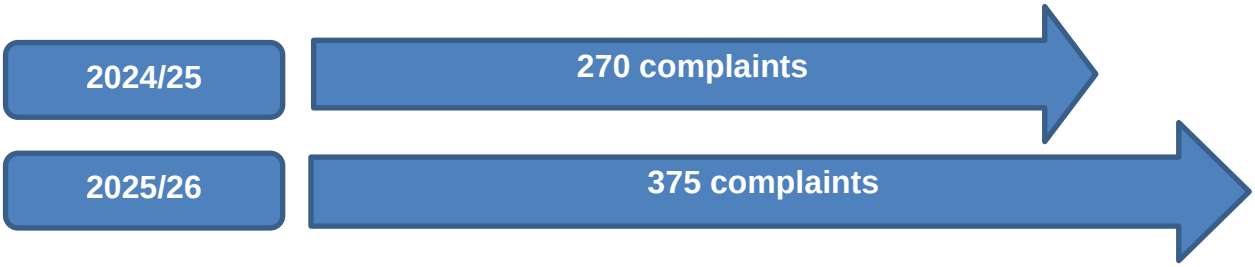
Insights gained from individual concerns and complaints are analysed to identify recurring themes, with intelligence shared across the organisation to drive meaningful improvements. Real-time data is available to divisions via bespoke Datix Dashboards, alongside. Divisional Dashboards and shared quarterly at the Patient Experience Committee.

Complaint cases are reviewed weekly with Divisional Leads and Divisional Patient Experience Leads. They are also discussed during monthly divisional governance meetings by the Patient Experience Manager supported by Divisional Patient Experience Leads, fostering a multidisciplinary approach to improving patient experience and implementing necessary enhancements.

1. Complaints:

Complaints Activity

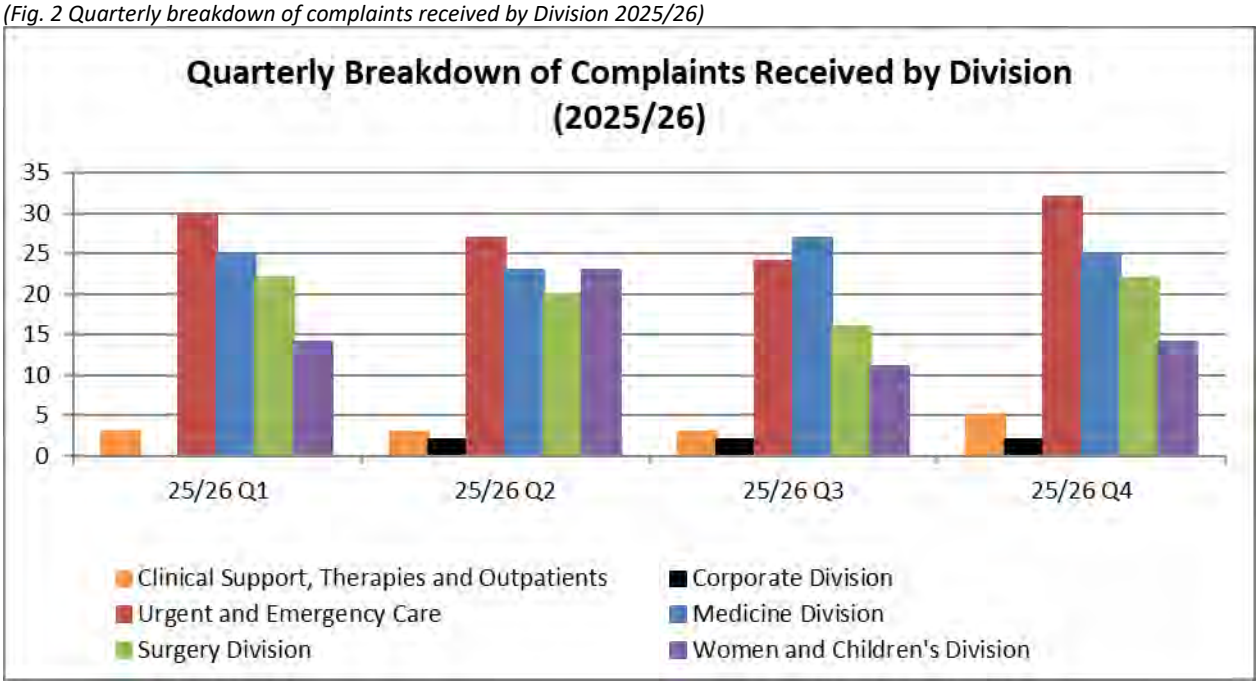
(Fig 1: The number of complaints received in 2024/25 and 2025/26)



Throughout 2025/26, Sherwood Forest Hospitals (SFH) received 375 complaints demonstrating a 39% increase compared to 2024/25. A recent poll undertaken by the National Complaints Network indicates a significant national increase in complaint volumes, with 71% of responding Trusts reporting an increase of at least 30%.

Figure 2 identifies the complaints received each quarter as per respective division.

(Fig. 2 Quarterly breakdown of complaints received by Division 2025/26)



Complaints are discussed at divisional monthly governance meetings. The Patient Experience Team continue to circulate the complaint's tracker on a weekly basis to ensure local monitoring and meet with divisional representatives to track complaints.

The Patient Experience Team have worked with the divisional teams to develop a central tracker within Datix. This is now operational and the divisional teams are encouraged to input their live updates into Datix. Further work is being undertaken to create an interactive dashboard that will be more accessible and visually engaging for users.

Timeliness of divisional responses improved to 54% this year, an 11% increase that reflects the work undertaken by divisional teams to strengthen complaint response processes. The Patient Experience Team continues to support investigations by gathering responses and drafting complaints to help ensure timely replies to complainants.

Divisions continue to work within the new complaints process, which is tailored to the needs of each area. The Director of Nursing, Quality and Governance maintains oversight of divisional complaint responses to provide assurance, with further support available to teams as needed. Cross-divisional responses are still coordinated centrally by the Patient Experience Team, although the next phase of the process will see divisions take greater ownership of these complaints.

Performance and compliance continue to be monitored through monthly KPI data, with findings reviewed at Divisional Governance Meetings and quarterly reports being presented to Patient Experience Committee with matters escalated to the Quality Committee where appropriate.

In 2025/26, SFH responded to 324 complaints. Of these, 44% were completed within the locally agreed timescales with the complainant demonstrating a 6% increase from the previous year. Whilst performance against the time frames standard was noted to be reduced, all complainants were kept updated on the progress of their complaint.

The table below shows the number of complaints each division has managed throughout this reporting period.

(Fig. 3 Number of complaints received in 2025/26, by division responsible for managing the response)

	Response timeframe				
Complaint Lead	**25 working days**	**30 working days**	**40 working days**	**60 working days**	**Total**
Corporate Led	2	0	2	2	6
CSTO Led	0	0	2	7	9
UEC Led	6	6	20	45	77
Medicine Led	5	1	20	56	82
Surgery Led	4	3	23	40	70
W&C Led	2	1	12	37	52
Total Division Led					**296**
PET Led	6	2	16	83	107

Please note that the total figure is higher than the new complaints figure for 2025/26 as this includes all reopened and complaints under review.

Throughout this period there is a backlog of complaints, and it is therefore anticipated that this will negatively impact the response times in the next reporting period, though measures are being taken to address and minimise any delays.

Communication issues are the most frequently reported sources of dissatisfaction, alongside concerns relating to the care and treatment provided by the nursing team and the clinical assessment and clinical treatment provided.

These complaints are triangulated to ensure any safeguarding or patient safety issues are promptly escalated and managed via the appropriate routes, and, to further analyse themes and trends for escalation to the relevant divisions.

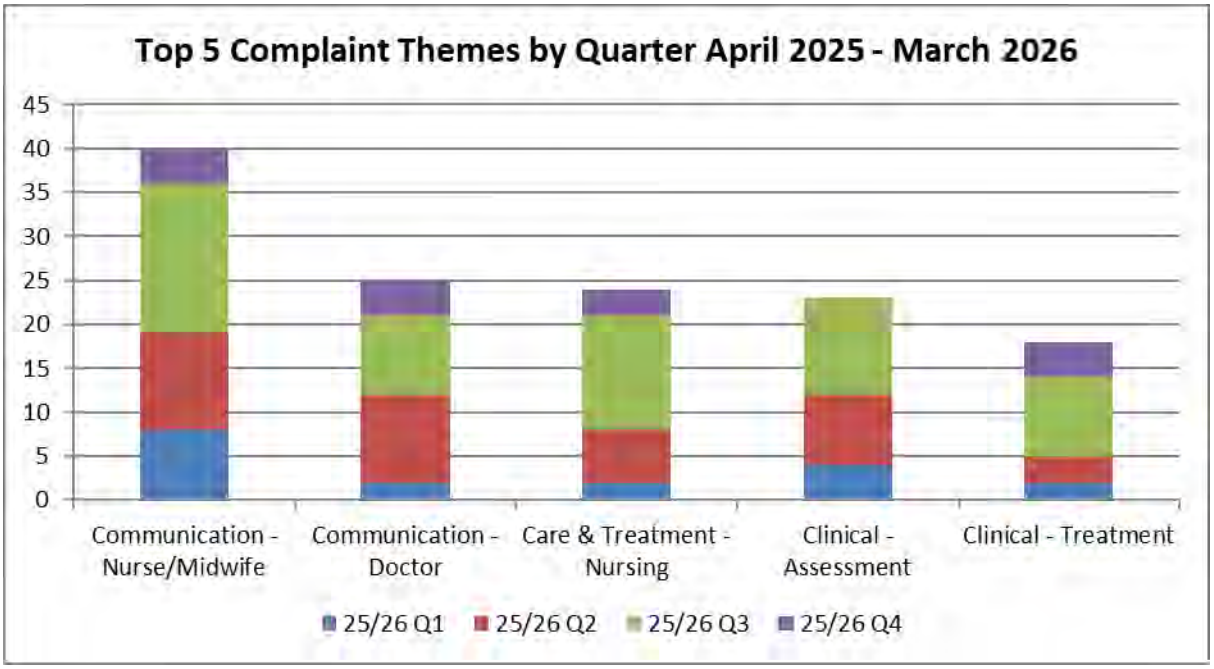
Figure 4 identifies the top five themes for the complaints closed throughout 2025/26.

(Fig.4 Top five themes for complaints 2025/26)

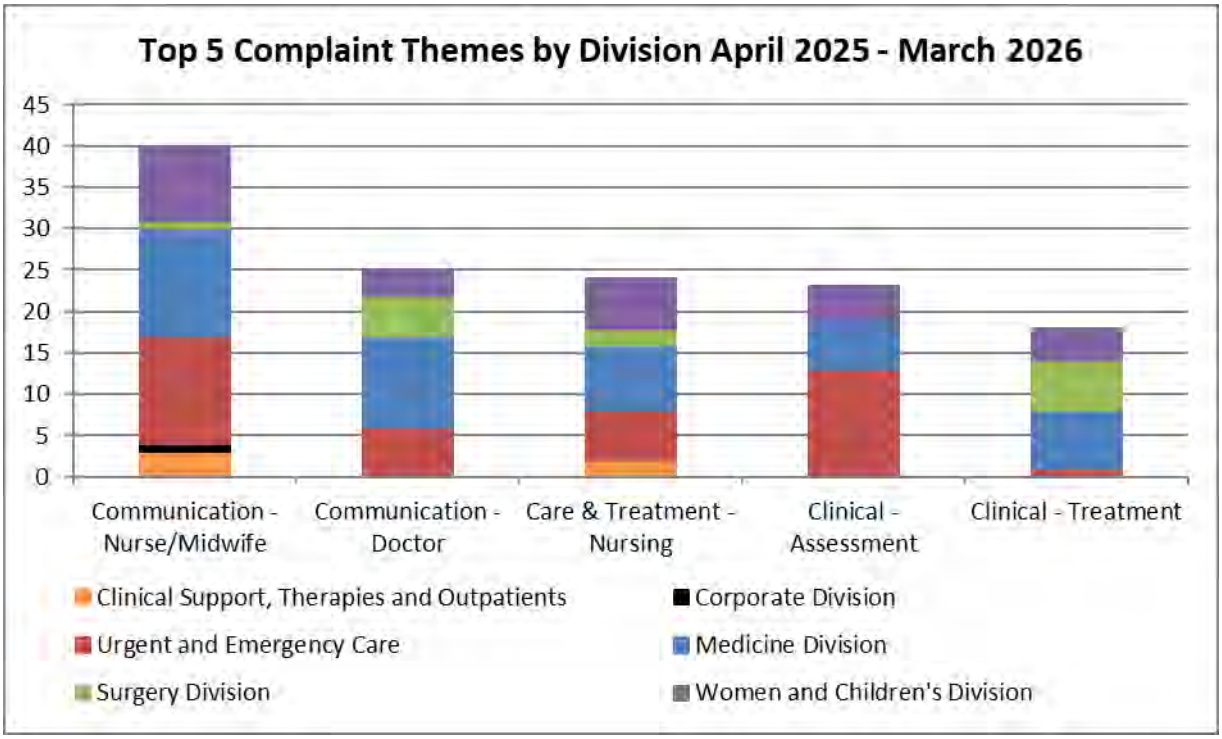
	Clinical Support, Therapies and Outpatients	Corporate Division	Urgent and Emergency Care	Medicine Division	Surgery Division	Women and Children's Division	Total
Communication - Nurse/Midwife	3	1	13	13	1	9	**40**
Communication - Doctor	0	0	6	11	5	3	**25**
Care & Treatment - Nursing	2	0	6	8	2	6	**24**
Clinical - Assessment	0	0	13	6	0	4	**23**
Clinical - Treatment	0	0	1	7	6	4	**18**
Total	**5**	**1**	**39**	**45**	**14**	**26**	**130**

The graph below provides a breakdown of complaint themes per quarter and what the themes are within these reporting periods.

(Fig. 5 Top 5 Complaint Themes received per quarter)



(Fig. 5 Top 5 Complaint Themes by Division)



A total of 22 complaints were re-opened in 2025/26 because the complainant had raised additional concerns to the original complaint, and it was agreed with the divisional teams that a further response could be provided. This reflects a 16% increase in the number of re-opened complaints, with 19 cases re-opened in 2024/25. All re-opened requests are formally responded to, reiterating the options relating to the next steps, which include Parliamentary Health Service Ombudsman (PHSO), independent advocate, and access to medical records procedure.

2. Actions and Learning

Following the investigation of each complaint, if any elements are upheld or areas for improvement are identified, an action plan is created by the investigating officer in collaboration with the relevant service or ward manager. Divisions then provide evidence of changes or shared learning.

Communication-related themes are addressed with the individual staff member and the wider teams during ward rounds, grand rounds, and other forums. Complaints involving a specific doctor are discussed and reflected upon during the doctor's appraisal.

If learning is identified from a complaint, a clear action plan should be put in place, this demonstrates to our communities and those that complain that we have listened and make any improvements required, this is captured by the Patient Experience Team.
Examples of how each division have completed this are identified below:

- Medicine Division - produced a monthly newsletter to share learning from incidents and complaints with themes identified throughout the Division.
- Urgent and Emergency Care (UEC) - use a dedicated WhatsApp group as an operational forum to review and share updates, learning, and key messages arising from compliments, concerns, and complaints raised within the Emergency Department.
- Surgery Division – discussion held in the Speciality and Divisional Clinical Governance meetings and minutes were shared following the meeting. A monthly newsletter is also being produced to feedback learning from, complaints, concerns and incidents.
- Women's and Children's – discussions are held regularly at the Labour Ward Forum and an agenda is shared ahead of the meeting.

Below is an example of actions for each division:

- **Medicine Division** – Concerns raised regarding a delay in the patient receiving her blood results. An audit of the processes for notifying clinicians of abnormal results will be undertaken to identify systemic weaknesses. Findings will be used to strengthen governance arrangements, clarify escalation pathways between departments and ensure prompt communication of abnormal or unexpected results to the appropriate clinical teams. Relevant staff will also receive updated guidance and training on escalation, documentation and follow up responsibilities.

- **Urgent and Emergency Care** – There was a missed opportunity to obtain observations prior to discharge. A reflective discussion will take place with the discharging clinician to reinforce key learning points, best practice, and the importance of clearly documenting all safety-netting advice provided to patients and families. Formal communication will be issued to the ED team regarding the requirement to record repeat observations prior to discharge in line with the PEWS escalation policy. Targeted paediatric training will be provided for middle grade doctors on the recognition and management of Haemolytic Uraemic Syndrome (HUS) and access to NUH protocols where no local guideline exists.

- **Surgery Division** – Patient was not provided the Golden Number at the point of discharge. Review of processes and ensure that the Golden number is given to all patients who are discharged with a catheter so they can contact the community nursing team for any emergencies or concerns with the catheter.

- **Women's and Children's** – The Butterfly Suite was not available as previously discussed and the patient felt the room provided was not calm or supportive. The team have now introduced calming lighting curtains permanently to all of the birthing rooms to improve the environment.

Communication continues to be a recurring theme throughout the feedback provided from patients and their families. The Patient Experience Team continues to identify families to take part in a patient story to highlight the importance and the impact communication has on patients and their relatives, given this has been identified as a powerful tool to share experience and drive improvement. In addition, consideration will be taken to identify further training opportunities. Example communication concerns identified have been highlighted below:

- **Medicine Division:** Families were not informed of the patient's transfer resulting in unnecessary confusion and distress
    - Although information was shared regarding the patient's deterioration, it is not clear that this had been understood by the relative.
    - Patients reports inadequate communicate relating to why the patient was referred for an outpatient follow up rather than being reviewed as an inpatient.

Feedback will be reviewed through the relevant speciality Clinical Governance and staff meetings. Learning will be outlined in the divisional newsletter and this will be shared with those involved to improve communication and coordination between specialist teams.

- **Urgent and Emergency Care:**
    - Poor communication regarding plan and ongoing management.
    - Family were not informed of patient transfer to Mansfield Community Hospital
    - Patients clinical condition was not effectively communicated to Next of Kin leading to confusion at the point of discharge.

The agreed actions state that feedback will be shared with the individuals involved in addition to the wider team to reinforce clear communication with patients and next of kin, timely updates on transfers, and effective handover of outstanding tasks.

- **Surgery Division:**
    - There was a missed opportunity to effectively communicate the plans for the patient's onward transfer with family members
    - Concerns raised relating to the communication and demeanour of the consultant during their outpatient appointment.
    - Staff were found to lack compassion and professionalism during communication.

Apologies were offered to the patient and their relatives for their experience, the individuals have been asked to reflect on the feedback and strengthen communication across teams. Multidisciplinary communication forms have been introduced in patient records to support timely updates to families.

- **Women's and Children's:**
    - Patient reported concerns regarding a lack of communication relating to the delays in their results being made available.
    - Insufficient information provided to patient during pre and post operative discussions relating to the risk of infection.

Feedback has been shared with the clinical teams and wider service to strengthen communication, particularly regarding waiting times and the availability of investigations out of hours.

3. Bench Marking

Benchmarking complaints and concerns across NHS Trusts is a crucial exercise for driving continuous improvement, ensuring the patient voice is embedded in service development, and enhancing the overall quality of care.

It should be acknowledged that there is currently limited comparative data available for the annual reports of 2025/26 across surrounding organisations, which restricts the extent to which meaningful benchmarking can currently be undertaken.

Available information from 2024/25, including Care Opinion, CQC reports and published organisational reports, indicates that neighbouring organisations reported concerns similar to those identified at SFH. Common themes included delays or dissatisfaction relating to diagnostics, treatment and care, and the quality or timeliness of communication with patients and families.
This suggests that the issues being reported at SFH are not isolated and are reflected more widely across comparable providers. In the examples reviewed, concerns were generally addressed through formal complaint responses or managed through local resolution processes, demonstrating a similar approach to responding to patient feedback and seeking service improvement.

4. Feedback Via External Partners

The Patient Experience team has reviewed feedback provided via NHS choices, Healthwatch, Social Media and Care Opinion with regrds to the care and services provided at SFH, examples provieded during the reporting period can be seen below.

Care Opinion:
Stories shared included positvie experiences and challenges, examples of this included:

- A patient praised the Dermatology team at King's Mill Hospital for excellent, friendly care over four years, highlighting the helpful reception staff and describing the team as an asset to the NHS.
- Concerns raised with regards to the cleanliness of the ED waiting area due to the limited sanitisation of seats and surfaces.
- Patient admitted after fall, reports excellent care on the fracture ward and shared that the physiotherapy support she received helped to regain both mobility and confidence.
- Feedback following surgery 'great anaesthetic team and brilliant surgery – appreciate it all 5 stars NHS well done'
- 'As someone who has been very unwell, I can honestly say I could not have been in a better place. You should be incredibly proud of the achievements of your team—excellence doesn't even begin to cover it.'
- Reports of a long wait for an urgent eye assessment as there appeared to be some disjoin between ED and ophthalmology consultant.
- 'Staff were friendly, kind and understanding and took their time with me. My comfort was considered, care was given in how I was and if I was in too much pain they stopped until I was ready again'.
- A family expressed heartfelt thanks for the compassionate and dedicated care provided, acknowledging the team's unwavering support during an extremely difficult and sad time.

Social Media – Facebook posts
'I had 3 operations in 2 weeks at kings mill last February and the operating room staff were great, I was awake throughout the operations and the staff were so friendly and happy to have a little chat with me.'

'Thankyou to all of the wonderful nurses and care staff on the lung wards who always take great care of me when I am in hospital. They are all amazing!'

'Thankyou so much for everything you do, there aren't enough words to describe how greatful I am for your dedication, love and care'

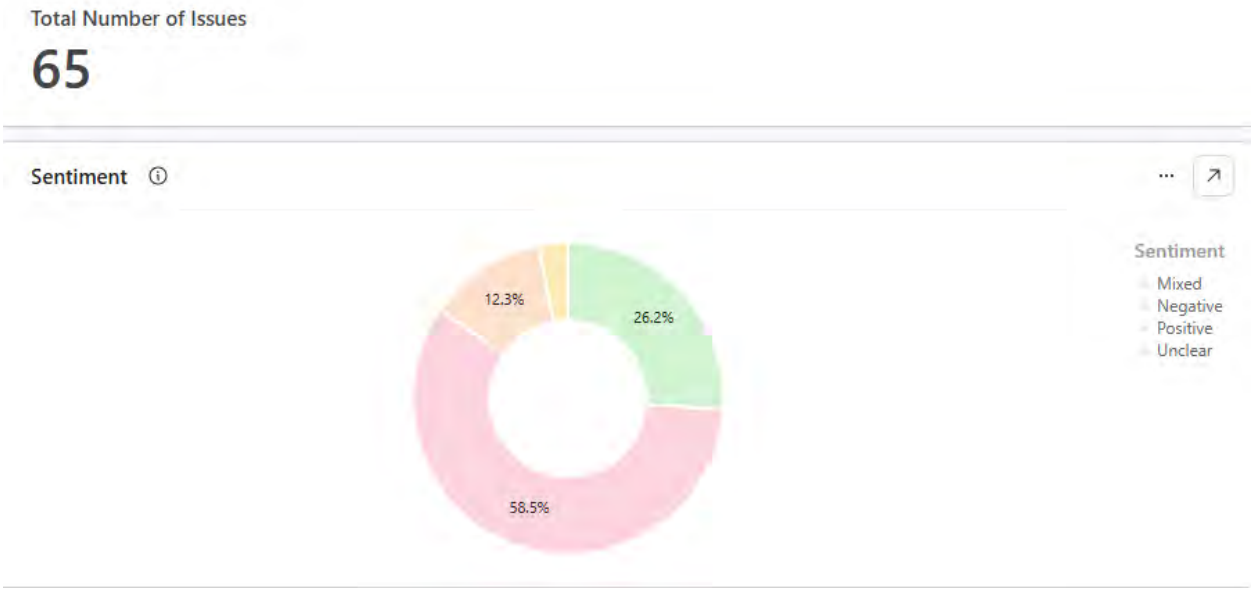
These sources of data, evidence, and viewpoints from various origins, allows us to systematically

compare them to verify accuracy, identify inconsistencies, and develop a comprehensive understanding of the feedback being shared across multiple sources.

Healthwatch
The Healthwatch dashboard presents patient feedback and experience data for 2025/26, identifying key themes, emerging trends, and areas of concern to inform service improvement and support the delivery of patient-centred care.

The graph below shows the number of Healthwatch contacts in the previous year, and the type of feedback received.

Fig 6. Number of Healthwatch contacts in the previous year and feedback type



Some examples of the feedback provided are as follows:

- Failure to book patient into ED leading to an extended wait.
- 'The nursing staff and reception are brilliant, clinicians explain what's going to happen really well and from my perspective the [breast] service is well managed'.
- Patient was diagnosed with a wrist fracture in Newark Minor Injuries Unit, though staff were caring and communicated clearly, the treatment could not be provided on site and the patient was requried to travel to King's Mill which was difficult for them to access.
- 'I gave birth by c section at hospital and the midwives on the unit and the lime green feeding team afterwards were incredible! They were so supportive and knowledgeable in helping start and continue our breastfeeding journey. Without their help I wouldn't be breastfeeding today. Super greatful for them'
- 'She assured me that she would take over my care and that she was confidant that within 6/12 my conditions would be improved. Miss Sharma has been true to her word and now following 2 surgeries i have my independence back. I cannot praise this lady and her team enough. My life has completely changed.'

5. Parliamentary Health Service Ombudsman (PHSO)

The Trust recognises the value of having an independent body to that patients, relatives, and carers can refer their complaints to, should the Trust not be able to resolve their concerns to their satisfaction. In such instances and in accordance with the regulatory requirements, the Trust advises patients, relatives, and carers of their option to refer their complaint to the PHSO.

The Trust embraces the PHSO's scrutiny of its complaint handling and uses findings as an opportunity to learn and improve. In addition to the PHSO's casework, the Trust review and seek to learn from the various reports that the PHSO produces throughout the year.

In 2025/26, the PHSO initiated 6 new complaints reviews, however closed 4 without further investigation. 1 case is currently under ongoing investigation, and the Trust await confirmation of the scope for 2 case. 11 investigations were concluded by the PHSO this financial year; of these, 7 did not require any further investigation.

The Parliamentary Health Service Ombudsman (PHSO) has recommended the Trust offers financial remedies as part of the complaints service provided by SFH. This approach aligns with the PHSO's injustice scale recommendations, which advocate compensating patients, relatives, or carers when harm or distress has been caused due to failings in care or complaint handling.

NHS Trusts are encouraged to incorporate financial remedy into their resolution processes where indicated by the complainant to demonstrate accountability and foster trust. By adopting this measure, alongside clear communication and transparency, the Trusts aim to create a more just and empathetic framework for addressing grievances while upholding the core values of patient-centred care. When considering offers of financial remedy the appropriate Divisions are asked to provide input and advice is sought in regard to legal recommendations.

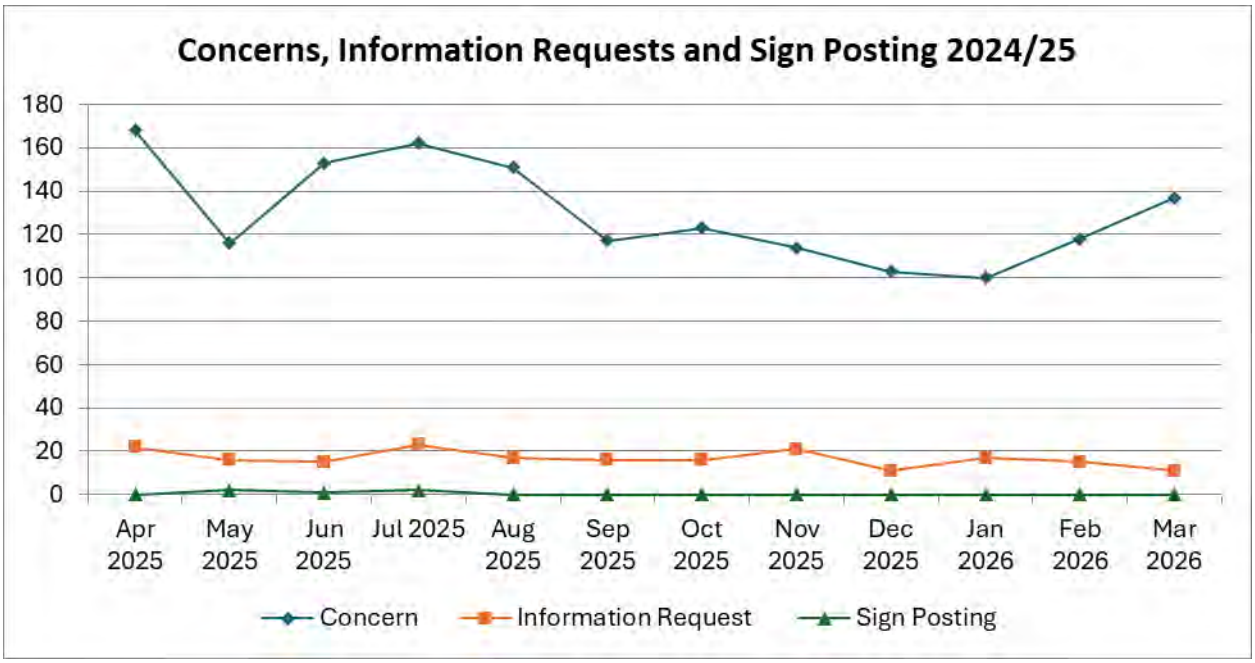
During 2025/26 the Trust made 1 payment for a complaint investigated and closed by the PHSO due to the distress the family experienced.

6. Concerns

Feedback from our patients, their relatives, and carers is a valuable opportunity to review our services and make improvements. We encourage dialogue with staff, giving an opportunity for immediate action and local resolution. To further support our patients, the Patient Experience Team (PET) provides information and advice on how concerns raised can be managed. In addition to a dedicated office for patients, relatives, and carers based at King's Mill and Newark Hospital, offering a satellite service at Mansfield Community Hospital. The PET can be contacted by telephone, email, website, in writing, or in person by visiting the office.

1562 concerns were received which shows a 6% decrease from the previous year. PET also received contacts from patients/relatives/carers requesting information (200) or required signposting (5). This reflects a total of 1767 contacts received throughout this period. This information is shown below:

fig 7: Graph to show number of contacts received 2025/26



This is broken down by month and divisions, as identified in figure 8.

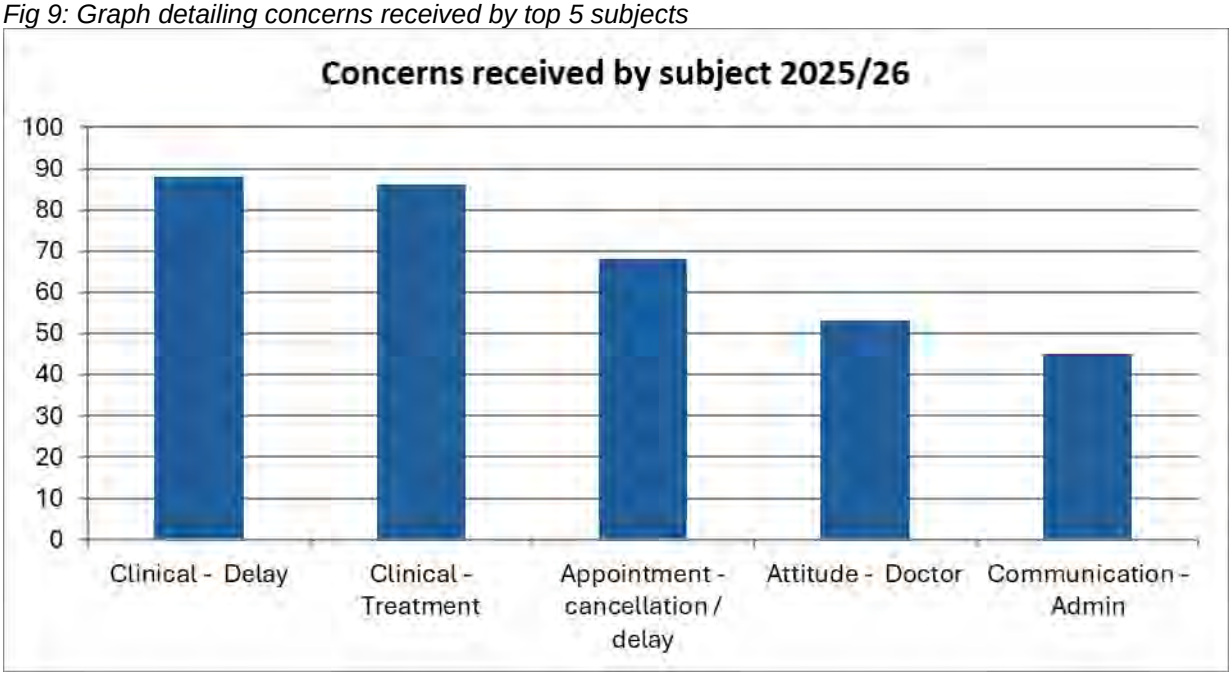
Fig 8: Table reporting number of concerns by division 2025/26

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Clinical Support, Therapies and Outpatients	13	6	10	18	14	8	9	7	11	3	7	10	**116**
Corporate Division	9	3	2	14	7	0	4	0	1	3	0	1	**44**
Urgent and Emergency Care	25	13	33	29	20	21	30	21	14	14	15	17	**252**
Medicine Division	54	39	42	34	38	44	26	28	38	27	27	44	**441**
Surgery Division	45	38	46	50	59	31	32	35	21	34	44	42	**477**
Women and Children's Division	20	15	19	17	13	13	21	20	14	16	25	20	**213**
Total	**166**	**114**	**152**	**162**	**151**	**117**	**122**	**111**	**99**	**97**	**118**	**134**	**1543**

Concerns are resolved with prompt responses from divisions/services, in the event a resolution is not achieved, this will be escalated as a complaint, with the complainant receiving a written response, this could be via letter or email and is recorded and captured on Datix.

The themes noted for concerns related to clinical delay and treatment, appointment cancellations, attitude and communication. Cancellation of appointments remains a recurring theme.

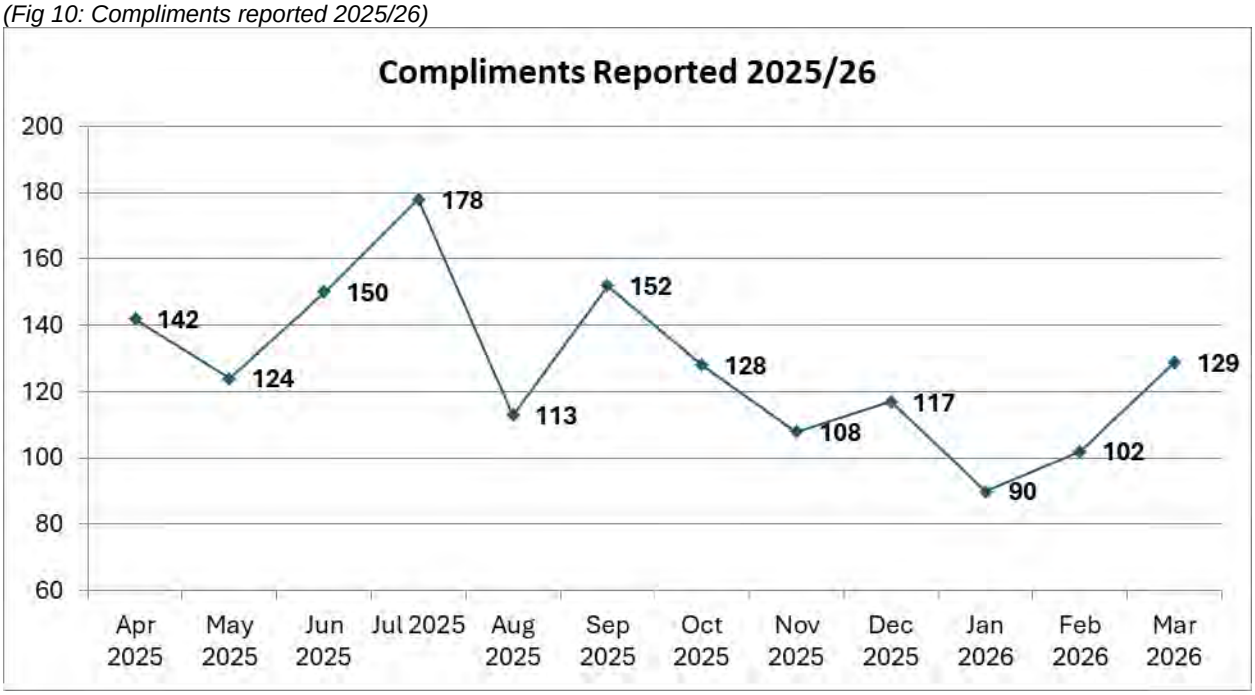
Fig 9: Graph detailing concerns received by top 5 subjects



7. Compliments

PET continues to receive compliments from services that are recorded onto the Datix system, in addition, staff access the Datix system to record all compliments locally.1533 compliments were received during this period demonstrating a 21% decrease from 2024/2025.

(Fig 10: Compliments reported 2025/26)



8. National Surveys

The National Survey is a programme coordinated by the CQC and is used to identify the experiences that patients receive, in relation to care and treatment and to give focus to improvements.

The Adult Inpatient survey was completed from January 2026 to April 2026, with full results due imminently. Publication for this survey is expected in August 2026.

Fieldwork for the National Survey for Urgent and Emergency Care and Maternity services commenced in April 2026 and will continue until July 2026. The results for these surveys are expected in November 2026.

Children and Young People's Survey fieldwork will run from July to October 2026, with results due in March 2027.

Once the survey results have been received, these will be reviewed across the divisions with action plans being developed to improve as required. Action plans and improvements are then shared through the Patient Experience Committee.

9. Friends and Family Test (FFT) themes and trends

The Friends and Family Test (FFT) data is reported across relevant areas within the Trust, helping to assess patient experiences, identify trends, and inform improvements. SFH continues to exceed national benchmark averages for response and recommendation rates. FFT data is primarily collected through text messaging where appropriate, providing valuable insights into patient experience.

This is an important feedback tool supporting the fundamental principle that people using NHS services should have the opportunity to provide feedback on their experience.

Every patient receiving treatment within SFH can provide feedback about the quality of care they have received. This enables the views of patients and their families to be heard, helping us to continuously improve our services and share evidence of good practice. Most patients rate their experience highly at SFH. However, we also want to know where we have not met expectations so that we can make improvements. FFT feedback is one of our best tools for understanding where we are doing well or where we could do better.
We use FFT feedback in conjunction with compliments, concerns, complaints, and the National Survey Programme, to understand what matters most to our patients and family members. There are several ways our patients can provide FFT feedback:

- Online questionnaire via the SFH website
- Text message
- QR Code
- Paper survey

Throughout 2025-26, FFT response rates have largely remained stable, with the exception of maternity services, which saw a decline in response rates in November.

During this reporting period, in the absence of the Patient Experience Involvement and Engagement Officer, the Divisional Patient Experience Leads have worked closely with clinical teams to develop bespoke surveys and provide training to support the effective use of patient feedback in monitoring and improving services. Demand for bespoke surveys also increased over the 12-month period, reflecting their value in supporting service-specific insight and improvement.

(Fig.11 - FFT data April 2025 – March 2026)

	Recommendation Rate %											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Inpatients	94%	95%	94%	94%	94%	95%	94%	94%	93%	91%	93%	94%
Emergency Urgent Care	88%	89%	86%	83%	83%	80%	80%	80%	84%	81%	77%	78%
Outpatients	96%	95%	95%	95%	95%	95%	94%	95%	96%	94%	95%	95%
Maternity	84%	90%	80%	85%	83%	79%	85%	58%	83%	89%	73%	78%

The FFT feedback is triangulated with compliments, concerns and complaints, the 15 Steps Challenge, and shared with all divisions for learning and reflection, sharing of both positive practices, and to focus on areas of improvement.

The following responses are examples of FFT feedback during 2025/26:

- "The whole team were fantastic, very knowledgeable and supportive, nothing was too much trouble."
- “Waiting too long to see a doctor after initial assessment. Waiting almost two hours for pain relief”
- "The staff I encountered were approachable, knowledgeable, and professional."
- “I had a scan and IV fluids, communication with my family should have been given but wasn’t. I didn’t know what my diagnosis was on discharge”
- "I am so grateful for the compassionate team that took care of me."
- "Really good communication and service."

Current ongoing aims:

- Increase engagement with patient families and carer’s, to continue FFT and support divisional teams to deliver FFT locally, resulting in increased recommendation rates.
- Develop a plan to expand QR access and implement across the Trust to support and improve the recommendation rates within the new system.
- Involve our newly recruited Patient Safety Partners with regard to feedback and data collection methods.

10. Engagement and Involvement

Our ambition is to improve health outcomes by working in partnership with patients and communities to shape services around their needs and experiences. We recognise that people who use our services are key partners in their own care and in shaping healthcare decisions. Their involvement is essential to improving the quality, safety and effectiveness of services and outcomes.

SFH is well placed to improve future health outcomes by working with patients, families, carers and the wider community as active partners in service co-design and improvement. We are committed to ensuring that patient and community voices are heard, valued and used to shape care delivery and service development.

We value lived experience as a powerful driver of improvement. By listening to people who use our services, we can better understand the needs of patients, carers, families and the wider community.

Our goal is for every interaction to deliver safe, compassionate and person-centred care. We are

committed to ensuring that the voices of patients, families and carers help shape the future of our services.

10.1 Patient Stories
Patient stories provide a valuable opportunity to gain in-depth insights into the care individuals receive. They serve as a powerful tool for continuous improvement, helping to identify areas where we can enhance service quality and transform the patient and carer experience.

By actively listening to and learning from the patient voice, these stories offer a deeper understanding of the emotional and personal aspects of care. Whether positive, negative, or a mix of both, patient stories help guide improvements that elevate trust, empathy, and communication, which are just as vital as medical treatment itself. During the reporting period patient stories have been shared that involved:

- Brian's Brain – Learning from a person living with Dementia Caring for Dementia patients
- Supporting Patient Flow – Fit2Sit
- Flu Patient
- The launch of new spirometry tests at MCH, as part of the CDC project

10.2 15 Steps Challenge
The 15 Steps Challenge is a valuable source of qualitative information that aligns patient and staff experience to collectively promote a positive experience for all and support staff to initiate local service improvement, triangulating with the Friends and Family Test, and peer reviews.

When analysing the qualitative data from the visits that have taken place, recurring themes and positive trends emerged across all visits. It is clear that the Trust CARE Values and behaviours are consistently reflected in the areas, with staff demonstrating pride, leadership, and engagement in their interactions with both the 15 Steps teams and the patients in their care.

There have been many improvements made following 15 Steps visits, examples of these are:
- Outdated education or posters removed.
- Improved storage and improved safety.
- Increased staffing levels
- Updates to Ward areas including decorating and small works

The programme of visits continues to endorse engagement and visibility of the Senior Leadership Team and Governor representation. The Governor's representation is a valuable element in the 15-step process as they provide a unique opportunity to capture real-time honest patient feedback. The outcomes of the visits continue to be overwhelmingly positive with many examples of person-centred compassionate care, pride and positivity, and a strong sense of CARE values being demonstrated across the organisation.

Work is progressing on a digital solution to enable visiting teams to upload feedback during the visit, removing the need for paper forms and improving the reliability of the 15 Steps feedback process.

10.3 Patient Safety Partners
Patient Safety Partners (PSPs) play a crucial role in improving patient safety within healthcare organisations. Their responsibilities can include:
- Committee Membership – Participating in safety and quality committees that review and analyse safety data.
- Improvement Projects – Contributing to patient safety initiatives and improvement efforts.
- Governance and Oversight – Working with organisation boards to enhance safety

measures.
- Training and Education – Supporting staff training on patient safety.
- Investigation Involvement – Taking part in oversight groups for safety investigations.
- System work - PSP's hold membership to a system level network and attend monthly meetings.

PSPs help ensure that patient perspectives are integrated into safety strategies, fostering transparency and accountability in healthcare settings.

During 2025/26 our Patient Safety Partners have:

- Provided the patient perspective to the peer review processes, undertook a Maternity peer review.
- Been involved in the complaints peer review process due to commence June 2025.
- Provided patient perspective for patient information leaflets.
- Provided comments on policies as appropriate.
- Membership to Patient Experience Committee.
- Involved in the recruitment.
- Met with the CEO to share ideas and information.
- Membership to the Patient Safety Committee.
- Completed safety syllabus one training.
- Taking part in the production for the Trust around fundamentals of care- working with the Communication team.
- Attend the Violence and Aggression Group
- Attended a rapid review in UEC
- Joined PSIRG after receiving the appropriate training around PSII's, Rapid Review process and after-action learning.

10.4 Coffee and Connect

Since July 2025, the Patient Experience Team has led the monthly Coffee and Connect forum as a structured mechanism for engagement with patients, families, carers, community representatives, staff and partner organisations. The forum supports the Trust's commitment to co-design by providing an established route for stakeholder insight to inform service development and wider improvement priorities.

During the reporting period, discussions have centred around patient experience, dementia services, health inequalities, digital inclusion and future models of care. The forum has strengthened stakeholder engagement, encouraged collaborative dialogue and generated valuable insight to inform ongoing service development. This has also translated into tangible involvement, with some forum members volunteering their time to support the development of digital projects, and another expressing an interest in contributing as a Patient Safety Partner.

Attendance and engagement have grown over time, with forum members contributing constructive insight on issues such as accessibility, digital exclusion and service design.

10.5 Health Inequalities

Patient Experience is supporting the Trust's work to reduce health inequalities by strengthening how patient insight is gathered, shared and used, and by widening engagement with communities whose voices are less often heard.

During 2026/27, the aims are to complete a Trust and system-wide map of engagement activity and intelligence sources; publish a gap analysis and engagement system map to support divisions and services; agree the governance, information requirements and minimum dataset needed for a digital repository of patient engagement intelligence; and continue developing this repository so insight can be used more effectively in planning and improvement.

A further aim is to increase participation from locally agreed priority and PLUS cohorts by delivering targeted outreach, working with system and specialty leads to promote inclusive engagement mechanisms, reviewing participation and diversity data, and embedding learning into future planning for 2027/28.

11 Aims for 2026/27

During 2026-27, the Trust aims to broaden its approach to ensure the voices of patients, families, and carers are heard across all areas of the organisation, from staff recruitment and training through service design and assessing the quality of our care.

Focus will be given to providing outstanding care, giving patients, carers, and families a positive experience, providing safer and clinically effective care, and improving coordination and potential health inequalities, across health and social care.

Aligning with the National, Regional guidance and Trust strategy and care values we continue to:

- Advance the integration of patient, family, and carer voices across every aspect of the organisation, ensuring their perspectives are central to staff recruitment, training, service design, and the evaluation of care quality.
- Drive continuous improvement in service delivery through strengthened co-production, actively involving stakeholders in shaping new initiatives and refining existing processes in line with the 10-year Healthcare Plan and PET strategy.
- Continued growth of engagement via Coffee and Connect including work around the 10 Year Plan, co-production and a focus on improvements and engagement
- New system implementation due to current FFT provider exiting the market.
- Collaborate closely with divisional teams to boost Friends and Family Test (FFT) response rates and scores, ensuring that feedback is actioned and visible improvements are communicated to all stakeholders.
- Continue collaboration with divisions to plan and implement improvements based on FFT findings, patient feedback resulting in an enhanced patient experience.
- Continue to strengthen partnerships with Patient Safety Partners and Patient Advocate volunteers, embedding their insights into safety strategies and promoting accountability and transparency throughout the Trust.
- Enhance the identification and triangulation of themes and trends from patient feedback, using this intelligence to drive targeted improvements in patient, carer, and family experiences.
- Prioritise reducing health inequalities and improving digital engagement, ensuring that all voices are heard and that services are accessible, equitable, and responsive to diverse community needs.

We will continue to triangulate and improve on the themes and trends identified from patient feedback, to enhance the patient, carer, and family experience.

Board of Directors – Cover sheet and report

Subject:	**Nursing, Midwifery, and Allied Health Professional Bi-annual Staffing Report.**	**Date:**	1 October 2026
Prepared By:	Rebecca Herring (Associate Director of Nursing - Workforce) Sarah Ayre (Divisional Director of Perinatal Services and Women's Health) Kate Wright (Chief Allied Health Professional)		
Approved By:	Phil Bolton, Chief Nurse & Paula Shore, Director of Midwifery/Deputy Chief Nurse		
Presented By:	Rebecca Herring (Associate Director of Nursing - Workforce)		

Purpose

This report aims to provide the Board of Directors with an overview of nursing, midwifery, and allied health professional (AHP) staffing capacity within Sherwood Forest Hospitals Foundation NHS Trust (SFH). It is also to assure our compliance with the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance, National Quality Board (NQB) Standards, and the NHS Improvement (NHSI) Developing Workforce Safeguards.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

Identify which Principal Risk this report relates to:

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

Committees/groups where this item has been presented before

Acronyms

Executive Summary

Background

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

NQB EXPECTATION 1: RIGHT STAFF

1.1 Evidence-based workforce planning arrangements remain in place across nursing, midwifery and AHP services. The Trust has maintained compliance with SNCT licensing requirements, continues

to utilise Birthrate Plus® within maternity services, and will undertake a nursing, midwifery and AHP establishment review in November 2026.

NQB EXPECTATION 2: RIGHT SKILLS

1.2 Nursing and midwifery vacancies peaked at 8.3% in April 2026 following establishment resetting but had reduced to 7.0% by July 2026. Band 5 vacancies remain the largest contributor to overall vacancy levels. Midwifery recruitment is expected to increase substantive workforce capacity from October 2026 following the planned recruitment of 9.6 WTE.

1.3 Leadership development activity has continued through local and national programmes, including the Leading Empowered Organisations Programme, Mary Seacole Programme and nationally recognised leadership schemes. The Trust has also received external recognition through national nominations, awards and professional honours.

1.4 Within maternity and neonatal services, a specialist midwifery establishment and succession planning review is planned during 2026/27, alongside an evaluation of the Transitional Care model and a multidisciplinary neonatal workforce gap analysis. The Trust will also consider the findings of the national home birth services review once published.

1.5 Within AHP services, workforce planning continues through establishment review programmes, capacity and demand modelling, job planning and workforce analytics. Recruitment challenges remain most significant within Sonography and Stroke Speech and Language Therapy, while Therapy services have reported recurring reductions in variable pay expenditure associated with strengthened workforce controls.

NQB EXPECTATION 3: RIGHT PLACE & TIME

1.6 Safe staffing has continued to be supported through daily acuity reviews, workforce escalation processes, temporary staffing and flexible workforce deployment. The SafeCare Workforce Deployment Tool has now been rolled out across all inpatient areas, providing real-time visibility of patient acuity and dependency to inform staffing decisions.

1.7 Trust-wide SafeCare compliance has shown an overall improving trend, while open staffing red flags reduced from 184 in November 2025 to 93 in August 2026. Redeployment activity continues to be utilised in response to operational pressures, with Enhanced Patient Observation requirements, workforce skills gaps and Band 7 clinical deployment identified as the principal themes.

1.8 Ongoing workforce pressures continue with high acuity, increased capacity and increased sickness levels, requiring clinical leaders to undertake regular risk assessments and deploy available resources strategically to maintain safe staffing levels. Registered staff fill rates have remained above 90%; however, it is recognised there have been occasions where registered staffing levels have not been optimal and will have impacted both patient care delivery and staff experience.

Recommendation

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

Report Title:	Nursing, Perinatal, and Allied Health Professional Bi-annual Staffing Report
Date:	September 2026
Author:	Rebecca Herring (Associate Director of Nursing - Workforce) Sarah Ayre (Divisional Director of Perinatal Services and Women's Health) Kate Wright (Chief Allied Health Professional)
Executive Sponsor:	Phil Bolton (Chief Nurse) Paula Shore (Director of Midwifery/Deputy Chief Nurse)

Purpose

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

2.1 The report will also analyse the Trust compliance with the NICE (2014) safe staffing guidance, NQB (2016) expectations, and the NHSI (2018) Developing Workforce Safeguards recommendations.

Nursing & Midwifery Overview

NQB EXPECTATION 1: RIGHT STAFF

3.0 Evidence-Based Workforce Planning

3.1 Scheduled nursing acuity and dependency reviews continue to be undertaken using the Safer Nursing Care Tool (SNCT), providing an evidence-based assessment of patient need. The findings are triangulated with quality indicators and professional judgement to inform the nursing establishment review programme scheduled to commence in November 2026. The Trust remains compliant with Imperial College licensing requirements, having completed 30-day SNCT data collection cycles in September 2025 and March 2026, with the September 2026 cycle currently underway. All SNCT licences remain valid until June 2027.

Figure 1: Imperial Licences

SNCT License	RENEWAL DATE
Emergency Department SNCT	✓ June 2027
Adult Inpatient Area SNCT	✓ June 2027
Adult Assessment Area SNCT	✓ June 2027
Children & Young People SNCT	✓ June 2027

3.2 Workforce planning for maternity services continues to be informed by Birthrate Plus® (BR+), the nationally recognised tool endorsed by NICE, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. Recommendations from the independent BR+ review completed in November 2025 were implemented within the perinatal establishment from April 2026.

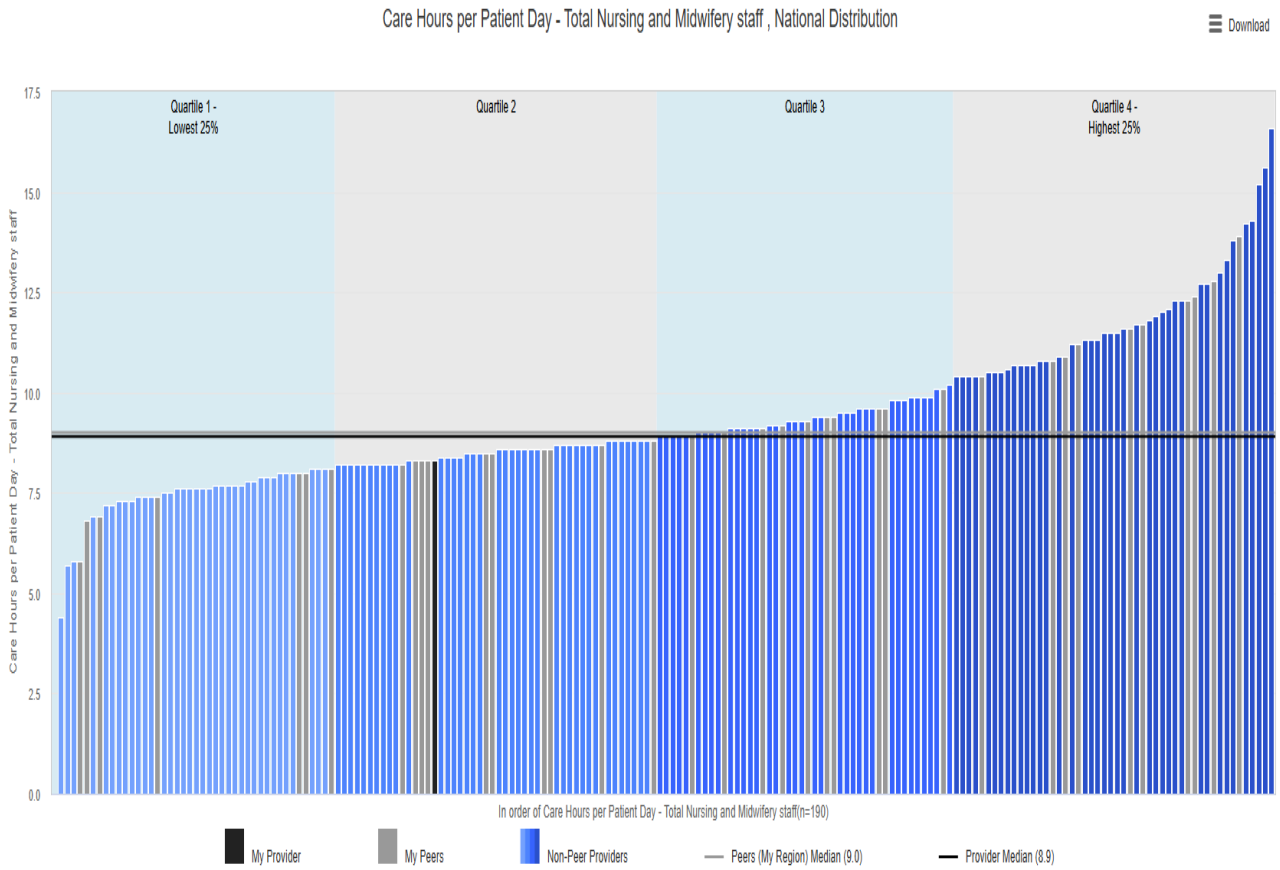
3.3 A confirm-and-challenge review of nursing and midwifery establishments is planned for November 2026 to ensure workforce models remain aligned to patient acuity, dependency and service demand. Subject to review outcomes, recommendations will be presented to the Trust Management Team in December 2026 and subsequently to the Trust Board in February 2027.

4.0 Benchmarking

4.1 Care Hours Per Patient Day (CHPPD) continues to be used as a key benchmarking metric, supporting comparison of staffing deployment against peer organisations and informing workforce planning decisions. CHPPD should be considered alongside workforce, quality and safety indicators to provide a comprehensive assessment of staffing effectiveness.

4.2 The Trust's CHPPD remains stable at 8.3 care hours per patient day compared to a peer median of 9.0. This indicates staffing levels remain broadly comparable with similar NHS organisations and do not represent a significant outlier.

Figure 2: Trust Level CHPPD



Data Source: Model Hospital, April 2026.

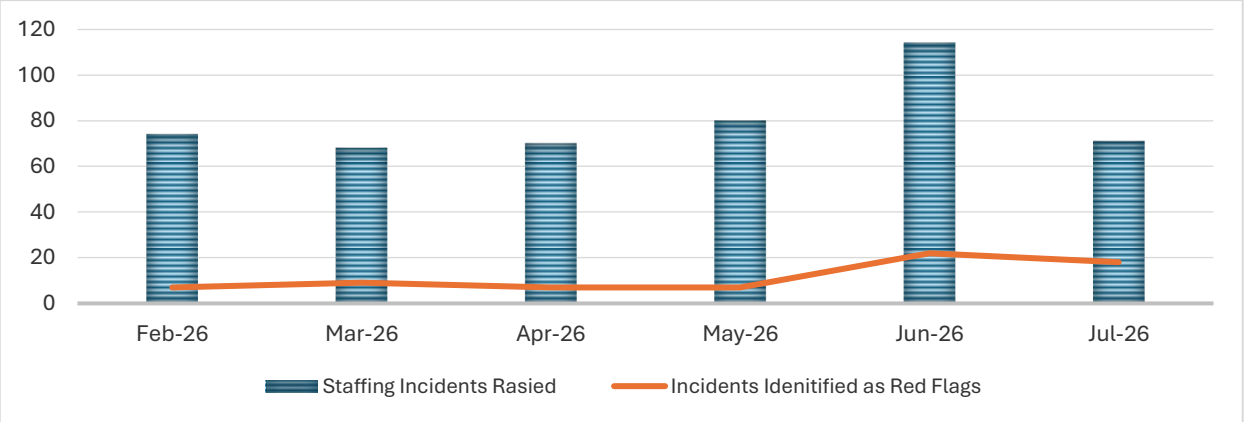
5.0 Measure & Improve

5.1 Datix remains the primary mechanism for reporting and monitoring staffing incidents at SFH, including red flag events as defined within NICE safe staffing guidance (2014). This is complemented by the SafeCare system, which enables clinical teams to raise red flag staffing concerns in real time.

5.2 Sustained increases in bed capacity, workforce pressures associated with rising service demand, and short-notice sickness absence continue to be the principal contributors to staffing-related incidents reported across the Trust. Enhanced Patient Observation remains a recurring theme; however, this primarily reflects the established escalation process for securing additional staffing support and accounts for only 4% of temporary staffing requests. In comparison, vacancy-related requests represent 35%, sickness absence 34%, and additional capacity requirements 19% of requests.

5.3 SafeCare red flag reporting and Datix incident data continue to identify delays in the delivery of fundamental care and service diversion during periods of heightened operational demand as the key workforce-related risks. Clinical teams continue to mitigate these risks through workforce escalation processes and flexible staff deployment, maintaining safe staffing levels where possible and supporting patient safety.

Figure 4: Staffing Incidents



Data Source: Datix` Reporting System 2026.

5.4 In June 2026, service diversion was introduced as a 'local' red flag criterion, strengthening workforce risk oversight and improving alignment with maternity staffing governance arrangements. The increase in red flag activity since this date reflects the inclusion of this additional reporting category. Service diversion at Newark Urgent Care Centre and delays in the delivery of fundamental care remain the principal categories of red flags reported through our reporting systems.

5.5 The Trust continues to participate in the national Enhanced and Therapeutic Observational Care workstream and remains compliant with monthly Patient Workload Return submissions. A service review is planned to establish a current baseline position and support ongoing benchmarking of productivity and service outputs.

NQB EXPECTATION 2: RIGHT SKILLS

6.0 Recruitment, Retention & Education

6.1 Despite continued improvement in national nursing and midwifery vacancy levels, workforce supply remains a significant challenge. As of March 2026, there were approximately 21,643 vacant nursing and midwifery posts across England, equating to a vacancy rate of around 5.0%. Although this represents a reduction compared with previous reporting periods, local vacancy levels remain above the national average and continue to impact workforce capacity, requiring ongoing mitigation to support safe and effective care delivery

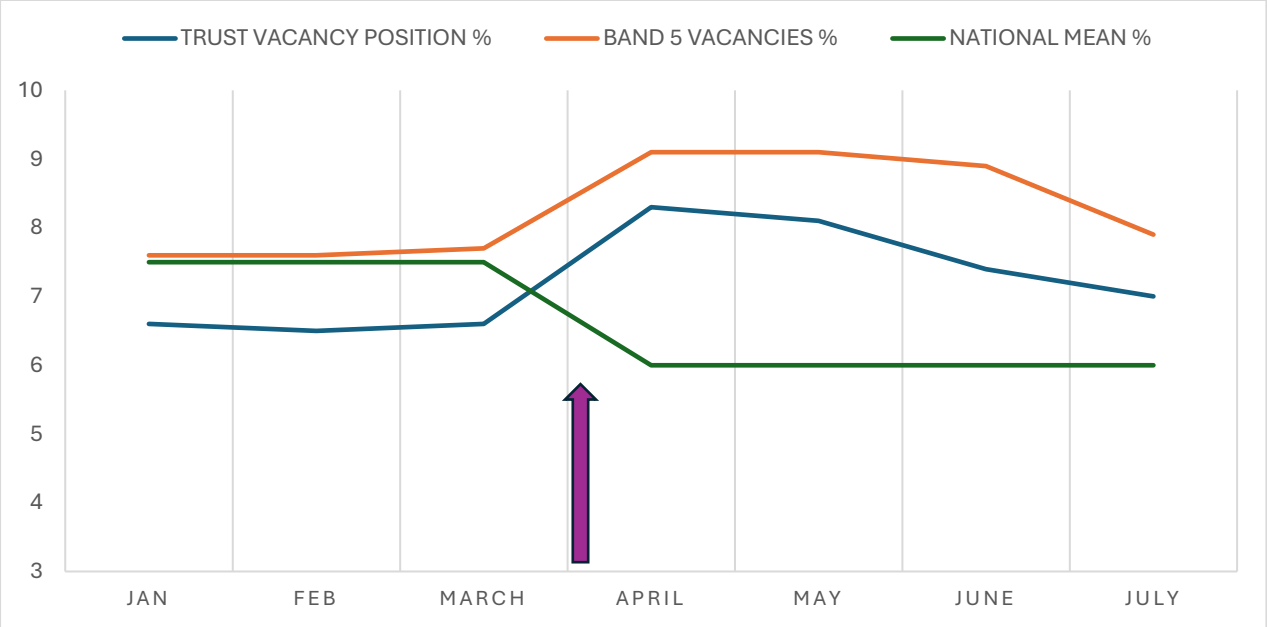
6.2 Trust-wide nursing and midwifery vacancies increased from 6.6% in January to a peak of 8.3% in April following the establishment resetting process, before showing sustained improvement, reducing to 7.0% by July. Although vacancies remained above the national benchmark following its reduction, the gap has gradually reduced month-on-month throughout the reporting period.

6.3 Band 5 vacancies continued to be the primary workforce challenge, increasing to 9.1% in April and May before reducing to 7.9% by July. As the largest registered nursing workforce cohort, Band 5 vacancies remain the main contributor to overall nursing vacancy levels. Recruitment strategies remain in place to support recruitment efforts for example; the golden ticket recruitment offer and an established preceptorship programme for newly qualified staff.

6.4 The overall trend demonstrates improving workforce stability and a reducing vacancy position following the April peak; however, continued focus on Band 5 recruitment and retention remains essential to achieve and sustain vacancy levels in line with the national benchmark.

6.5 In midwifery, the anticipated recruitment of 9.6 WTE from October 2026 is expected to strengthen substantive workforce capacity, improve staffing resilience and reduce reliance on temporary staffing. Subject to safe staffing assessments and the successful appointment of recruits, the service aims to cease routine agency utilisation by mid-November 2026.

Figure 3: Nursing and Midwifery Vacancy Position



Data Source: Workforce Informatics August 2026

6.6 Retention of the workforce remains a key driver for workforce stability and investment in nursing and midwifery leadership development continues to support workforce capability, succession planning and professional growth across the Trust. During 2026/27, internal delivery of the Leading Empowered Organisations programme and the first onsite Mary Seacole Programme have expanded access to leadership development opportunities, with positive feedback reported from participants. Staff have also successfully secured places on a range of nationally recognised programmes, including the Rosalind Franklin Programme, Florence Nightingale Foundation leadership programmes, the Rising Leaders Fellowship, Scholarships, and the Royal College of Midwives Leadership Programme.

6.7 The Trust continues to strengthen its commitment to inclusive leadership, with staff participating in targeted development programmes designed to support underrepresented groups within the nursing workforce. In addition, Team Resource Management (TEREMA) human factors training will be significantly expanded during 2026/27, increasing capacity from 20 places in 2025 to 120 places across six sessions.

6.8 External recognition of workforce initiatives and leadership development has continued throughout the reporting period, with the Trust receiving national nominations and shortlisting's across several

award programmes, including the Nursing Workforce Awards, HSJ Awards and a winning achievement at the RLDatix Awards. Individual achievements have also been recognised nationally through the award of a Chief Nursing Officer Award and a Chief Midwifery Officer Award to members of the nursing and midwifery workforce.

6.9 During 2026/27, the division will undertake a specialist midwifery establishment and succession planning review to assess workforce capacity, resilience and service requirements. Findings will inform the divisional workforce plan and be reported through the Perinatal Assurance Committee.

6.10 The Neonatal Unit continues to benefit from a dedicated Clinical Educator supporting Qualification in Specialty (QIS) training. External peer review conducted in June 2026 provided positive assurance regarding leadership, culture and family experience, while identifying the need for a sustained focus on QIS development. Progress against QIS compliance will continue to be monitored through divisional governance arrangements.

6.11 The Transitional Care model, relaunched in March 2026, continues to support care for eligible babies alongside their mothers while optimising neonatal nursing capacity within the Neonatal Unit. An evaluation during 2026/27 will assess activity, staffing, outcomes and financial performance to confirm the ongoing sustainability of the model. This will include a neonatal multidisciplinary workforce gap analysis in collaboration with AHPs, pharmacy, psychology and Operational Delivery Network partners. The outputs will inform future workforce and business planning and be reported through our established perinatal governance structures.

6.12 The outcome of the national review of home birth services will form a further component of the 2026/27 workforce programme. Undertaken in response to the Jennifer and Agnes Cahill Prevention of Future Deaths report, the review is expected to consider workforce resilience, clinical oversight, competency assessment, training requirements, data collection and service sustainability. The Trust will consider the findings once published and assess any implications for future service delivery models

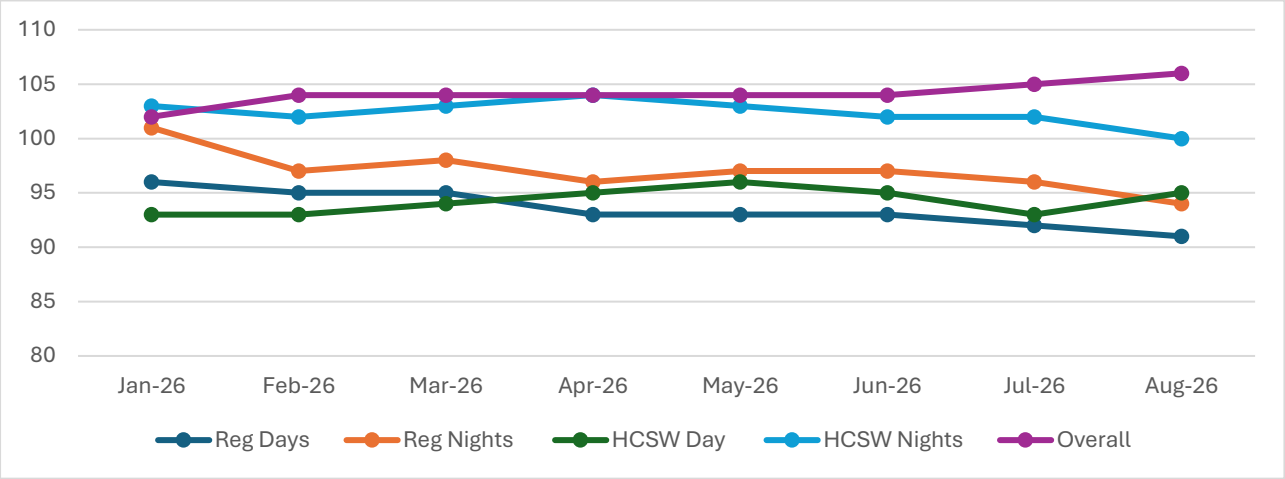
NQB EXPECTATION 3: RIGHT PLACE & TIME

7.0 Productive Working, Deployment & Minimising Agency

7.1 Since the last report, maintaining safe staffing levels has continued to be challenging due to sustained high patient demand and ongoing workforce pressures. Patient activity and acuity remain elevated, resulting in multiple activations of the OPEL 4 and Business Continuity Incident protocols. During these periods, wards have been required to activate additional capacity through the "one over" process.

7.2 It is important to note that staffing requirements associated with this additional capacity sit outside the established ward establishments. The need to flex beds beyond the commissioned ward bed base through the ‘one, two or three over’ process increases patient-to-registered nurse ratios and places additional pressure on staffing resource. This can impact the ability to provide timely care and increases the risk of staffing levels falling below planned requirements, particularly on night shifts where baseline staffing levels are lower. To mitigate staffing shortfalls, Ward Sisters frequently utilise their supervisory capacity to provide direct clinical support. Whilst this represents a proportionate operational response, the regular backfilling of clinical shifts reduces the time available for leadership, quality oversight, staff management and administrative responsibilities

Figure 5: Planned vs Actual Fill Rates



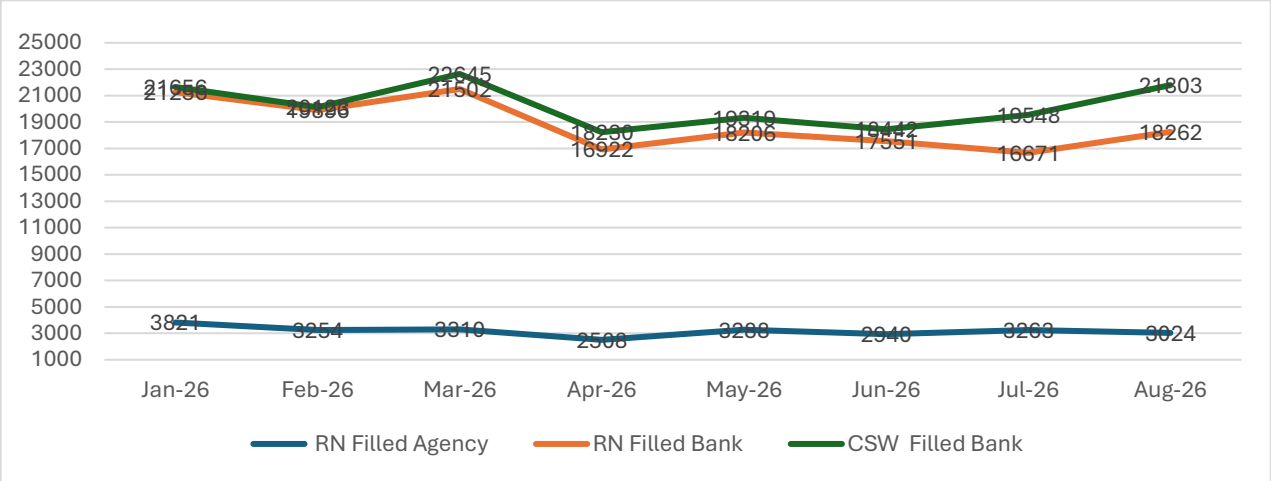
Data Source: Strategic Data Submission NHSE 2026.

7.2 Despite ongoing workforce pressures, clinical leaders have continued to undertake regular risk assessments and deploy available resources strategically to maintain safe staffing levels. Registered staff fill rates have remained above 90%; however, there have been occasions where registered staffing levels have not been optimal, impacting both patient care delivery and staff experience.

7.3 Nursing and Perinatal services continue to mitigate workforce risks through daily acuity reviews, established escalation processes, senior operational oversight, flexible workforce deployment and the use of temporary staffing.

7.4 Reliance on temporary staffing remains driven primarily by vacancies, sickness absence and additional capacity requirements. For example, during August, vacancies accounted for 46% of all Temporary Staffing Office requests, reflecting the ongoing need to maintain safe staffing levels while substantive recruitment is progressed. Sickness absence represented 30% of requests, with additional capacity accounting for a further 14%. Whilst Enhanced Patient Observation requests represented a small proportion of Temporary Staffing Office demand, accounting for approximately 3% of all staffing requests.

Figure 6: Agency and Bank Usage (Hours)



Data Source: Temporary Staffing Office, August 2026

7.5 The SafeCare Workforce Deployment Tool has now been fully rolled out across all inpatient areas. The tool supports workforce deployment and staffing risk assessment through real-time visibility of patient acuity and dependency. Its implementation has enhanced operational oversight of staffing requirements and supports informed decision-making when responding to workforce pressures and changes in patient demand. Existing staffing escalation processes remain in place and are complemented by the additional intelligence provided through SafeCare.

7.6 Trust-wide SafeCare compliance has seen some month-to-month variation, however overall performance and engagement is demonstrating an overall positive trend. The number of red flags remaining open has reduced significantly over the reporting period, falling from 184 in November 2025 to 93 in August 2026. demonstrating a consistent downward trajectory since May 2026 and indicating improved management and resolution of staffing-related risks.

7.7 Monthly redeployment activity has fluctuated in line with operational pressures, ranging from 21 episodes in May 2026 compared to a peak of 96 episodes in January 2026. During August 2026, 69 redeployment episodes were recorded, above the Trust average of 55 episodes per month, reflecting continued use of workforce redeployment to support safe staffing across services. The principal workforce themes identified were Enhanced Patient Observation (EPO) requirements, workforce skills gaps, and the deployment of Band 7 staff into clinical shifts to support.

7.8 Overall, the data demonstrates improving SafeCare compliance, a sustained reduction in open red flags, and ongoing reliance on workforce redeployment to respond to service pressures and staffing challenges.

Allied Health Professional (AHP) Overview

NQB EXPECTATION 1: RIGHT STAFF

8.0 Evidence-Based Workforce Planning

8.1 There remains no nationally mandated safe staffing workforce planning methodology for AHPs. As a result, local staffing decisions are informed through a combination of demand and activity data, patient acuity and dependency, job planning, staff rostering and establishment review processes. Unlike nursing and midwifery workforce planning methodologies, there is no nationally prescribed headroom allocation within AHP establishments.

8.2 To mitigate workforce shortfalls, AHP services routinely deploy staffing flexibilities within professional, competency and skill-mix boundaries. Whilst this supports continuation of essential services, it can result in reduced capacity elsewhere. Professional judgement is applied daily to prioritise workload and manage clinical risk, with smaller specialities particularly vulnerable to operational pressures during periods of escalation, including Business Continuity Incidents. Nationally, significant variation continues to exist across AHP safe staffing approaches so the Trust's ongoing participation within the East Midlands Acute Provider AHP Network provides shared learning, benchmarking and collaboration of emerging approaches to AHP safe staffing.

NQB EXPECTATION 2: RIGHT SKILLS & NQB EXPECTATION 3: RIGHT PLACE & TIME

9.0 Recruitment, Productive Working, Deployment & Minimising Agency

9.1 Sonography remains the most significant AHP recruitment challenge, reflecting a national workforce shortage of 24%. A workforce recruitment summit is planned to identify and progress targeted solutions. While local ‘grow your own’ training posts are supporting future workforce supply, the workforce profile is becoming increasingly junior, creating resilience and experience risks as service demand continues to increase.

9.2 Speech and Language Therapy (SLT) recruitment remains positive overall despite a reported national workforce shortage of 25%. However, recruitment and retention challenges persist within the Stroke SLT service, where high turnover, limited applicant interest and vacancies within Band 7 team leader

roles continue. A task and finish group has been established to explore alternative recruitment approaches and consider opportunities to apply learning from the Sonography workforce review.

9.3 Radiology has completed an initial establishment review, with findings scheduled for presentation to the Radiology Establishment Review Meeting in November 2026. The review has examined workforce establishment, and service risks across Reporting Radiography, CT, Breast Services, Plain Film, MRI, Nuclear Medicine, PACS, Ultrasound and Imaging Assistants at all three hospital sites, including the Community Diagnostic Centre. The review has established the baseline workforce position and will report identified risks and recommendations upon completion. Preparatory work is also underway to support the implementation of electronic rostering within the service.

9.4 Year two of the Therapy Establishment Review Programme is nearing completion across Physiotherapy, Occupational Therapy, Speech and Language Therapy (SLT), Dietetics and Orthotics. Building on the baseline review undertaken in 2024/25, the programme has included capacity and demand modelling, assessment of emerging risks, workforce planning, service transformation opportunities and efficiency reviews. Early benefits are being realised, with a reduction in unwarranted variation in areas such as variable pay, application of HR processes and job planning.

9.5 Key achievements during 2025/26 include the introduction of capacity and demand modelling across several Therapy services. Inclusion of Therapy services within electronic rostering has improved oversight of annual leave, TOIL and sickness absence. In addition, strengthened controls on bank, overtime and additional hours have contributed to a sustained reduction in variable pay expenditure, delivering recurring savings of approximately £25,000 per month.

9.6 ODP and Orthoptic workforce planning continues to progress through established review mechanisms. ODP staffing is monitored through the Theatre establishment review process, while baseline workforce data for Orthoptics has been collected and aligned to the methodology used across other AHP services in preparation for a future establishment review.

National Compliance

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

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

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

Recommendations

11.0 The Board of Directors is asked to receive this report and note the ongoing plans to provide safe staffing levels across nursing, midwifery, and AHP disciplines.

11.1 The Board of Directors is asked to note the ongoing recruitment, and retention plans to support each service.

11.2 The Board of Directors is to note the Developing Workforce Safeguards compliance standards.

12.0 Appendix One: Developing Workforce Safeguards Compliance Standards (2018, NHSI)

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

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Freedom to Speak Up / Raising Concerns	**Date:**	**1st October 2026**
Prepared By:	Kerry Bosworth, FTSU Guardian		
Approved By:	Sally Brook Shanahan – Director Of Corporate Affairs		
Presented By:	Sally Brook Shanahan – Director Of Corporate Affairs		

Purpose		
This report provides an overview of speaking up cases for Q1 and Q2 2026/27, covering the period since the FTSU report was last presented to the SFH Board in April 2026. Included within the paper are FTSU activity updates, and the wider FTSU agenda, locally and nationally.	**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**		

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

Acronyms

FTSU – Freedom to Speak Up	FTSUG - Freedom to Speak Up Guardian
LTS – Long Term Sickness	EM – Ethnic Minority
TMT – Trust Management Team	WRES – Workforce Race Equality Standard
JSPF – Joint Staff Partnership Forum	AFC – Agenda For Change
OH - Occupational Health	OD – Organisational Development
EDI – Equality, Diversity & Inclusion	MAST- Mandatory & Statutory Training
NHSE – NHS England	NGO – National Guardians Office

Recommendations

The Board is asked to:

- Note the Q1 and Q2 2026/27 speaking-up activity, themes and concern-raiser feedback
- Seek assurance that patient safety, staff wellbeing and cultural concerns have clear executive ownership, timely action and visible feedback to staff.
- Endorse targeted action to improve completion of the Listen Up and Follow Up modules, with progress reported through the established governance route.

- Endorse implementation of the maternity specific Guardian arrangement, subject to completion of NHS England Foundation Training and appropriate executive oversight.
- Note the Thirlwall Inquiry findings and seek assurance that the Guardian remains an internal, visible and operationally independent function, with direct access to the Chief Executive and Board, adequate protected time, resources, training and authority to challenge and escalate.

Executive Summary

This report provides assurance on Freedom to Speak Up activity for Q1 and Q2 2026/27. 73 concerns were raised, with patient safety and quality the leading theme (30; 41.1%), followed by worker safety and wellbeing (23; 31.5%).

Open reporting remains the predominant route, indicating improved willingness to allow escalation; however, confidential and anonymous feedback continues to identify fear of detriment, low confidence in follow-up and perceived futility as barriers, particularly for concerns about workplace experience and team culture.

The main assurance requirement is consistent organisational response. Common themes include unclear ownership, delayed resolution, variable leadership response and limited feedback; a significant number of concerns remain open beyond the 20-working-day guidance.

Positive assurance includes favourable concern raiser feedback, evidence of local learning and improvement, active triangulation of workforce intelligence, and CQC confirmation that staff in Medicine and Urgent and Emergency Care were aware of FTSU routes and local Champions.

Governance developments include refreshed staff and manager process guidance, an updated Speaking Up Policy, national data submissions and strengthened psychological support for the Guardian.

Leadership training completion requires continued attention, with 96 Band 6 and above staff completing all three modules.

A maternity-specific Guardian arrangement has been agreed in principle, subject to NHS England Foundation Training and executive oversight.

The Thirlwall Inquiry reinforces that the Guardian should remain an internal, visible and operationally independent function, with adequate resource, protected time, training and direct access to the Chief Executive and Board.

The Board is asked to note the activity and themes, seek assurance on ownership and timeliness of responses, support improvement in leadership training, endorse the maternity arrangement and maintain oversight of Guardian feedback and organisational learning.

Freedom To Speak Up Report

Overview

During Q1 26/27 and Q2 26/27, there were 73 concerns raised to the FTSUG.

Out of the 73 concerns, 3 are now in a formal ER process, having not found resolution in the informal stage.

FTSU Concerns Statistics

Quarterly Comparison of all FTSU Concerns				% change
Quarter	24/25 Concerns	25/26 Concerns	26/27 Concerns	
Q1	42	41	27	-34%
Q2	47	36	YTD 46	+28%
Q3	75	30		—
Q4	42	27		—

Q1 and Q2 2026/27

During Q1 2026/27, 27 concerns were raised through FTSU, compared with 41 in Q1 2025/26, representing a 34% reduction.

By Q2, 46 concerns have been reported to date, representing a 28% increase compared with the 36 concerns recorded in Q2 2025/26.

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

Status of FTSU concerns raised

Quarter	Openly raised	Confidential	Anonymous	Total
Q3 2025/26	9	21	0	**30**
Q4 2025/26	18↑	9	0	**27**
Q1 2026/27	15 ↑	9	3	**27**
Q2 2026/27	37 ↑	7	2	**46**

Open reporting remains the predominant way in which concerns are raised. This is a sustained, position this year and a stable shift from the 2025/26 position, when FTSU data indicated a more closed reporting culture.

This enables staff to be signposted to appropriate escalation routes and supports concerns being progressed more openly, indicating a more open speaking-up culture. Concern raiser feedback indicates workers are more willing to permit onward escalation where the concern relates to patient safety and quality of care, while concerns connected to their own workplace experience are more often raised confidentially because of perceived detriment, low confidence in follow-up and futility. All 5 concerns received anonymously relate to workplace experiences and leadership culture in teams.

Workers across all divisions continue to engage with FTSU. Medicine Division accounted for the largest proportion of concerns raised in Q2, reflecting a concentration of concerns submitted by several staff members from a single area rather than a division-wide trend.

People Profile of Concern Raisers

Workforce Groups –

Out of the 73 concern raisers, 9 were from an ethnic minority background, representing 12.3% of all concern raisers. This sits below the ethnic minority representation within the SFH workforce, which is circa 19% for Agenda for Change and Very Senior Manager staff according to SFH WRES data.

This suggests that ethnic minority colleagues were underrepresented among those accessing FTSU during the reporting period. However, triangulation with Staff Side, Staff Networks, the People Directorate and FTSU Champions indicates that colleagues from ethnic minority backgrounds are using alternative services and safe spaces to raise concerns. This may partly explain the lower use of the FTSU route and should be considered alongside the FTSU data, rather than interpreted as evidence that concerns are not being raised. FTSU continues to support

engagement through representation within the Ethnic Minority Staff Network, ethnic minority FTSU Champions and monthly contact between the FTSU Guardian and the EDI Lead.

The proportion of concerns raised by workers with a disability decreased during this reporting period. Workers with a disability accounted for 8% of concerns, compared with 18% in the previous reporting period. In these cases, the concerns related to their experience of SFH processes, policies and leadership approaches, including perceived variation in how these were applied to disabled workers.

Overview Q1 & Q2 FTSU Concerns – 73 concerns

Reporting Category	Description - NGO Categorisation	Number of Concerns	% of Total
Staff Group	Registered Nurses and Midwives	36	49.3%
	Administrative and Clerical	8	11.0%
	Medical and Dental	6	8.2%
	Additional Professional, Scientific and Technical	1	1.4%
	Allied Health Professionals	2	2.7%
	Additional Clinical Services	17	23.3%
	Other	1	1.4%
	Unknown	2	2.7%
Case Themes	Patient Safety and/or Quality	30	41.1%
	Worker Safety or Wellbeing	23	31.5%
	Bullying and/or Harassment	8	11%
	Other Inappropriate Attitudes or Behaviours	11	15.1%
	Detriment - as a result of speaking up	1	1.4%

Patient safety and/or Quality was the leading theme, accounting for 30 of 73 concerns (41.1%), followed by worker safety or wellbeing (31.5%). Patient safety and quality concerns were concentrated within Medicine Division, reflecting multiple concerns from 2 areas rather than a Trust wide pattern.

FTSUG insight from confidential conversations where consent for onward escalation was not provided:
During confidential conversations, concern raisers who did not consent to onward escalation described fear of detriment, including possible effects on career progression and working relationships. Other factors included limited confidence that concerns would be addressed, particularly where issues were longstanding or perceived to require financial investment.
Some concern raisers also reported limited leadership visibility, few opportunities for face-to-face discussion and insufficient feedback. Collectively, these accounts suggest potential barriers relating to escalation, leadership engagement, timely follow-up and communication of outcomes.

Overview of the themes / examples of 73 FTSU concerns

Patient Safety & Quality Concerns

Reported patient safety and quality concerns included:

- Ward security arrangements and associated risks to patients and staff.
- Decision to withdraw a patient service and the potential effect on patients and quality of care.

- Standards of medicines administration.
- The potential impact on communication and care delivery from working relationships between agency/ bank and substantive ward staff.
- Leadership absence, with staff reporting an impact on care quality and burnout where additional roles are being covered.
- Mixed specialties and over boarding on wards, with staff reporting reduced opportunities to optimise care and concerns that standards are below those expected.
- Over boarding described as an increasingly routine and prolonged practice rather than an exceptional occurrence, with concern that associated risks may become normalised.
- Corridor care extending into ward environments and the potential implications for patient safety, dignity and quality of care.
- Communication regarding patient transfers and status not accurate or accurately updated on Nervecentre leading to higher acuity needs on arrival on wards, or inappropriate transfers, impacting care and staff.

Worker Safety & Wellbeing Concerns

- Variable or limited communication about Trust and divisional developments, particularly where potential workforce changes were under consideration. Some concern raisers described the communication as unclear and insufficiently compassionate.
- Breakdowns in team relationships and workplace cultures perceived as harmful, with limited urgency or local ownership to address concerns.
- Protracted decision-making in operational and individual processes, including an annual leave carry over decision that remained outstanding for four months without updates, affecting staff wellbeing and the ability to plan leave.
- Smoking outside the Emergency Department and vaping on site, indicating inconsistent adherence to the smoke-free policy, feeling low confidence in the trust enforcement of such policies.
- Return-to-work interviews described by some concern raisers as punitive or intimidating, with perceived power imbalances and an approach that did not align with the intended supportive process.
- Limited compassion and continuity of support during redundancy and redeployment processes, including individuals being passed between People Team and operational leadership without clear ownership or central support for individuals
- Impact of continued pressure of managing high volumes of patients care needs, over boarding impacts – lack of breaks, increased agitation and frustration from patients and visitors – staff feel they are constantly apologising.
- Lack of wellbeing support and a package of care following violent and aggressive behaviours to staff. No follow up after initial reporting, no feedback on actions taken.

People Processes – Four concern raisers were involved in active sickness absence processes. Reported contributory factors included adverse workplace experiences, team dynamics and prolonged grievance or Dignity at Work procedures. All four stated that, in their view, their long-term sickness absence may have been avoided had the workplace culture and leadership response been different.

Inappropriate Attitudes & Behaviour Concerns

- **Incivility:** reports of dismissive, disrespectful or discourteous communication between colleagues, including interactions perceived to undermine individuals or discourage constructive challenge.

- **Perceived gaslighting behaviours:** concern raisers described occasions where their recollection, interpretation or experience of events was questioned or minimised, contributing to uncertainty and reduced confidence in process.
- **Professional boundaries:** concerns were raised about colleagues expressing personal views on political and social issues in the workplace in ways that were perceived to cross professional boundaries.
- **Lack of compassion in processes:** organisational and people processes were described as insufficiently sensitive to individual circumstances, with limited communication, support or consideration of the personal impact on those involved.
- **Professionalism and hierarchy:** concerns included inappropriate tone or conduct and hierarchical relationships that some workers felt inhibited challenge, questioning or speaking up about practice and behaviour.
- **Experience of local recruitment processes:** colleagues shared bias and unprofessional communications via WhatsApp ahead of interview processes, leading to lack of trust and integrity in recruitment process.

Bullying & Harassment

- **Management style:** concerns included communication, tone and management approaches perceived as intimidating, controlling or undermining.
- **Fact-finding and follow-up:** processes were described as insufficiently comprehensive, with limited communication and support for those who had raised concerns.
- **Bullying towards managers:** some line managers reported experiencing persistent challenging or undermining behaviour from workers, affecting their wellbeing and ability to manage teams effectively. Poor support from senior team to review and report in a timely way. Managers exposed to upward bullying and no priority/ guidance to support this being refuted.
- **Disability related disadvantage:** some disabled colleagues reported feeling less favourably regarded by managers and less likely to access workplace flexibility, including flexible working or home working arrangements.

Positive Feedback received –

✓ Concern raisers valued the time to be heard, the confidential space provided and clear signposting to relevant services and escalation routes.
✓ Some reported improved wellbeing after speaking with FTSU, particularly where concerns had affected their health.
✓ FTSU support enabled some workers to remain at work or progress a return from sickness absence while concerns were being addressed.
✓ Concern raisers reported improved understanding of available policies, processes and support, including access to wellbeing services.
✓ Reported outcomes included access to role related training, phased return arrangements, coaching and personal development support.
✓ Some colleagues described improved team relationships and greater understanding of cultural differences, supporting inclusion and retention.

Individual Concern Raiser Feedback

listening • compassion • practical support • improvement	
Feeling heard and supported *"Contacting FTSU was enormously helpful. It opened up avenues for me to discuss my issue, and it was so good to feel that I wasn't alone and someone was there for me."* *"The FTSU Guardian has been of great support to me through a long process and glad they are alongside"*	**Compassionate and professional** *"I found the Guardian calm and full of advice, help and support."* *"Very compassionate, supportive and helpful in signposting; very knowledgeable and kind."*
Professional support through a difficult period *"The Guardian was professional, communicated clearly and demonstrated compassion and insight throughout the process. It was a very difficult time, and the support provided was invaluable."*	
Support was valued; clarity on resolution *" I didn't know who to go to above my line manager but was supported to raise higher and heard. Happy and feel better that senior people now know of our concerns and that hopefully patient care and how we work together will be better. All we want is a seat at the table to be consulted and our expertise heard. FTSU has helped start this improvement and grateful for the time from all involved, knowing how busy everyone at this trust is"*	
Improvement and resolution *"I did not want to be off sick; it was not good for anyone, and I felt guilty that my team was having to carry my workload. With support from FTSU, I have been able to return to work with appropriate support and a better understanding of my experiences. I now feel happier."*	

Learning, triangulation and developments from FTSU concerns

Patient safety and quality concerns raised by whole ward teams have been triangulated with divisional intelligence and escalated for senior oversight. The Divisional Nurse and Corporate Executive Team are working with the areas concerned to organise listening events, understand staff experience and identify improvements to patient flow and patient placement. Concerns relating to standards of care and medicines management are being overseen by the Divisional Nurse, who remains in direct contact with concern raisers to support feedback, action and assurance.

In response to concerns about patient flow and allocation, one medical ward is trialling a time-limited process that enables ward staff to select patients for admission. The trial is intended to provide greater local autonomy and oversight of admissions, allowing the team to consider patient acuity, specialty requirements and ward capacity when agreeing admissions. The impact on patient flow, quality of care and staff experience will inform any further development.

Learning from concerns raised by medical staff has informed improvements to return to work arrangements following absence. Interviews are now undertaken by an appropriate level of leadership and are supported by relevant guidance to promote clear, consistent and supportive communication. Feedback indicates that this approach has strengthened trust, openness and the quality of discussion during the return to work process for this team.

Feedback from exit interviews and anonymous concerns about leadership style and team culture has informed divisional action. The Divisional Nurse has undertaken further staff interviews, introduced Matron oversight and supported a reset of team values, behaviours and expectations through a team charter. This has provided additional insight into team dynamics and identified opportunities to strengthen leadership practice and workplace culture. It is also hoped this will stabilise retention and recruitment in this area.

Feedback from the FTSU Guardian to divisional management teams has highlighted the importance of timely decisions and clear responses on operational matters, including annual leave carry over. It has also reinforced the need for open, transparent and compassionate communication when potential workforce changes are being considered. While divisional leadership teams manage competing priorities and often rely on information being cascaded through local structures, concern raiser feedback indicates that follow up and communication are not consistently undertaken across all teams and divisions. This creates variation in staff experience and may affect trust, wellbeing and confidence in organisational processes.

Regular intelligence-sharing sessions bring together representatives from Organisational Development, FTSU, EDI, Learning and Development, and Occupational Health. Supported by a shared live tracker, the sessions triangulate concerns, themes and workstreams to identify emerging risks, coordinate actions and support organisational learning.
The FTSU Guardian and representatives of the divisional triumvirates, aim to meet every 12 weeks; however, operational pressures and competing priorities have affected the consistency of these meetings. To strengthen assurance, the FTSU Operational Meeting, attended by the Director of People and Director of Corporate Affairs, has agreed to develop a periodic reporting template to the Trust Management Team for divisions to report their speaking up themes, actions and learning. This will supplement local touchpoints with the FTSUG, with a more structured feedback loop, enabling oversight of progress, ownership and accountability.

FTSU Governance, Developments & Assurance

During the CQC inspection of Medicine and Urgent and Emergency Care services in July 2026, inspectors noted that staff within U&EC were aware of FTSU arrangements and knew how to access local FTSU Champions. Workers in Medicine also confirmed that they were aware of the established speaking up arrangements and how to make contact. This provides positive assurance regarding the visibility and accessibility of FTSU routes across the inspected services.

FTSU Champions remain active across the organisation, providing visible, accessible support and early conversations for the workforce. The network now comprises approximately 30 Champions, including a newly trained medical Champion for Surgery. Feedback indicates that medical staff may prefer to raise concerns initially with a medical peer; this additional role strengthens access to profession specific support and provides further support for medics in the wider FTSU process.

The FTSUG role is focussed on reactive and proactive activity. The FTSUG continues to provide bespoke, proactive support to teams. During the reporting period, the Guardian delivered a lunchtime webinar for the People Directorate focused on FTSU, available support and routes for raising concerns. The Guardian also provided written thematic feedback from colleagues within the People Directorate, which has informed existing and planned cultural improvement work.

In Surgery, the Guardian has supported listening events within Theatre teams and contributed to the Workforce and Professional Leadership Standards Working Group, with a particular focus on strengthening psychological safety and supporting sustainable cultural improvement.

The FTSUG is an active member of the People Safety, Wellbeing and Support Group. The group's current focus includes strengthening support for staff following incidents of violence and aggression and ensuring that pathways provide appropriate follow up. The Guardian contributes anonymised insight from staff experiences to inform local responses, identify gaps in support and help shape practical improvements to staff safety and wellbeing.

Enhanced arrangements for FTSU in Maternity

A new maternity specific FTSU arrangement has been agreed with executive oversight. An experienced, current FTSU Champion has agreed to undertake the required development and transition into a Maternity FTSU Guardian role, providing a dedicated route for colleagues working within maternity services. This arrangement is intended to strengthen speaking up access and psychological safety within Maternity, reflecting learning from national maternity reports and recommendations.
The additional route also responds to feedback that the current FTSUG's previous long-standing employment within maternity services may create a perceived barrier for some colleagues. The maternity specific Guardian will offer an alternative choice, alongside the current FTSUG, for the maternity workforce.
Before commencing the role, the champion will complete the required NHS England Guardian Foundation Training and will receive ongoing development, support and oversight to ensure the role is delivered in line with national expectations.

FTSU Process & Timescale Guidance

The refreshed FTSU Process and Timescale Guidance was approved by the JSPF in August 2026. It now comprises two separate documents—one for staff and one for managers—providing clear, distinct expectations for each audience and reducing the potential for confusion when concerns are raised and managed.

Current performance indicates that concerns are generally received and acknowledged within the expected timescales. However, operational pressures, complexity, capacity and leave periods, continue to affect follow-up and resolution; meaning a significant number of concerns remain open beyond the 20-working-day timeframe set out in the guidance.

Speaking Up Policy
The SFH Speaking Up Policy has been reviewed, updated and was approved by the JSPF in August 2026. The revised policy remains aligned with the national NHSE Freedom to Speak Up Policy.

Leadership Training in Handling Concerns

As of 20 August 2026, completion of the Freedom to Speak Up e-learning modules was as follows:

Module	**All staff completed**	**Agenda for Change Band 6 and above completed**
Speak Up — all staff	633	291
Listen Up — managers	248	219
Follow Up — senior leaders	141	131
Band 6 and above who completed all three modules		**96**

The Director Of Corporate Nursing provides updates to the Local MAST Group and training numbers have slowed since launch at the beginning of the year. Continued targeted communication, monitoring and follow up will therefore be required to improve full pathway completion among leaders.

National Updates latest

FTSU National Governance

The National Guardian's Office closed on 30th June 2026. From 1st July 2026, NHSE assumed responsibility for specified national FTSU functions, including Guardian support and development, national policy and guidance, foundation training and national data collection. NHS organisations now hold greater direct responsibility and accountability for ensuring that effective local speaking up arrangements are maintained, while the Care Quality Commission continues to assess their effectiveness through the Well Led domain of inspection.

Engagement and next steps

NHS England has issued revised expectations for provider organisations following the transition. A review of the Trust's arrangements against these expectations indicates that SFH is compliant. This includes ensuring that Guardian contact information is accessible, appointed FTSUGs complete mandatory foundation training, continuing professional development is supported and appropriate independent psychological support is available. Independent external psychological support sessions are now underway for the FTSUG, completing the identified local actions arising from the NHS England expectations.

The FTSU Guardian role remains included within the NHS Standard Contract for 2026/27. Freedom to Speak Up data is now reported through NHSE National Data Collections Framework, and SFH have submitted the required data through the NHS data portal.

Thirlwall Inquiry

Findings: The Thirlwall Inquiry confirms that FTSU Guardians should remain an internal, organisation embedded function and a core component of NHS safety arrangements. This model provides the Guardian with knowledge of local culture, processes and people, and enables active involvement in local governance and greater visibility to staff.

Guardians require operational independence, sufficient protected time, resources, training and organisational support, together with authority to act impartially, challenge at all levels and escalate concerns without interference, conflict of interest or fear of detriment. The Inquiry's concerns about the closure of the National Guardian's Office reinforce the need for sustained national leadership, consistent standards and training, peer support and effective reporting.

Implications for the Trust:

- Support the independence and visibility of the FTSUG function. Recommends this is an internal role and not outsourced.
- Provide appropriate resources, support and protected time to deliver the role effectively.
- Ensure concerns raised through FTSU routes are listened to, investigated appropriately and acted upon where required.
- Use speaking up intelligence to inform organisational learning, improvement and patient safety.
- Continue to develop a culture of psychological safety, openness, inclusion and continuous improvement.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Research strategy Update	**Date:**	1st October 2026
Prepared By:	Alison Steel, Head of Research and Innovation		
Approved By:	Miss Jyothi Rajeswary, R&I Director		
Presented By:	Miss Jyothi Rajeswary, R&I Director		

Purpose		
Bi yearly performance and strategy update Q1-2 2026-27	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Recommendation

To review R&I Bi yearly performance and strategy update

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**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

A modified version of this report has been presented to Patient Safety Committee- performance and finance data has been updated to reflect more accurate timelines

Acronyms

NTU-Nottingham Trent University
ISF-Investigator Site File
EPR-Electronic Patient Record
NIHR-National Institute of Health Research
CRF-Case Report Form
IAOCR - International Accrediting Organisation for Clinical Research

Executive Summary

<u>Performance</u>

- Patient recruitment: 839
- Actively recruiting studies: 78

- Research metrics from the NHS Oversight Framework, Domain 6: 80% of commercial clinical trials set up within 90 days (20th best performing Trust in England)
- Non-commercial clinical trials set up within 90 days: 71% of
- 150 Day metric: Median set up times 25 days
  Median first patient first visits 25 days

Finance

- RRDN Delivery Income: £931,664.00
- Additional income through RRDN bids: £115,716.16
- Commercial income: £57,373.28
- RCF: £40,425
- NIHR Training income for SFH NMAHP's: £330,190

My Research Experience: move from paper to digital 26/27: 43 responses

Strategy Update

1. **Progress: Transform our approach to managing Research at SFH**
   - FLORENCE implementation-Digital ISF's and EPR
   - Medicine Pilot: Embedding Respiratory research
   - IAOCR: Gold certified workforce and clinical research site
   - New streamlined set up system
   - Dedicated R&I Pharmacist
2. **Place: Invest in research infrastructure**
   - Clinical Research Facility
   - New mobile Research Unit
   - NIHR Capital Investment secured: Stage 2 CRF development pending
3. **People: Develop a confident, research-active workforce**
   - New Research Academy success
   - 1st R&I Clinical Research Fellow appointed
   - NMAHP NIHR research training funding achievements
   - Annual Pump Priming competition secured
   - SFH-NTU Research Symposium-Nov 26
4. **Partnerships: Strengthen academic, NHS and commercial relationships**
   - Emerging commercial relationship: Quotient, Eli Lilly
   - Strong collaboration with NTU
   - Building early connections with Sheffield Hallam for NMAHP support
   - NUH: CRF, Florence and single sign off project
   - Hybrid devolved research delivery model

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Research & Innovation

Q2 2026/27 | Performance & strategy update

PURPOSE

Expand access to high-quality research that improves care for patients and staff.

PRIORITIES

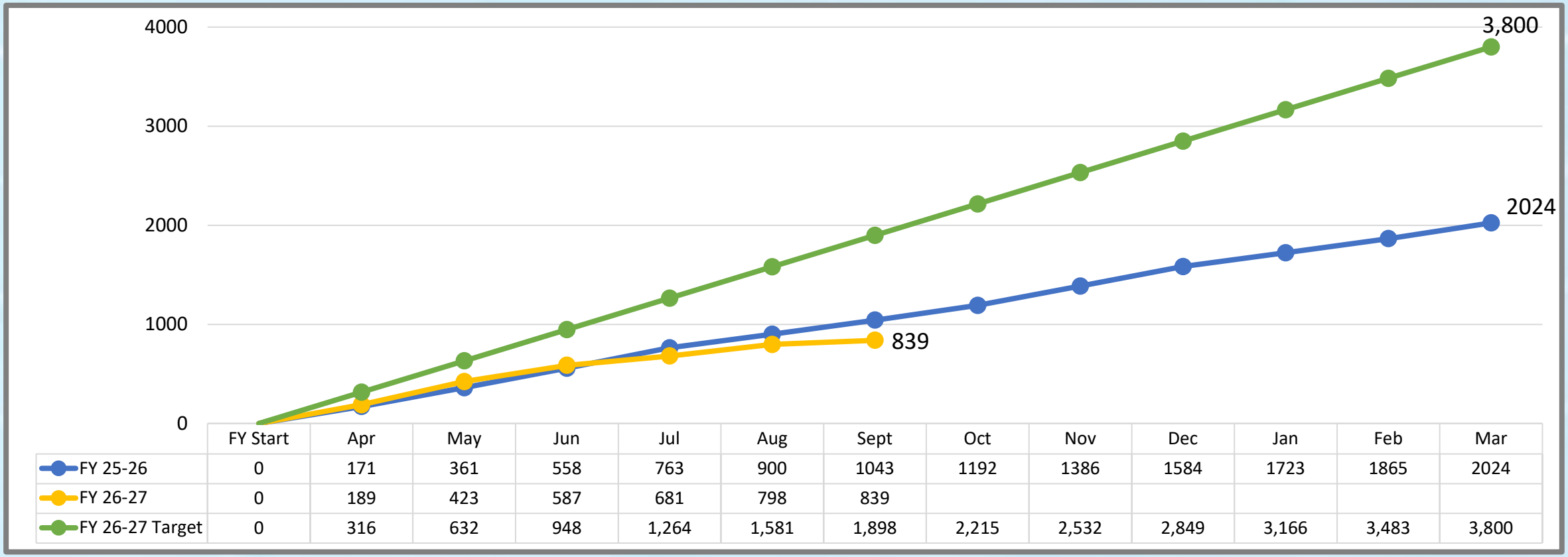
Grow a balanced portfolio, increase commercial activity and strengthen performance oversight.

STRATEGY

Embed research in everyday practice through Place, Progress, People and Partnerships.

Performance

FY 2026 – 2027 Cumulative Recruitment

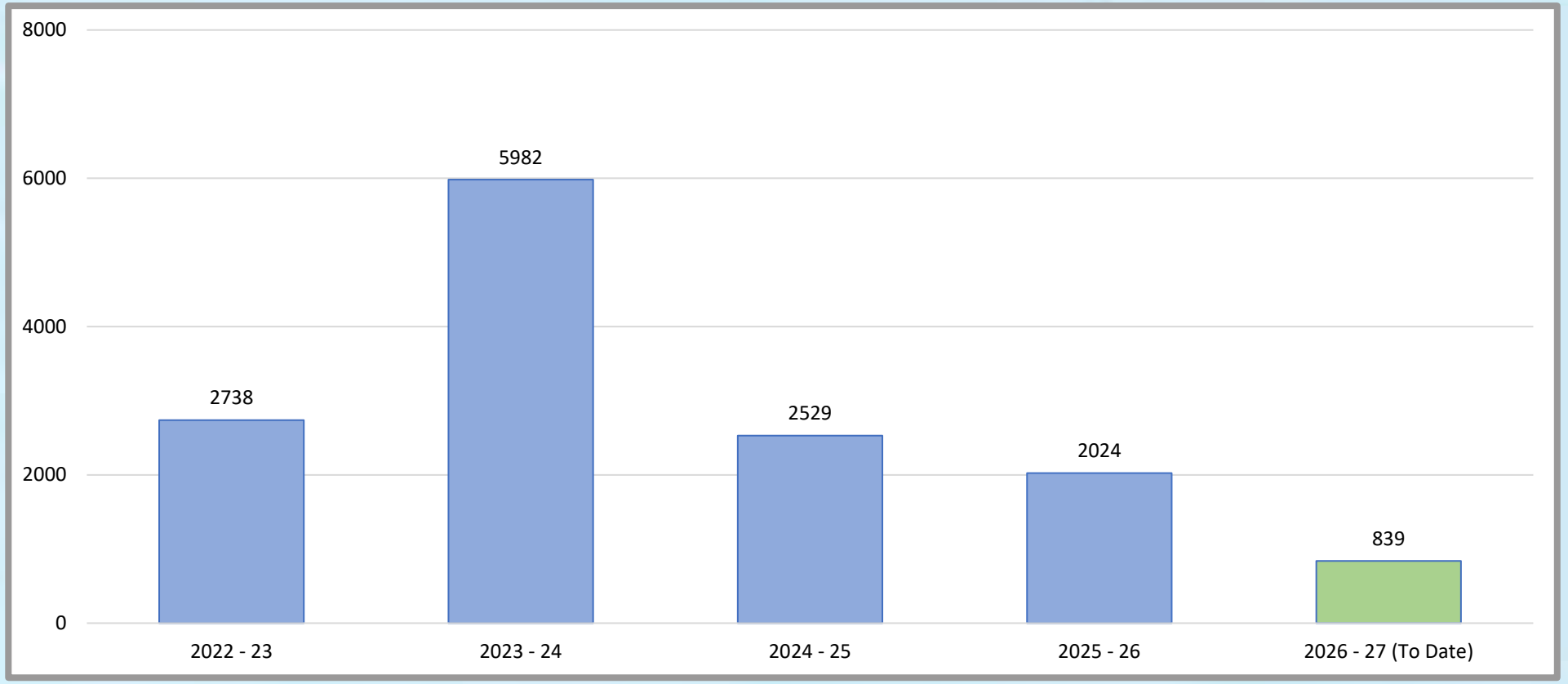


	FY Start	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
FY 25-26	0	171	361	558	763	900	1043	1192	1386	1584	1723	1865	2024
FY 26-27	0	189	423	587	681	798	839						
FY 26-27 Target	0	316	632	948	1,264	1,581	1,898	2,215	2,532	2,849	3,166	3,483	3,800

(Data cut: 16/09/2026)

Recruitment

Annual Recruitment Over Five Years

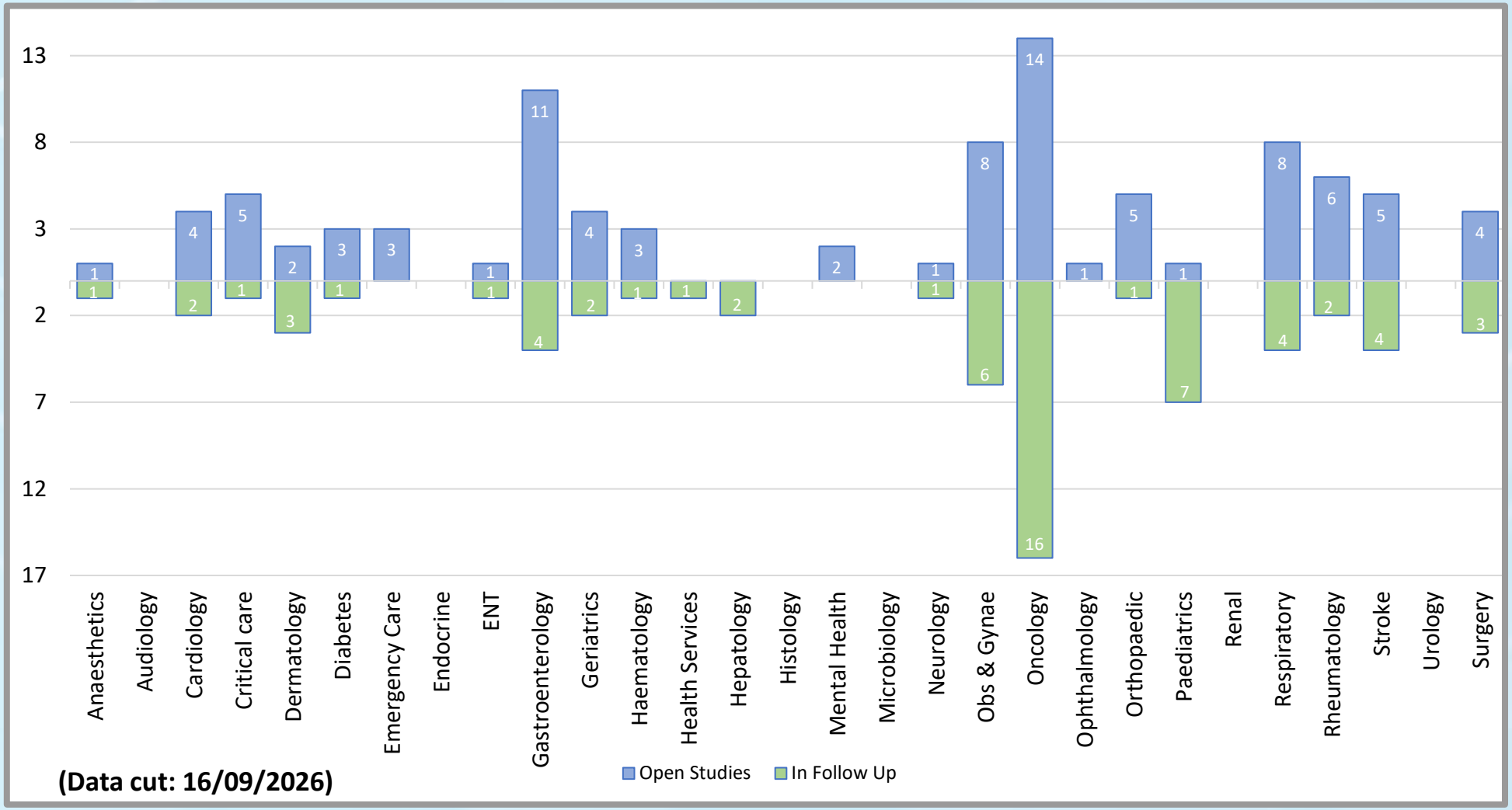


(Data cut: 16/09/2026)

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Total Studies Open & In Follow up



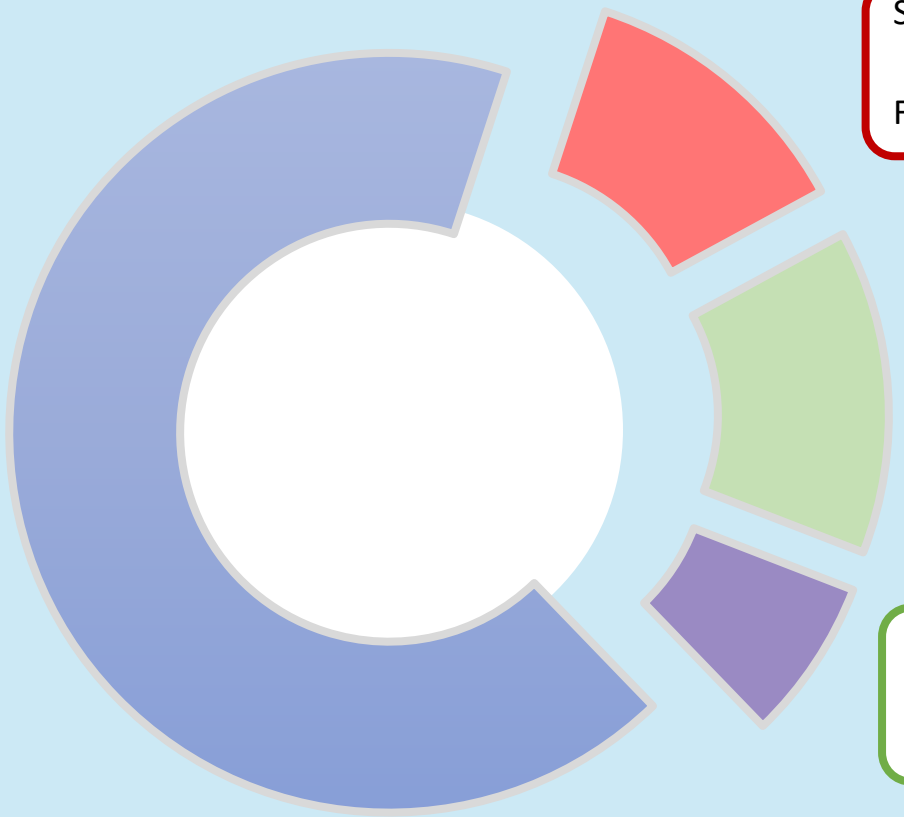
(Data cut: 16/09/2026)

	Open	In Follow Up
Anaesthetics	1	1
Audiology		
Cardiology	4	2
Critical care	5	1
Dermatology	2	3
Diabetes	3	1
Emergency Care	3	
Endocrine		
ENT	1	1
Gastroenterology	11	4
Geriatrics	4	2
Haematology	3	1
Health Services		1
Hepatology		2
Histology		
Mental Health	2	
Microbiology		
Neurology	1	1
Obs & Gynae	8	6
Oncology	14	16
Ophthalmology	1	
Orthopaedic	5	1
Paediatrics	1	7
Renal		
Respiratory	8	4
Rheumatology	6	2
Stroke	5	4
Urology		
Surgery	4	3

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Portfolio Management



Studies Closed
FY26-27: **14**

New Studies
FY26-27: **16**

Studies Currently in
Set-up: **8**

Studies Actively
Recruiting: **78**

(Data cut: 16/09/2026)

Outstanding Care,
Compassionate People,
Healthier Communities

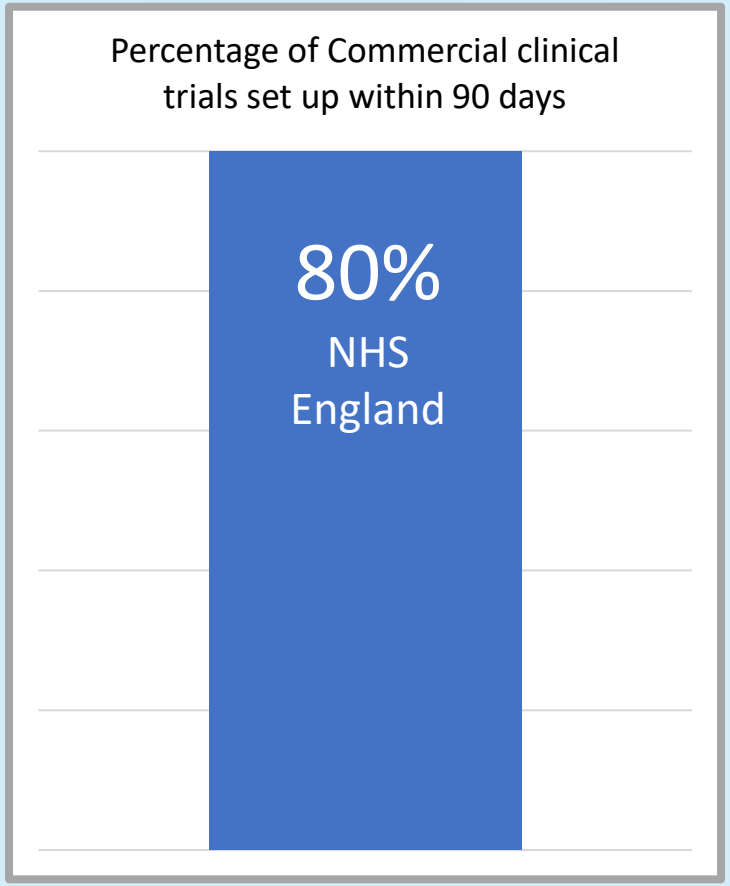
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

NHS Oversight Framework: Domain 6

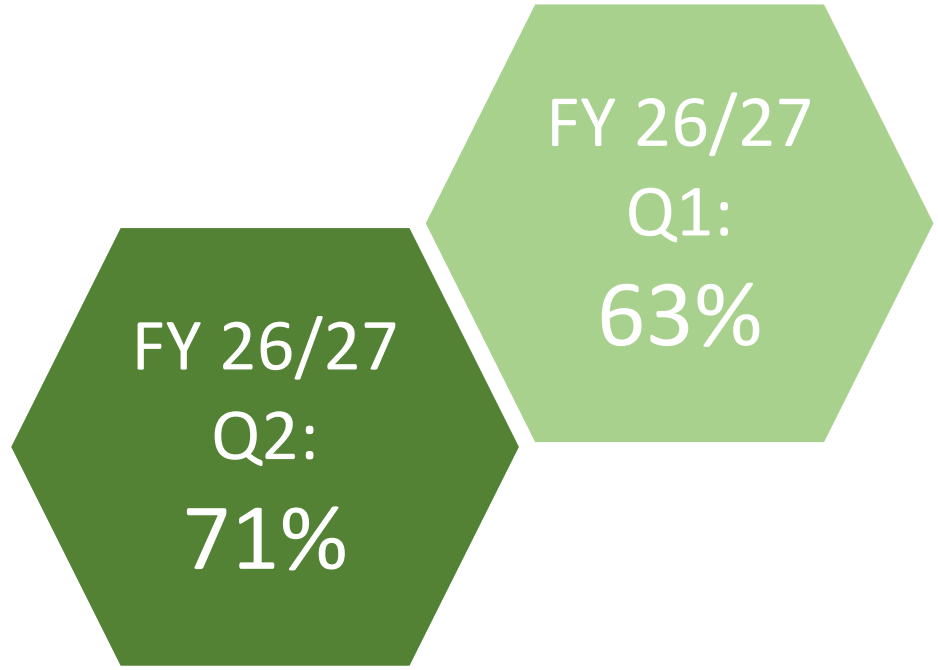
Score:
2.29

Rank:
20

Percentage of Commercial clinical trials set up within 90 days



Percentage of Non Commercial clinical trials set up within 90 days



(Data Source NHS England: 16/09/2026)

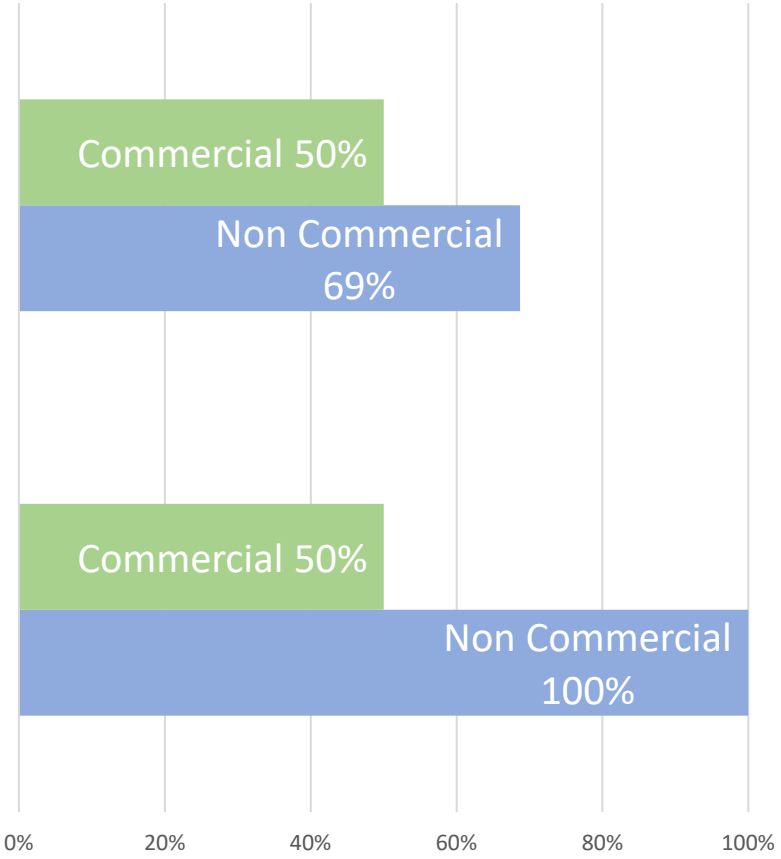
(Data Source SFHT: 16/09/2026)

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

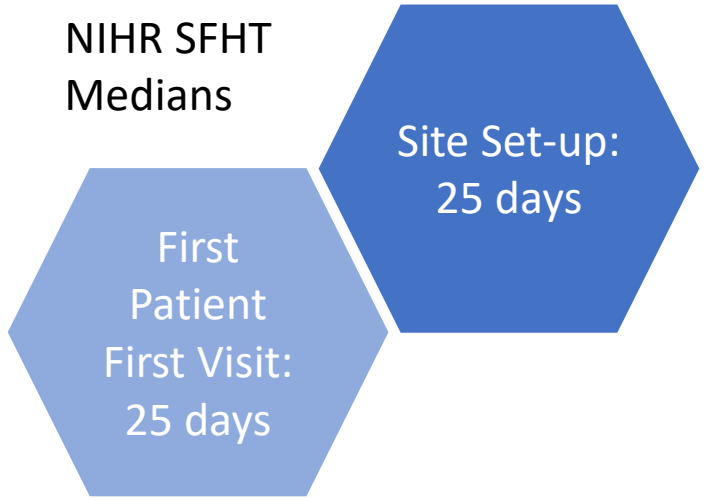
150 Day Metrics – FY 2026/27

SFHT Studies Recruiting within 30 Days of Site Readiness



SFHT Studies Opened within 60 Days of HRA Approval / Site Selected

NIHR SFHT Medians



(Data Source NIHR: 16/09/2026)

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Finance

2026/27

RRDN East Midlands Income

Delivery Budget
£931,664.00

RRDN Bids:
£115,716.16

2026/27

Q1-2 Commercial Income
£57,273.28

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

Research Capability Funding

£40,425
To maintain research capability and capacity

2026/27

NIHR Research Training Fund

£330,190

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

My Research Experience

My Research Experience has replaced the former Participant In Research Experience Survey (PRES) in April 2026.

My Research Experience is a national platform with a refreshed set of questions and further reporting on results will come in 2027.

FY 2026 – 2027
Responses:

43

(Datacut: 16/09/2026)

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Strategy update: four pillars

Progress

OBJECTIVE

Transform our approach to managing Research at SFH

UPDATE

- FLORENCE implementation-Digital ISF's and EPR
- Medicine Pilot: Embedding Respiratory research
- IAOCR: Gold certified workforce and clinical research site
- New streamlined set up system
- Dedicated R&I Pharmacist

Place

OBJECTIVE

Invest in research infrastructure

UPDATE

- Clinical Research Facility
- New mobile Research Unit
- NIHR Capital Investment secured: Stage 2 CRF development pending

People

OBJECTIVE

Develop a confident, research-active workforce

UPDATE

- New Research Academy success
- 1st R&I Clinical Research Fellow appointed
- NMAHP NIHR research training funding achievements
- Annual Pump Priming competition secured
- SFH-NTU Research Symposium-Nov 26

Partnerships

OBJECTIVE

Strengthen academic, NHS and commercial relationships

UPDATE

- Emerging commercial relationship: Quotient, Eli Lilly
- Strong collaboration with NTU
- Building early connections with Sheffield Hallam for NMAHP support
- NUH: CRF, Florence and single sign off project
- Hybrid devolved research delivery model

Trust Board of Directors - Cover Sheet

Subject:	Outcomes of NHS Impact Self-Assessment Exercise	**Date:**	1st October 2026
Prepared By:	Jim Millns, Associate Director of Transformation		
Approved By:	Simon Roe, Chief Medical Officer		
Presented By:	Jim Millns, Associate Director of Transformation		

Purpose

The purpose of this report is to provide the Trust Board of Directors with an update on the outcomes of the NHS Impact Self-Assessment Exercise undertaken in June 2026, and how the findings are being addressed.	**Approval**	
	Assurance	
	Update	**x**
	Consider	**x**

Recommendation

Trust Board members are asked to:

a. Note the key outcomes of the NHS Impact Self-Assessment Exercise undertaken in June 2026 (as summarised below and detailed in *Appendix A*).

b. Note the progress that has already been made, acknowledging that whilst the NHS Impact Self-Assessment (coupled with the outcomes of the recent AQUA review) has reaffirmed that the Trust has the '*building blocks*' of an improvement-mature organisation, the cultural elements highlighted by the NHS Impact Assessment need to be proactively addressed for us to fully embed continuous quality improvement across every aspect of our work.

c. Consider what other actions can be taken organisationally so that we continue to improve against each of the NHS Impact domains.

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**	

Identify which Principal Risk this report relates to:

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

Committees/groups where this item has been presented before

Quality Committee 24th August 2026 (as part of a wider Improvement Update).

Acronyms

NHS IMPACT = National Health Service Improving Patient Care Together
AQUA = Advancing Quality Alliance
GIRFT = Getting it Right First Time
CQC = Care Quality Commission

Executive Summary

1.1 The NHS IMPACT self-assessment was undertaken in June 2026. The purpose of the exercise was to provide the Trust with a structured diagnostic of organisational (not team specific) capability and maturity in relation to continuous improvement.

1.2 The basis of the self-assessment exercise is designed to support local improvement and organisational development, rather than to be used as a formal performance assessment.

1.3 We undertook the assessment via three stakeholder sessions involving the Improvement Faculty Senior Team, key organisational partners and the Clinical Transformation Leadership Team, providing a broad organisational perspective.

1.4 The assessment considered 22 pre-set questions across five core domains: **Building a Shared Purpose and Vision**; **Investing in People and Culture**; **Developing Leadership Behaviours**; **Building Improvement Capability and Capacity**; and **Embedding Improvement into Management Systems and Processes**.

1.5 Overall the results of the assessment indicate a developing improvement infrastructure, with particular strengths identified in our improvement capability, improvement methodology and the use of data and measurement.

1.6 For comparison purposes, to help highlight areas for further development, the outcomes have been compared to the outcomes of the 2023 assessment (the last time a full assessment was undertaken). However, when interpreting the changes between the two assessments, caution should be exercised, given the two assessments were undertaken using different approaches and are therefore not directly comparable. That said, a simple numerical mapping of the five maturity levels has nevertheless provided a useful indication of areas where progress has been made and (more importantly) those where scores have remained static or reduced.

1.7 The areas where further development has been highlighted relate mainly to using lived experience to drive improvement; coaching and empowering staff to undertake improvement; leadership values and behaviours; alignment of improvement goals; and linking improvement planning with business planning and organisational strategy.

1.8 From an overarching perspective therefore, the findings point to a common underlying theme: **the need to strengthen the culture and conditions in which improvement becomes part of everyday organisational practice**.

1.9 The findings are being considered alongside work already underway, including the AQUA Review Action Plan, delivery of the current Improvement Faculty workplan and development of the 2027/28 Workplan. Further consideration will also be given once our new Chief Improvement Officer commences in post; particularly in relation to leadership behaviours and senior-level preparedness. This will ensure that any actions arising from the assessment are

aligned with wider Trust priorities and therefore avoid unnecessary duplication.

1.10 Importantly however, the assessment reinforces the emerging view that the Trust has already developed the '*building blocks*' of an improvement-mature organisation, but these now need to be better connected and embedded to maximise their collective impact. This will provide the basis for the development of the 'Sherwood Way': a consistent approach to improvement that connects people, culture, capability, data and the Trust's existing improvement infrastructure. The immediate areas of focus are therefore to connect improvement with what matters to people, to create the conditions for staff-led improvement, and establish clearer organisational alignment and Trust-wide improvement leadership.

1.11 Please see *Appendix A* for full details.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Outcomes of NHS Impact Self-Assessment Exercise

Completed June 2026

Trust Board of Directors Meeting
1st October 2026

Contents

Introduction and Methodology

Overview

- The NHS IMPACT self-assessment is a **voluntary** diagnostic tool designed to support NHS organisations in evaluating their continuous improvement capability (Click Here). It is intended to provide senior leadership teams with a structured framework to identify organisational strengths and areas for development. **It is not a formal performance assessment**.

- The exercise is designed to assess organisational (not team specific) maturity and capability. The results are not published, nor do they get submitted centrally. The purpose is to inform local improvement and organisational development.

Approach

- The assessment was completed through three stakeholder sessions - all held in June 2026. These sessions involved the Improvement Faculty Senior Team (session 1), key partners (session 2) and the Clinical Transformation Leadership Team (session 3). The key partners session included representation from Research and Development, Digital, Patient Safety, Finance, and the Chief Medical Officer's senior team - ensuring a broad organisational perspective.

- The assessment methodology was not based on a structured or methodical approach - participants essentially provided scores based on their individual perceptions, with the '*final score*' representing the average across each stakeholder group. Undertaking the exercise via 3 separate stakeholder sessions proved valuable in stimulating discussion and debate regarding organisational capability.

- Comparative scores from the November 2023 assessment have been included for reference (*see slide 10*); however, caution should be exercised when interpreting trends, as the previous exercise was undertaken using a different approach and was led and significantly influenced by the then Director of Strategy and Partnerships. It is not therefore a direct like-for-like comparison – although is clearly helpful in identifying areas where progress has been made and from which lessons can potentially be learnt.

Introduction and Methodology (cont.)

- In addition, it is worth noting that, although the exercise appears to be linear in nature - with progression through the various '*scores*' suggesting an increasingly positive position - many of those involved in the assessment process observed that progression does not necessarily equate to improvement. Rather, it reflects a different status or stage of development. This distinction is important and should be carefully considered when determining our response and any subsequent actions.

Domains

- The NHS IMPACT Self-Assessment is structured around five core domains of an effective improvement system**: Building a Shared Purpose and Vision** (*see slide 5*); **Investing in People and Culture** (*see slide 6*); **Developing Leadership Behaviours** (*see slide 7*); **Building Improvement Capability and Capacity** (*see slide 8*); and **Embedding Improvement into Management Systems and Processes** (*see slide 9*).

- Each domain is further divided into a series of questions (22 in total), against which participants assess the Trust's current level of maturity using a five-stage framework: **Starting**, **Developing**, **Progressing**, **Spreading**, and **Improving and Sustaining**. Although the NHS IMPACT Self-Assessment is not formally a scoring exercise, the five maturity descriptors represent a progression from 'Starting', as the lowest level of maturity, through to 'Improving and Sustaining', as the highest (see above for caution in interpreting this as a purely linear exercise).

- The following slides (*5-9*) provide a definition of the respective domains (i.e. what is actually being assessed), a summary of the *average score* provided by those who contributed to the stakeholder sessions and a description of what the respective '*scores*' mean.

Domain 1: **Building a Shared Purpose and Vision**

Domain Definition

- Create a vision and shared purpose in an inclusive and transparent way ensuring meaningful input from all, including those with lived experience. The executive leadership of the organisation must drive this work, but it cannot be designed and created by one team.
- Find ways to involve diverse communities, people with lived experience and staff as partners in the design of the vision and shared purpose.
- Find ways to make the shared purpose and vision practical, so that they are lived everyday by its people and are underpinned by core values.
- Ensure all improvement work is focused on the shared purpose and vision and question any work which does not align to these. Start by focusing on the current NHS priorities and your own organisation's context, including the pressures it is facing.
- Create a powerful, purpose-driven context and narrative for improvement work so that people are more likely to engage, based on commitment to the purpose rather than compliance with a process.
- Understand the world in which your staff are working, their challenges, their successes, and the improvement they'd like to see to guide this shared purpose and vision through methods of co-design and collaboration.
- Take account of the current quality indicators (for example, staff survey scores, Care Quality Commission well-led framework, value-based healthcare) and where there are areas for improvement.
- The shared purpose and vision should allow staff to understand the importance of their work and to see it from the patient or service user's perspective. Celebrate and share good practice where possible.

Outcome of Assessment

Question	Score	Definition
1. Board and executives setting the shared purpose and vision.	Developing	Our Board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.
2. Improvement work aligned to organisational priorities.	Developing	Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation but generally seen as organisational goals rather than something which is directly meaningful to them.
3. Co-design and collaborate – celebrate and share successes.	Developing	The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.
4. Lived experience driving this work (patients, staff, communities).	Starting	There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.

Domain 2: **Investing in People and Culture**

Domain Definition

- Set the expectation (for example, through new joiners' welcome and induction process) that all staff should have a common understanding of improvement, that it is a priority for the organisation and that they will be supported to make improvements in their own area of work.
- Engage with people who work in healthcare roles and organisations and those with lived experience to design and implement the improvements based on what matters to them.
- Facilitate opportunities for people to visit other organisations to understand different ways of operating and different organisational cultures.
- Invest in and support people to understand and own their work, enabling them to make improvements in their own area of work.
- Undertake planned and deliberate cultural readiness work prior to any improvement programme or activity, to establish and maintain a shared set of values that everyone can align to.
- Use a coaching-based approach to leadership in areas where improvement is required, encourage idea generation and run PDSA (Plan, Do, Study, Act) cycles regularly. Encourage the use of measurement to evaluate improvements and to learn.
- Have a locally agreed method to measure and assess organisational improvement culture, including drawing on current quality indicators (for example, staff survey scores, Care Quality Commission well-led framework) to support organisational development and learning.

Outcome of Assessment

Question	Score	Definition
5. Pay attention to the culture of improvement.	Developing	Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (for example, using a cultural survey or the NHS staff survey) and readiness for improvement.
6. What matters to staff, people using services and carers.	Developing	We understand well as an organisation what matters most to staff, people using services and carers and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.
7. Enabling staff through a coaching style of leadership.	Starting	There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.
8. Enabling staff to make improvements.	Developing	Some staff and teams feel able to make improvements (for example, if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.

Domain 3: **Developing Leadership Behaviours**

Domain Definition

- Have a clear leadership and management development strategy in place, outlining capability requirements and access to training.
- Understand current leadership styles and approaches through Board and executive development sessions identifying strengths and gaps for each individual and as a team.
- Create Board and executive leadership stability and continuity of approach.
- Support senior leaders and managers to live and breathe the values and behaviours of the organisation focussing on enabling all staff to improve their daily work. Regularly visit staff in their place of work.
- Hold senior leaders and managers to account for behaviours, not just improvement outcomes through a clear framework and agreed expectations.
- Clearly agree and outline the support which is in place for people to improve their own services.
- Provide induction, training and development for everyone who has a formal leadership or management role so they have skills and experience of delivering improvements and can role model leading for improvement.
- Encourage Board development to better understand how current senior leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps.
- Engage with peer support networks to understand different approaches to the issues, as well as leadership and management behaviours.
- Empower teams delivering on the ground to carry out and test improvement projects.

Outcome of Assessment

Question	Score	Definition
9. Leadership and management development strategy.	Developing	Our executive and senior leadership team have started to develop their improvement knowledge and are gaining an understanding of how it can impact their role.
10. Leadership and management values and behaviours.	Developing	Executive and senior leadership values and behaviours (that acknowledge the health and wellbeing/psychological safety of staff) are agreed across our organisation.
11. Leadership and management acting in partnership.	Progressing	Our executive and senior leadership team have shared goals with the organisations they work with in their wider systems.
12. Board development to empower collective improvement leadership.	Developing	Our Board has received some improvement training and visits parts of the organisation at least monthly. Improvement is discussed at every board meeting.
13. ‘Go and see’ visits.	Developing	Our executive and senior leaders understand the importance of engaging directly with staff, but we have variation in leader participation; some leaders and managers use our improvement tools.

Domain 4: **Building Improvement Capability and Capacity**

Domain Definition

- Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement.
- Give all people access to induction, improvement training and support, so that everyone can run improvement projects and continuously improve their daily work.
- Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience.
- Demonstrate the impact of co-producing improvements with people who use services as an integral part of daily work.
- Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace.
- Create and embed a training strategy to increase improvement capability.
- Senior leaders and managers attend team huddle boards and work to unblock issues which teams are facing.

Outcome of Assessment

Question	Score	Definition
14. Improvement capacity and capability building strategy.	Progressing	Training is a balance of technical skills, behavioural attributes and data analysis. Coaching support is available during, and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing improvement capability.
15. Clear improvement methodology training and support.	Progressing	Clarity exists on which improvement methodology and approach is being consistently applied. There is a longer-term commitment to training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.
16. Improvements measured with data and feedback.	Progressing	We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.
17. Co-production.	Developing	People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvement, but this is rarely shared across departments.
18. Staff attend daily huddles.	Developing	There is a plan in place for team huddles to focus on continuous improvements in some areas with clinical and operational staff in attendance.

Domain 5: **Embedding into Management Systems and Processes**

Domain Definition

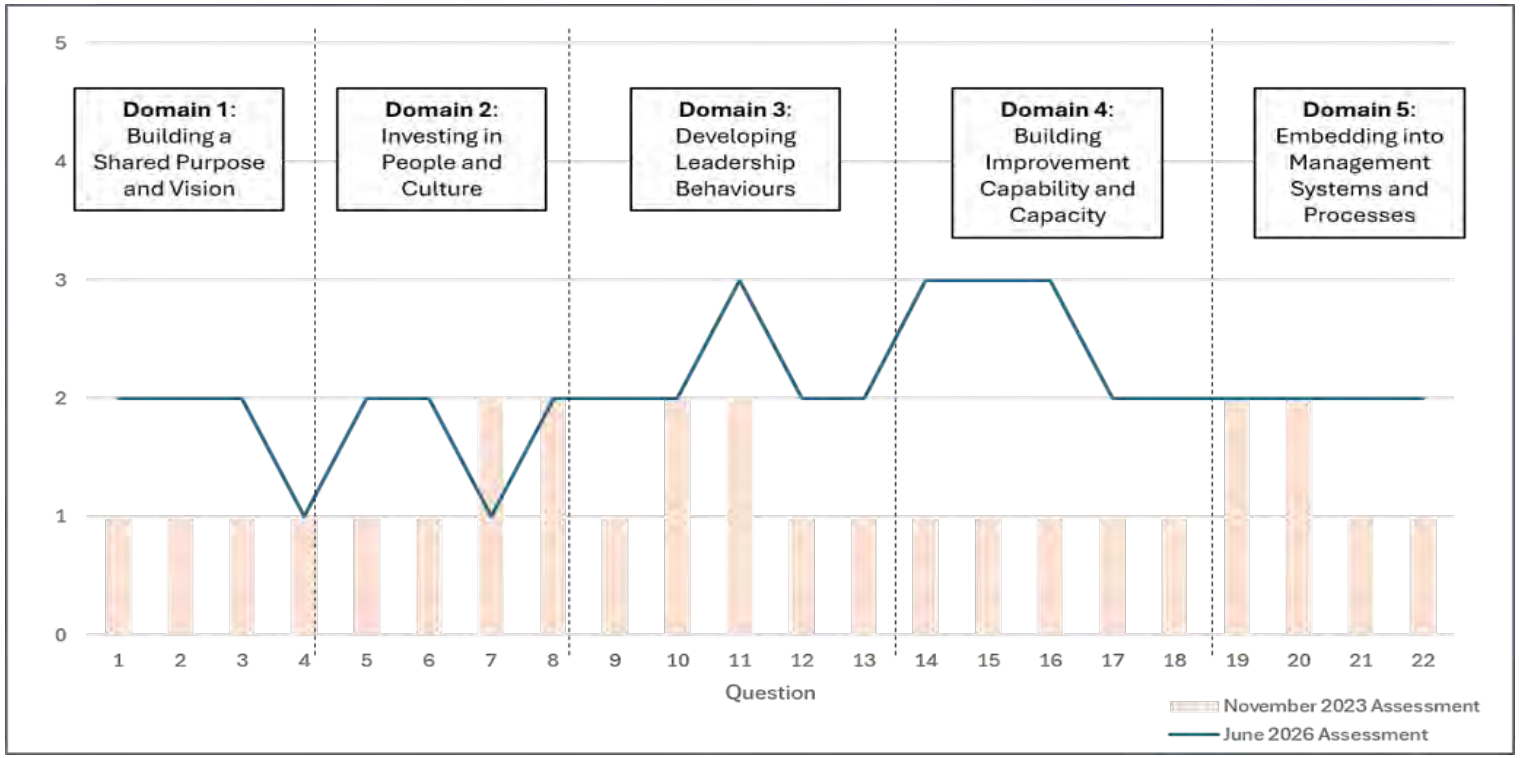
- Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at Board level, throughout and across all services and functions.
- Put systems in place to identify and monitor early warning signs for all organisational process and quality risks. Ensuring clear standard processes of how to respond to these.
- Set up the management system as a standard way of operating that enables ongoing continuous improvement of access, delivery, quality, experience, value and outcomes whilst ensuring financial sustainability.
- Build a management system with a consistent and coherent set of systems and processes that enables the organisation to respond to system and national priorities more easily and with greater agility.
- A committed Board and senior leadership team who own and use this approach to manage the everyday running of their organisation, including simple and visual ways of understanding performance with tracking progress.

Outcome of Assessment

Question	Score	Definition
19. Aligned goals.	Developing	We do not share improvement planning across our organisation with departments and directorates feeling siloed. Our business planning is an activity conducted at executive leadership level to produce goals that are cascaded top-down to the rest of the organisation.
20. Planning and understanding status.	Developing	Our business planning and performance management processes give the executive leadership team reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.
21. Responding to local, system and national priorities.	Developing	Across the organisation, we believe having a management method (for example, lean) is important to our success. Some of our leaders are using management methods, which is recognised to be helping.
22. Integrating improvement into everything we do.	Developing	Improvement is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some areas.

Outcomes and Recommendations

Despite not being a numerical exercise, to enable comparison with the previous assessment we have mapped the five maturity levels to a simple numerical scale. This provides a consistent basis for identifying areas where the Trust has demonstrated progress (i.e. the score has increased), as well as areas where further development is required (i.e. the score has remained the same or has got worse). The numerical mapping used is detailed below.



Key	
5	Improving and Sustaining
4	Spreading
3	Progressing
2	Developing
1	Starting

Outcomes and Recommendations (cont.)

As already noted, caution should be exercised when interpreting trends, given differences in how the exercise has been undertaken. That said, the application of a simple scoring methodology has given us an **indication** of those areas where progress has been made, alongside those where scores have remained static or reduced. The areas where the score has remained the same or has reduced are:

Question 4 – Using lived experience to drive improvement work (*score* has stayed the same)
Question 7 – Enabling staff to undertake improvement through a coaching style of leadership (*score* has reduced)
Question 8 – Empowering staff to undertake improvement work (*score* has stayed the same)
Question 10 – Evidence of Board, Executive and Senior Leadership and Management displaying the right values and behaviours (*score* has stayed the same)
Question 19 – Having an aligned set of goals for improvement (*score* has stayed the same)
Question 20 – Planning and understanding status, linked to business planning (*score* has stayed the same)

Whilst specific actions have not yet been developed for each area, the findings are being considered and, where appropriate, incorporated into existing action-planning processes, including the AQUA Review Action Plan, delivery of the current workplan and development of the 2027/28 Workplan. Further consideration will also be given once our new Chief Improvement Officer commences in post, particularly in relation to recommendations concerning leadership behaviours and senior-level preparedness. This will help ensure actions are aligned with the Trust's wider improvement priorities and avoid unnecessary duplication.

A key outcome of the assessment, however, is the fact that **the developmental areas as noted above share an underlying cultural theme**. This reinforces the emerging view that, while the Trust has developed many of the component elements of an improvement-mature organisation (the '*building blocks*' – also referenced in the AQUA report), these now need to be brought together and embedded to maximise their collective impact. This will help us to clearly define the '**Sherwood Way**' – a consistent approach to improvement that connects our people, culture, capability, data and improvement infrastructure. The component elements of our current Improvement approach are described overleaf.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Delivery of WAVE rapid improvement reviews - which are based on a structured, data-driven approach to rapidly understanding variation and identifying opportunities for improvement – then working with speciality leadership teams to implement changes that deliver measurable improvements in quality, productivity, patient experience and value.

Delivery of the Urgent and Emergency Care and Planned Care Programmes – supporting clinical and operational teams to identify and deliver improvements across key pathways, with a focus on improving patient flow, access, experience, quality and productivity, while creating sustainable changes in how services operate.

The provision of hands-on insight and practical support to help clinical specialties understand and respond to GIRFT metrics and recommendations, with the aim of reducing unwarranted variation, improving clinical outcomes and productivity, and ultimately strengthening GIRFT compliance.

Supporting the delivery of a focused and purposeful clinical audit programme that uses evidence and data to identify opportunities for improvement, assure compliance with standards and demonstrate the impact of changes on patient care and outcomes.

Interpreting clinical, operational and workforce data to provide actionable insight into performance, variation and opportunities for improvement - enabling teams to make better-informed decisions and target improvement activity where it will have the greatest impact.

Continuing to develop and deliver a proportionate (and 'dosed') programme of improvement training to build capacity, capability and confidence across the workforce so that staff have the skills to identify and undertake improvement activity in their own areas of work and cross-organisationally as required.

Strengthening awareness, engagement and understanding of Improvement activity across the organisation, sharing successes and learning. The aim is to create stronger connections between teams, to support a culture of continuous improvement.

Outcomes and Recommendations (cont.)

- Defining '**The Sherwood Way'** will require a consistent and (importantly) an embedded approach to how the Trust identifies, delivers, measures and sustains improvement. To help us achieve this, the areas for further development, as identified by the outcomes of the NHS Impact assessment include:
  - **Connecting improvement with what matters to people** – ensuring lived experience, staff insight and patient experience are consistently used alongside data and evidence to identify and prioritise improvement opportunities (this will have the added benefit of positively contributing to the CQC Well Led domain).
  - **Creating the conditions for staff-led improvement** – by strengthening coaching, leadership and capability so that staff feel empowered and supported to identify problems, test solutions and take ownership.
  - **Establishing clear organisational alignment and leadership** – by creating a shared understanding of the Trust's improvement priorities, supported by visible leadership, consistent values and behaviours, and clear links between improvement, strategy and business planning.

- Whilst each of these will in part be addressed through the work already underway in response to the AQUA review (e.g. creation of a QI Network), delivery of the current workplan (e.g. the implementation of a training dosing model, appointment of a Governor Lead role for Improvement and Transformation and a greater focus on QI coaching) and the development of the 2027/28 workplan – **Trust Board members are asked to consider what other actions can be taken organisationally so that we continue to improve against each of the NHS Impact domains** – thus ensuring that continuous quality improvement underpins every aspect of our work.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – To August 2026	**Date:**	1 October 2026
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	

Recommendation

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Domain reports have been considered by the appropriate Trust Board sub-committee.
The full report was approved by Trust Management Team on 23 September 2026.

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 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 Aug-26. The integrated scorecard presents the last two months data for each metric (where available) together with making data count icons that provide summary messages from the statistical process control charts. The blue and amber icons draw attention to indicators where the performance data is showing areas that are statistically relevant. 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 multi-year period and the plan or standard for the rest of 2026/27. Appendix B contains relevant benchmarking data to show our performance relative to other Trusts in England.

The integrated scorecard includes an assessment against STAR data quality assurance. Further details explaining the composition of the data assurance assessment are included within Appendix C. Areas of weakness in our indicator data quality assurance mainly relate to the 'A' item which is 'audit and accuracy'. The instances of low assurance relate to a lack of regular internal or external audit processes. This is being reviewed by our Analytical and Intelligence team for the selected metrics.

During Jul-26 and Aug-26 (latest reporting period), we saw a mixed position. We recognise the performance challenges and are committed to improving. Behind the performance challenges are discrete drivers which, in some cases, have caused variation to the plans we set ourselves for 2026/27.

Briefly considering each performance domain over the past two months:

- **Quality of Care** saw three key challenged metrics in the reported period including a never event in Aug-26, a hospital-onset healthcare associated MSRA case in Aug-26 and complaints per 1,000 occupied beds days in Jul-26. Positive outcomes included a low rate of c-difficile and e-coli, strong position for hospital acquired pressure ulcers and summary hospital-level mortality indicator remaining as expected.
- **People and Culture** had a mixture of on and off-track metrics in the latest period. Strong performance verses our plan was seen in turnover, mandatory and statutory training, medical job plan compliance, and employee relations metrics. Challenging performance areas in this domain include appraisals, sickness absence and bank and agency use.
- Within the **Timely Care** domain, Jul-26 and Aug-26 saw continued challenges but early signs of recovery within our Urgent and Emergency Care (UEC) pathway following a difficult first quarter of 2026/27. Targeted recovery actions supported better Emergency Department four-hour performance, reduced 12-hour waits, and improved ambulance handovers. From a planned care perspective, areas of strength include diagnostic DM01, cancer 28-day and cancer 31-day metrics. Challenged areas with recovery actions in place include 18-week, 52-week waits and cancer 62-day performance.
- Financially, from a **Best Value Care** perspective, the Trust has reported an in-month surplus of £0.6m in Aug-26 with a year-to-date deficit of £9.7m; this is £6.3m adverse to our deficit plan of £3.4m. The year-to-date position is driven by several factors including Industrial Action in Apr-26, shortfalls in the delivery of our Financial Improvement Programme, patient demand and flow pressures, a shortfall on interest receivable and bank and agency expenditure being higher than our plan. We are forecasting a breakeven year-end position in line with our plan.

There were 11 metrics triggering special cause variation in the latest reporting period. There were five metrics triggering due to challenges/deteriorations:

- **Complaints** per 1,000 occupied bed days has remained elevated which has driven a control limit change (increase) for this metric since our last report. The Aug-26 position was on that 1.9 standard reducing from levels seen in Jun-26 and Jul-26.
- **Mandatory and Statutory training** rate has remained low compared to 2025 performance which has driven a control limit change (reduction) since our last report. However, performance remains favourable to the standard of 90% at 92.3% in Aug-26.
- The number of **bed days lost due to medically safe for transfer** for greater than 24 hours has been on an increasing trend in the last 3-months breaching the upper control limit in Aug-26; to a level we have not seen since Mar-24. We have the equivalent of over four wards of medically safe for transfer patients across our hospitals experiencing a delayed discharge.
- **52-week wait** performance triggered as special cause variation in Jul-26 and Aug-26. Performance deteriorated to sit above the upper control limit and has not achieved plan (as a percentage of our waiting list) for the last four reported months.
- Reported **agency expenditure** triggered as special cause variation in Jul-26 after going above the upper control limit at £0.94m. It has since reduced in Aug-26 to be back within control limits.

There were six metrics triggering because of improvements:

- **Appraisal** rate reached 88.9% in Aug-26 which is above the upper control limit. Whilst this metric remains below the 90% standard our Aug-26 position represents our strongest performance since May-25.
- **Medical job plan compliance** has been at 100% in Jul-26 and Aug-26 which is above the upper control limit in both month and better than the 95% standard.

- **ED 24-hour length of stay** performance improved in Jul-26 and Aug-26 to be our lowest levels since Oct-25. Together with improvements in the metric since we exited the winter 2025/26 period, we have seen a control limit change (reduction) for this metric since our last report. The Jul-26 and Aug-26 position was 0.3%; this remains above the target which is not to have any patients in ED over 24 hours.
- **18-week RTT** performance has driven a control limit change (increase) for this metric since our last report due to continued strong performance. However, we have fallen behind our plan in the last two months, which requires month-on-month improvement through to the end of 2026/27.
- **Outpatient procedure activity levels** triggered as special cause variation in Jul-26 due to levels being higher than the upper control limit. In Jul-26 activity levels in this area were also above our plan.
- **Day case activity levels** triggered as special cause variation in both Jun-26 and Jul-26 due to levels being higher than the upper control limit. Day case activity levels have also consistently been above plan.

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

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals

Integrated Performance Report

Reporting Period: To August 2026

Outstanding Care,
Compassionate People,
Healthier Communities

Integrated Scorecard (1/2)

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

Performance is assessed for the most recent month using variation and assurance icons based on the Making Data Count approach. The adjacent key provides further information. Details of the plan/standard for the forthcoming year for each metric are included in the graphs in the appendix.

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

Metrics have a data quality assessment. Guidance on the STAR data quality assurance can be found in the key and within appendix C.

This page provides an overview of performance in the Quality of Care and People and Culture domains. The Timely Care and Best Value Care domains are presented on the next page.

Domain	At a Glance	Indicator	Jul-26	Aug-26	Standard (Aug-26)	Benchmark	STAR Data Quality
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	2.7	2.8	No standard		
		Never events reported in month	0	1	0		
		Hospital-onset MRSA reported in month	0	1	0		
		Rate of c-difficile	0.3	0.2	≤0.3		
		Rate of e-coli	0.1	0.2	≤0.3		
		Number of gram-negative bloodstream infections reported in month	4	7	≤8		
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0.0	0.1	No standard		
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	0		
		New category 3 or 4 pressure ulcers per 1000 occupied bed days	0.0	0.0	0		
		Patient Safety Incident Investigations (PSII) and Duty of Candour	11	10	No standard		
		Percentage of inpatient Service Users undergoing risk assessment for VTE	-	-	≥95%		
		Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)	49	41	TBC		
	Caring	Complaints per 1000 occupied bed days	2.2	1.9	≤1.9		
		Compliments received in month	120	99	No standard		
	Effective	SHMI	107	107	As expected		
		Still births per 1000 live births	3.3	3.6	≤4.4		
		Early neonatal deaths per 1000 live births	0.0	0.0	≤1		
		30 day readmission rate band	TBC	TBC	TBC		
		14 day readmission rate	9.6%	10.1%	TBC		
People and Culture	Belonging in the NHS	NHS staff survey engagement theme score	-	-	≥6.74	66 / 121	
		National Education and Training Survey satisfaction rate	TBC	TBC	TBC		
		NHS staff standards score	TBC	TBC	TBC		
	Growing the Future	Vacancy rate	9.3%	8.3%	≤9.0%		
		Time to hire	43	33	≤40		
		Turnover in month	0.4%	0.6%	≤0.9%	55 / 118	
		Appraisals	87.6%	88.9%	≥90%		
		Mandatory & statutory training	92.2%	92.3%	≥90%		
		Medical job plan compliance (Consultants)	99.7%	99.7%	≥95%		
		Medical job plan compliance (SAS Doctors)	100.0%	100.0%	≥95%		
	Looking after our People	Sickness absence	5.1%	5.0%	≤4.2%	52 / 118	
		Flu vaccinations uptake (front line staff)	-	-	≥56.9%		
		Employee relations management	19	20	<24		
	New Ways of Working	Bank usage	6.4%	6.0%	≤5.3%	119 / 195	
		Agency usage	3.0%	2.8%	<1.5%	158 / 193	
		Agency (off framework)	0.0%	0.0%	0%		
		Agency (over price cap)	39.7%	34.8%	≤40.0%		

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Summary Icon Key

Variation
- Common cause - no significant change
- Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
- Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Assurance
- Variation indicates inconsistently hitting passing and failing short of the target
- Variation indicates consistently (P)assing the target
- Variation indicates consistently (F)ailing short of the target

Benchmark Key
- Best performing 40%
- Middle performing 20%
- Worst performing 40%

STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

- Substantial assurance
- Limited assurance
- No assurance

Outstanding Care,
Compassionate People,
Healthier Communities

Integrated Scorecard (2/2)

This page provides an overview of the second part of the Integrated Scorecard, with metrics from the Timely Care and Best Value Care domains presented alongside Activity information.

Domain	At a Glance	Indicator	Jul-26	Aug-26	Standard (Aug-26)	Benchmark	STAR Data Quality
Timely Care	Urgent Care	Average ambulance handover time (mins)	24	24	≤19	▲ 4 / 15	
		Percentage of ambulance handovers within 15 minutes	25.9%	27.4%	≥73.5%	▼ 125 / 174	
		Percentage of ambulance handovers within 45 minutes	91.1%	91.4%	100%	▲ 5 / 15	
		ED 4-hour performance	71.2%	71.5%	≥83.3%	▼ 128 / 140	
		ED 12-hour length of stay performance	4.7%	5.7%	≤1.1%	▬ 83 / 177	
		ED 24-hour length of stay performance	0.3%	0.3%	0%		
		Number of ED patients cared for in corridors for over 45 minutes	-	824	0%		
		Adult G&A bed occupancy	96.1%	96.5%	≤97.1%	▬ 80 /177	
		Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base	86	99	≤40		
		Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base	2653	3058	≤1240		
	Electives	Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment	64.0%	63.8%	≥65.9%	▼ 94 / 148	
		Percentage of RTT waits over 52 weeks for incomplete pathways	1.4%	1.4%	≤1.0%	▬ 88 / 148	
	Diagnostics	Diagnostic DM01 performance under 6-weeks	92.5%	92.1%	≥92.0%	▲ 39 / 135	
	Cancer	Cancer 28-day faster diagnosis standard	81.6%	-	≥80.7%	▲ 47 / 130	
		Cancer 31-day treatment performance	90.8%	-	≥91.3%	▬ 69 / 130	
		Cancer 62-day treatment performance	70.4%	-	≥77.0%	▬ 76 / 134	
Best Value Care	Financial Performance	Financial surplus / deficit	-£2.57	£0.84	≥0.21		
		Variance YTD to financial plan	-£2.65	£0.62	≥£0.00m		
	Efficiency	Financial efficiency variance YTD to plan	-£0.47	-£1.21	≥£0.00m		
		Risk adjusted efficiency forecast to plan (%)	67.0%	75.0%	100%		
		Relative cost difference (National Cost Collection Index)	103	103	TBC		
		Implied productivity growth (YTD compared to last year)	-	-	TBC		
	Variable Pay	Reported agency expenditure	£0.94	£0.86	≤£0.45		
		Reported bank expenditure	£1.99	£1.86	≤£1.53		
		Temporary staffing cost relative band	TBC	TBC	≤6.7%		
	Cash & Liquidity	BPPC - Number of bills paid within target (%)	7.1%	16.2%	≥95%		
		BPPC - Value of bills paid within target (%)	57.4%	69.1%	≥95%		
		Operating expenditure days	1	1	≥5		
	Capital	Capital expenditure against plan	£0.65	£1.36	≤1.46		
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	593	537	≤523		
		Non-elective admissions	155	-	≤142		
	Electives	Average daily elective referrals	373	299	No plan		
		Outpatients - first appointment	343	-	≥320		
		Outpatients - follow up	837	-	≤772		
		Outpatients - procedures	320	-	≥280		
		Day case	135	-	≥116		
		Elective inpatient	12	-	≥13		
	Diagnostics	Diagnostics	511	498	≥465		

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Summary Icon Key

- Variation
  - Common cause - no significant change
  - Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
  - Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
- Assurance
  - Variation indicates inconsistently hitting passing and falling short of the target
  - Variation indicates consistently (P)assing the target
  - Variation indicates consistently (F)alling short of the target

Benchmark Key

- ▲ Best performing 40%
- ▬ Middle performing 20%
- ▼ Worst performing 40%

STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

- Substantial assurance
- Limited assurance
- No assurance

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Quality of Care

At a Glance	Indicator	Jul-26	Aug-26		Standard (Aug-26)	STAR Data Quality
Safe	Rate of inpatients to suffer a new hip fracture	2.7	2.8		No standard	STAR
	Never events reported in month	0	1		0	STAR
	Hospital-onset MRSA reported in month	0	1		0	STAR
	Rate of c-difficile	0.3	0.2		≤0.3	
	Rate of e-coli	0.1	0.2		≤0.3	
	Number of gram-negative bloodstream infections reported in month	4	7		≤8	STAR
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0.0	0.1		No standard	STAR
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0		0	STAR
	New category 3 or 4 pressure ulcers per 1000 occupied bed days	0.0	0.0		0	
	Patient Safety Incident Investigations (PSII) and Duty of Candour	11	10		No standard	STAR
	Percentage of inpatient Service Users undergoing risk assessment for VTE	-	-		≥95%	
	Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)	49	41		TBC	
Caring	Complaints per 1000 occupied bed days	2.2	1.9		≤1.9	STAR
	Compliments received in month	120	99		No standard	STAR
Effective	SHMI	107	107		As expected	
	Still births per 1000 live births	3.3	3.6		≤4.4	STAR
	Early neonatal deaths per 1000 live births	0.0	0.0		≤1	STAR
	30 day readmission rate band	TBC	TBC		TBC	
	14 day readmission rate	9.6%	10.1%		TBC	

Summary Icon Key

Variation		Common cause - no significant change
		Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
		Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
Assurance		Variation indicates inconsistently hitting passing and falling short of the target
		Variation indicates consistently (P)assing the target
		Variation indicates consistently (F)alling short of the target

Benchmark Key

- Best performing 40%
- Middle performing 20%
- Worst performing 40%

STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

- Substantial assurance
- Limited assurance
- No assurance

Outstanding Care,
Compassionate People,
Healthier Communities

Domain Summary: Quality of Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead: Executive Chief Nurse and Chief Medical Officer

During the latest reported period of Jul-26 and Aug-26, the Trust continued to face challenges across the Urgent and Emergency Care (UEC) pathway. We maintained patient services and safety during days of high emergency attendances that created operational pressure and strained our ability to deliver timely and safe care. Persistent delays for admission beds and overcrowding in the Emergency Department (ED) affected patients, carers and staff and led to a Business Continuity Incident (BCI) being declared in mid-Aug-26 driven by challenges discharging patients. Ongoing issues remain with timely access to packages of care for patients that have completed their acute hospital stay. Despite this, our teams performed exceptionally, enabling us to continue providing safe, high-quality care.

Within the Quality of Care domain during Jul-26 and Aug-26, there were three key challenged metrics:

- **Never Events reported in month:** One never event was reported in Aug-26 relating to a wrong site block. This is our first never event since May-25.
- **MRSA:** One case of hospital-onset healthcare associated (HOHA) was reported in Aug-26 alongside one community-onset healthcare associated (COHA) of Methicillin-Resistant Staphylococcus Aureus (MRSA).
- **Complaints per 1,000 bed days:** The Patient Experience Team saw a continued elevated number of complaints which has driven a control limit change (increase) for this metric since our last report. We have also seen an increase in AI-generated contacts, which is making early informal resolution more challenging. This increase is being seen nationally.

No Patient Safety Incident Investigations (PSIIs) were commissioned during Jul-26 and Aug-26. No incidents met the threshold for reporting to Maternity and Newborn Safety Investigations (MNSI).

Summary Hospital-level Mortality Indicator (SHMI) remains as expected and continues to be monitored monthly using the value as reported by NHS Digital (national database) alongside the Trust benchmarking tool, HED (Healthcare Evaluation Data).

Performance relating to the percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE) has been temporarily removed from reporting whilst a validated and accurate position is established in alignment with the new national definition.

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

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 there were:

- Zero PSIIs commissioned during Jul-26 and Aug-26.
- No incidents met the threshold for reporting to Maternity and Newborn Safety Investigations (MNSI).
- One never event reported in Aug-26.

Never Event

The never event related to a wrong site block. The incident occurred in a theatre anaesthetic room, a swarm huddle was held within three hours of the incident occurring with Surgery, Anaesthetics and Critical Care. Actions were agreed and a paper was presented to the Trust-level Patient Safety Incident Response Group (PSIRG) the following day. A key contributing factor was that the formal stop moment was not completed immediately prior to undertaking the block.

Although team members described that they routinely complete stop moments and understood the purpose of the process, this did not happen on this occasion. Immediate learning was shared with anaesthetic, theatre and Operating Department Practitioner (ODP) teams through safety huddles and team briefings. Duty of Candour was undertaken with the patient when he returned to the ward, and a formal letter followed in line with Trust process.

PSIIs

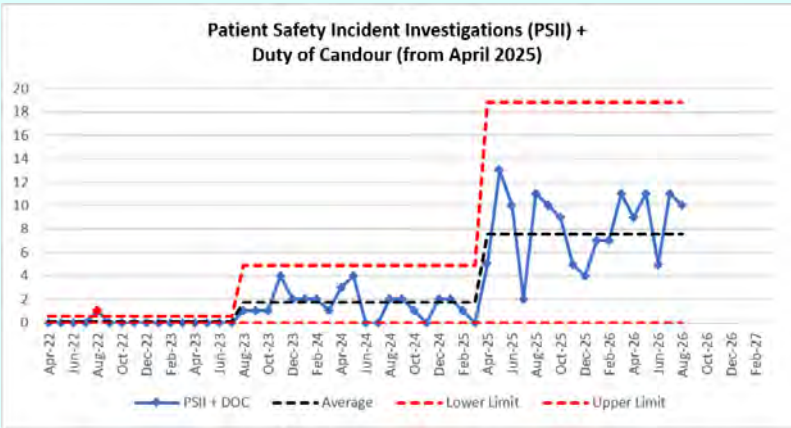
During the latest reporting period, there were zero PSIIs signed off at the PSIRG. One PSII was brought back to PSIRG for amendments to be made to the terms of reference due to additional information regarding the ReSPECT process being identified during the investigation.

Addendums

- One addendum to a MNSI report was signed off. It was confirmed that the addendum provided a comprehensive update against the MNSI recommendations and safety prompts.

- One addendum was signed off through PSIRG, with further recommendations identified from a PSII regarding telemetry.

Data



Indicator in Focus: Infection Prevention and Control

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

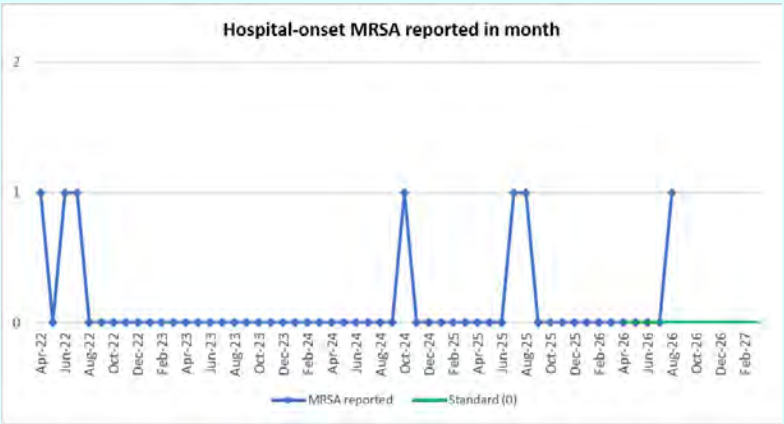
MRSA
We have not met our zero-tolerance threshold for MRSA in 2026/27. By the end of Aug-26 we had identified two cases, one HOHA and one COHA. Benchmarking shows a continued regional and national rise in MRSA, with eight peer organisations exceeding their thresholds to date.

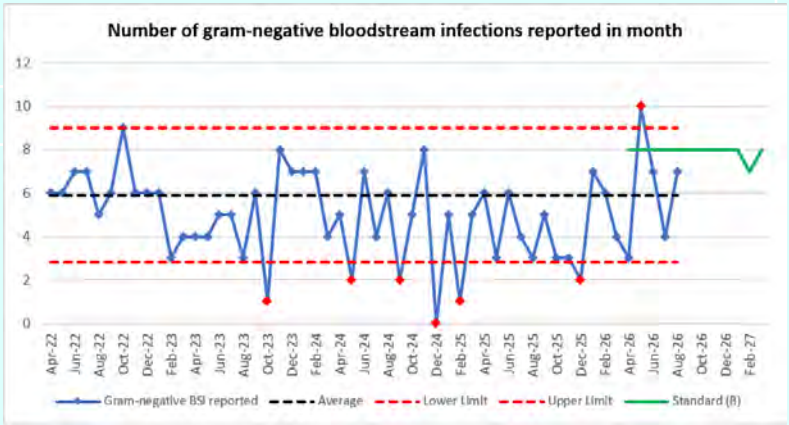
Clostridioides difficile (C. diff)
Our 2026/27 target for hospital-onset (HOHA) and community-onset hospital-associated (COHA) C. difficile is 65 cases. At the end of Aug-26, we have had 35 cases, which is four below the position from last year. Benchmarking shows that we sit mid-group among our peer trusts. In the last three months, we recorded 24 hospital-onset (HOHA) and 11 community-onset (COHA) infections.

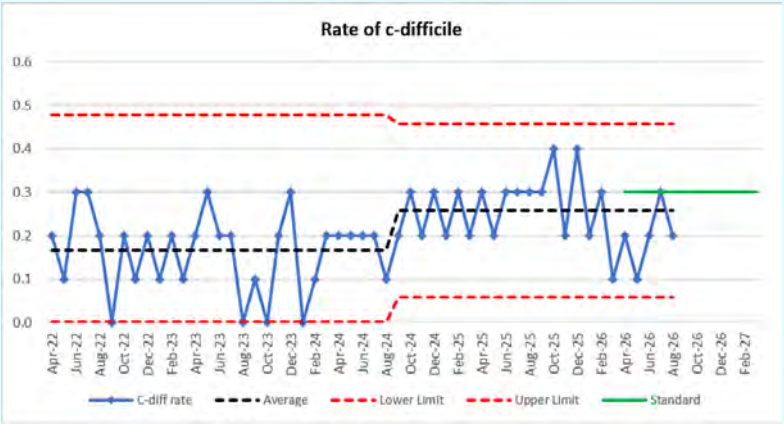
Gram-negative bacteraemia
Our thresholds for 2026/27 have been set: E. coli is 72. Klebsiella and Pseudomonas trajectories have stayed the same at 15 and 9, respectively. For 2026/27 to date, there has been an increase in the number of cases identified compared to the same period last year; with increases observed for Ecoli (16 cases), Klebsiella (4 cases) and Pseudomonas (3 cases). The source of over 50% of cases is urinary tract infection. Benchmarking continues to show we are the worst performing for Pseudomonas and fourth worst performing for E. coli and Klebsiella among peer acute trusts.

Root causes	Actions and timescale	Impact
Increase in our mandatory reportable infections.	Implement a new Healthcare Association Infection (HCAI) improvement task and finish group.	Improve the patient journey and reduce number infections identified.
	Create a HCAI Improvement action plan.	

Data







Indicator in Focus: Complaints per 1000 bed days

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Between Jul-26 and Aug-26, Sherwood Forest Hospitals received 91 complaints demonstrating a 36% increase compared to the same reporting period in 2025. This reflects both local pressures and a wider national trend across health services.

The Patient Experience Team continues to receive an increasing number of complaints, which is reflected in the Jul-26 and Aug-26 figures. There has also been a noted rise in the number of contacts using AI, which can make it increasingly challenging to resolve concerns informally at an early stage.

The team continues to monitor feedback trends closely, working with divisions to ensure that complaints and concerns are responded to in a timely, proportionate and person-centred way while also identifying opportunities for learning and service improvement.

From 1 October 2026, the Parliamentary and Health Service Ombudsman (PHSO) will be known as the Public Service Ombudsman; its remit and services will remain unchanged The Ombudsman has also published its 2026–2031 strategy and the Trust is reviewing its complaints policy and associated processes to ensure continued alignment with the new strategy and any related guidance.

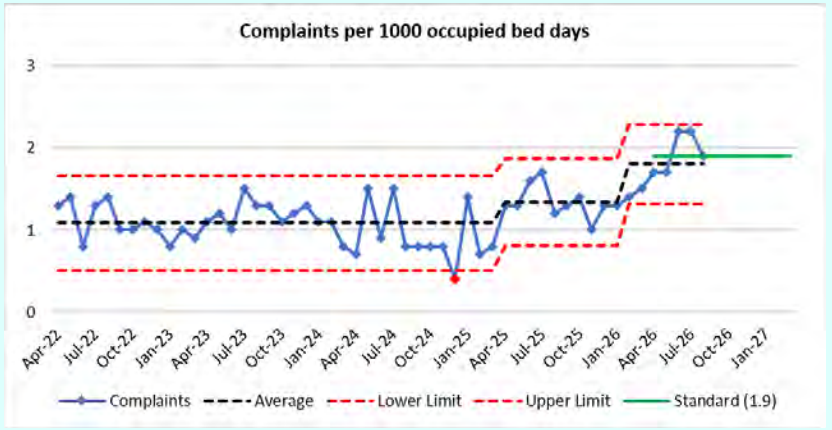
The Trust is also working with the PHSO as it develops a national dashboard identifying themes and trends arising from its investigations. Once available, the dashboard will provide the Trust with further insight into national learning and areas for improvement. Relevant findings will be included in future reports following the dashboard's publication.

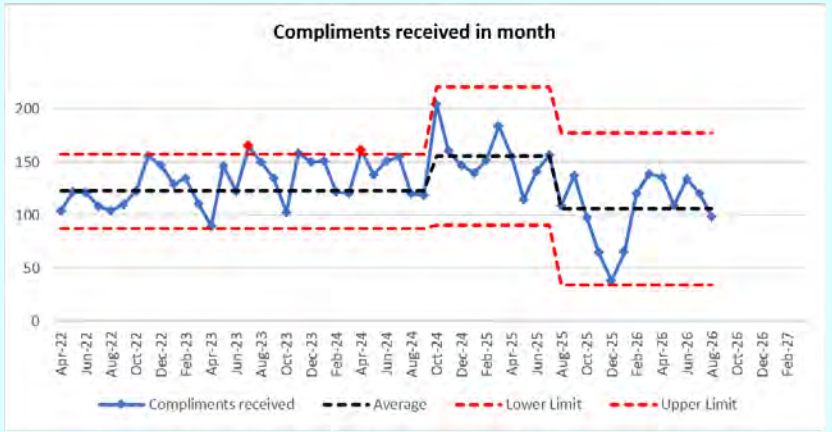
Between July-26 and Aug-26, the PHSO initiated 2 new complaints reviews, either awaiting a response confirming an investigation, or confirming the scope and are under review. 0 investigations were closed during this timeframe. The Trust have 8 ,complaint cases with the PHSO currently.

219 compliments were received during this period. Divisions are encouraged to record compliments locally, and positive feedback is routinely shared with teams to recognise good practice and support staff morale. The Patient Experience Team continues to explore ways to ensure all compliments are captured comprehensively, strengthening the visibility of positive patient feedback across the organisation.

Feedback received through Healthwatch, Care Opinion and social media continues to highlight examples of compassionate and responsive care across services, while also identifying areas for further improvement, including appointment delays and poor communication.

Data





Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

People and Culture

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: People and Culture

At a Glance	Indicator	Jul-26	Aug-26		Standard (Aug-26)	Benchmark (Mar-26)	STAR Data Quality
Belonging in the NHS	NHS staff survey engagement theme score	-	-		≥6.74	66 / 121	STAR
	National Education and Training Survey satisfaction rate	TBC	TBC		TBC		STAR
	NHS staff standards score	TBC	TBC		TBC		STAR
Growing the Future	Vacancy rate	9.3%	8.3%		≤9.0%		STAR
	Time to hire	43	33		≤40		STAR
	Turnover in month	0.4%	0.6%		≤0.9%	55 / 118	STAR
	Appraisals	87.6%	88.9%		≥90%		STAR
	Mandatory & statutory training	92.2%	92.3%		≥90%		STAR
	Medical job plan compliance (Consultants)	99.7%	99.7%		≥95%		STAR
	Medical job plan compliance (SAS Doctors)	100.0%	100.0%		≥95%		STAR
Looking after our People	Sickness absence	5.1%	5.0%		≤4.2%	52 / 118	STAR
	Flu vaccinations uptake (front line staff)	-	-		≥56.9%		STAR
	Employee relations management	19	20		<24		STAR
New Ways of Working	Bank usage	6.4%	6.0%		≤5.3%	119 / 195	STAR
	Agency usage	3.0%	2.8%		<1.5%	158 / 193	STAR
	Agency (off framework)	0.0%	0.0%		0%		STAR
	Agency (over price cap)	39.7%	34.8%		≤40.0%		STAR

Summary Icon Key

Variation	Common cause - no significant change
	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
Assurance	Variation indicates inconsistently hitting passing and falling short of the target
	Variation indicates consistently (P)assing the target
	Variation indicates consistently (F)alling short of the target

Benchmark Key

- Best performing 40%
- Middle performing 20%
- Worst performing 40%

STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

- Substantial assurance
- Limited assurance
- No assurance

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Domain Summary: People and Culture

Overview	Lead: Chief People Officer

In Aug-26, nine of 13 People and Culture indicators were meeting or exceeding standards, reflecting our continued commitment to supporting and investing in our people. Areas of strong compliance against our targets include staff turnover, recruitment timelines, medical job plan compliance, off-framework agency levels and Mandatory and Statutory Training (MaST). This performance demonstrates sustained operational grip and effective workforce management. Benchmarking comparators are once again included, providing greater insight into the Trust's performance against other organisations nationally and further strengthens our assurance and improvement focus (the timeliness of benchmarking data is reliant on national data being available).

Within the People and Culture domain, the off-track metrics during the latest reported period include:

- **Appraisal** compliance is slightly below the 90% Trust target at 88.9% for Aug-26 but triggering special cause variation for positive performance. Our below plan position reflects the continued pressures across services, including high patient demand, annual leave, and staff absence, which have impacted the capacity to release time for appraisals. Focus is on the areas of non-compliance, with a view to understand these drivers, including individuals who are on the top of the banding and near retirement. Focused support will continue to reinforce the importance and benefits of appraisal conversations in supporting our people and organisational performance.

- **Sickness absence** remains above the 4.2% standard, with the Aug-26 position of 5%. While outside of target, this position improved during the spring and summer period. Stress and anxiety remain the leading causes of absence, reflecting the sustained operational pressures experienced across the Trust. Most areas are seeing elevated levels across both long-term and short-term absences. In response, we have introduced a refreshed Managing Attendance at Work policy, embedded absence management within leadership fundamentals training, and are delivering targeted preventative programmes focused on musculoskeletal (MSK) and stress-related absence hotspots. Through this, combined focus on proactive prevention and strengthened management of absence, the Trust is well positioned to deliver on the planned absence levels (4.2%) and achieve more sustainable improvements in staff wellbeing and attendance.

- **Bank usage** is currently outside standard at 6% (against a 5.3% target), and **agency usage** is 2.8%, also outside the standard in Aug-26. Plans for 2026/27 set out a clear trajectory towards achieving the planned position over the course of the year and will be closely monitored. Positively, there has been zero use of off-framework agency, with over price-cap agency below standard.

During Aug-26, we arranged and hosted a wellbeing event and a temporary staffing summit. These have been developed to help us tackle areas of non-compliance across the Trust. Each event has generated key actions that we will be progressing across the organisation.

The following pages provide more detailed performance insights across the identified areas of exception within the People and Culture domain. These areas were explored in depth at the Trust People Committee, supported by comprehensive analysis.

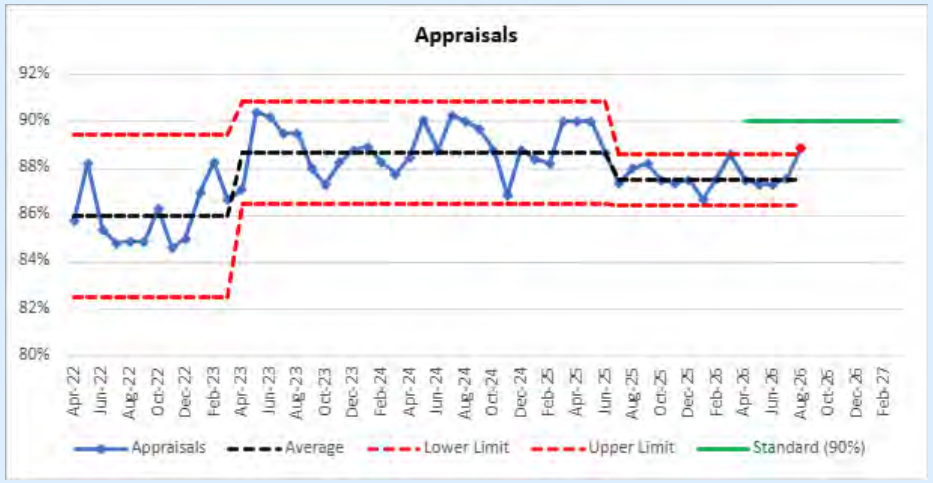
Indicator in Focus: Appraisals

Sherwood Forest Hospitals NHS Foundation Trust

Observations

Our appraisal level was 88.9% in Aug-26, below the Trust target (90%), but triggered special cause variation due to positive performance above the upper control limit. Performance has been lower than the current standard since Aug-25; however, actions have been developed and implemented with increases noted within month.

Data



Root Causes	Actions and Timescale	Impact
Patient demand and hospital acuity has impacted on compliance. Annual leave and absence levels.	To support with meeting compliance level, additional actions have been implemented. These actions, which are aligned to the staff survey, include: • Communication around promoting the importance and benefits of appraisals. • For a short period, enhanced reporting to managers to support achievement of the standard. • Proposing showing a monthly and rolling average appraisal position. We will be revisiting options to support and increase our compliance levels.	Appraisal compliance levels to gradually increase, with an ambition to see levels of 90% and above.

Indicator in Focus: Sickness Absence

NHS Sherwood Forest Hospitals NHS Foundation Trust

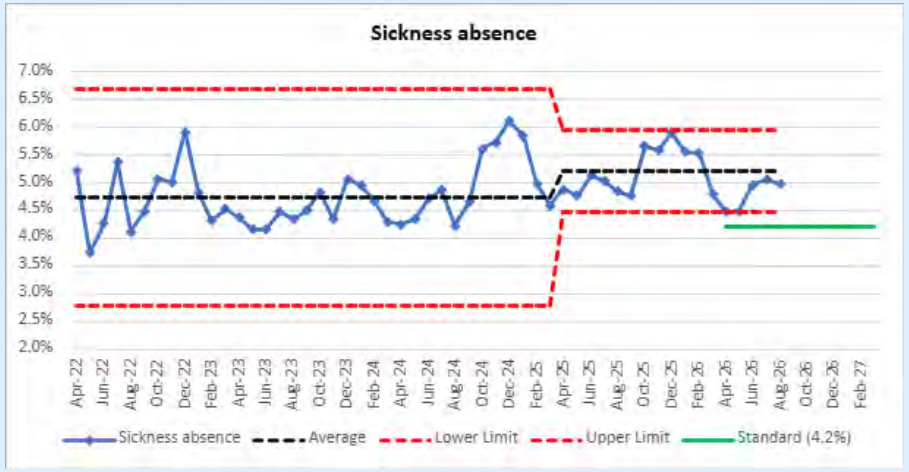
Observations

The monthly sickness position for Aug-26 was 5%, sitting outside our standard (4.2%). Performance has been between the average and lower control limit for the last six months. The trend chart shows seasonality in 2024 and 2025 in this metric with increased sickness levels between October and January (autumn and winter period). Stress and anxiety remain the leading causes of absence year-round.

The Mar-26 benchmarking shows the Trust ranking within the sixth decile; our overall position rank as 52 out of 118 trusts. We are showing an improving position relative to other Trusts nationally and across the Integrated Care System (ICS).

The increase in sickness absence directly relates to the workload and stresses of the hospital. The current position sits above the previous Aug-25 period (4.8%).

Local Data (to Aug-26)



Root Causes

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

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

Actions and timescale

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

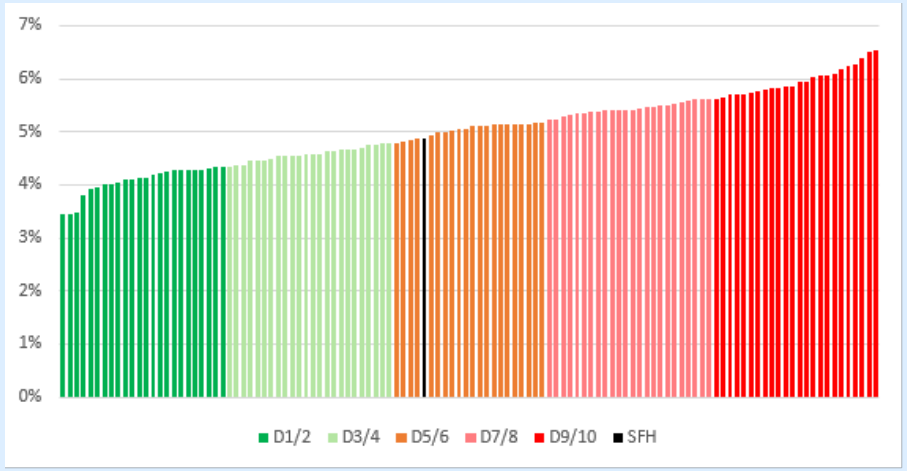
As well as the management of absences, we are looking at root causes. We are seeing absence hotspots, primarily across our healthcare assistant workforce, and have identified service line and ward areas. Aligned to these areas, we are validating our assumptions and plan to bring in preventative programmes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

Impact

Reduce levels of sickness.

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

Benchmark Position (Mar-26)



Indicator in Focus: Bank Usage

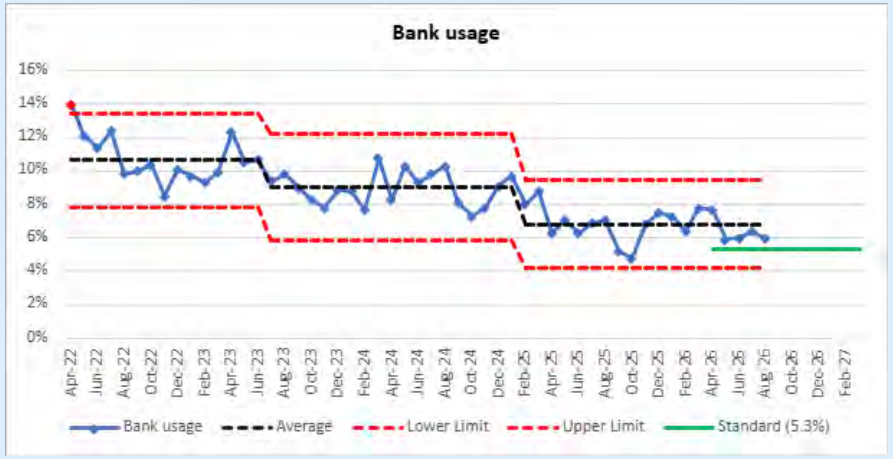
Sherwood Forest Hospitals NHS Foundation Trust

Observations

The Aug-26 bank usage position was 6% and sits outside the new standard (5.3%). This shows a marginally improved position from Jul-26, where a level of 6.4% was reported. The current position is better than the previous Aug-25 period (6.3%). Performance has been between the average and lower control limit for the last four months.

The latest benchmarked position shows that the Trust sits within the seventh decile nationally. It is noted that this is Feb-26 position, when the Trust bank usage level was at 6.4% and was adversely impacted by winter pressures and sustained escalation pressures.

Local Data (to Aug-26)



Root Causes

- Reliance on bank to fill rota gaps and escalated rates where substantive recruitment has lagged or where services are under-established.
- Increased activity levels and service models (e.g. 7-day services, clinic changes) driving short-term workforce requirements.

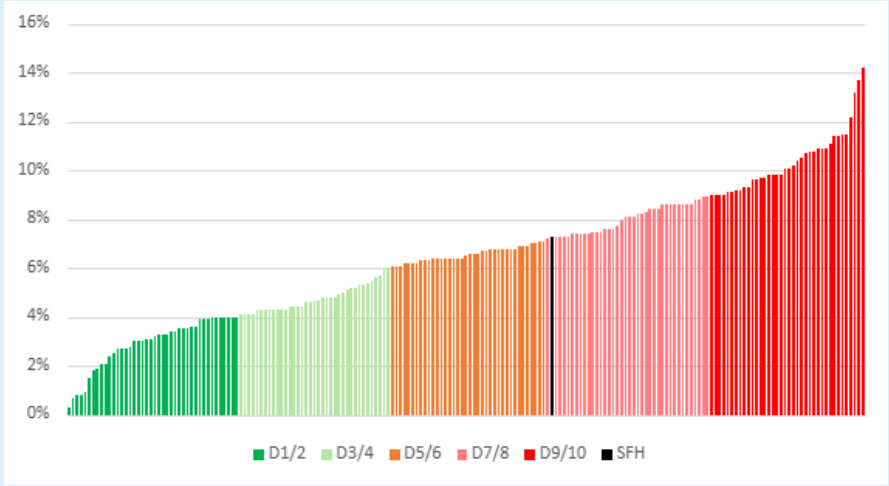
Actions and Timescale

- Deliver exemplar rostering and improve e-rostering utilisation.
- Increase job plan compliance (targeting near-full compliance).
- Strengthen approval processes for bank usage (daily/weekly review).

Impact

Target to reduce the bank level to 5.3%.

Benchmark Position (Feb-26)



Indicator in Focus: Agency Usage

Sherwood Forest Hospitals NHS Foundation Trust

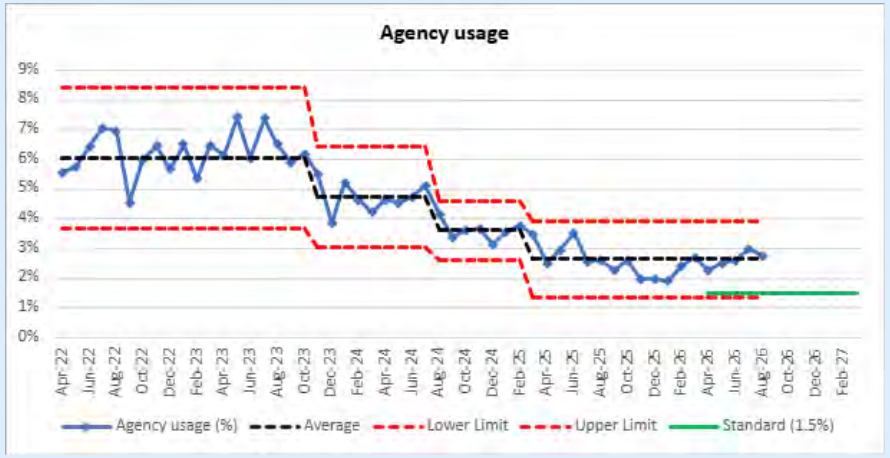
Observations

The Aug-26 agency position is reported at 2.8% and sits outside the standard (1.5%). The position shows a worsening position over the quarter, moving within the statistical process control limits. The current position sits above the previous Aug-25 period (2.6%).

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

The latest benchmarked position from Feb-26 shows that the Trust sits within the ninth decile nationally.

Local Data (to Aug-26)



Root Causes

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

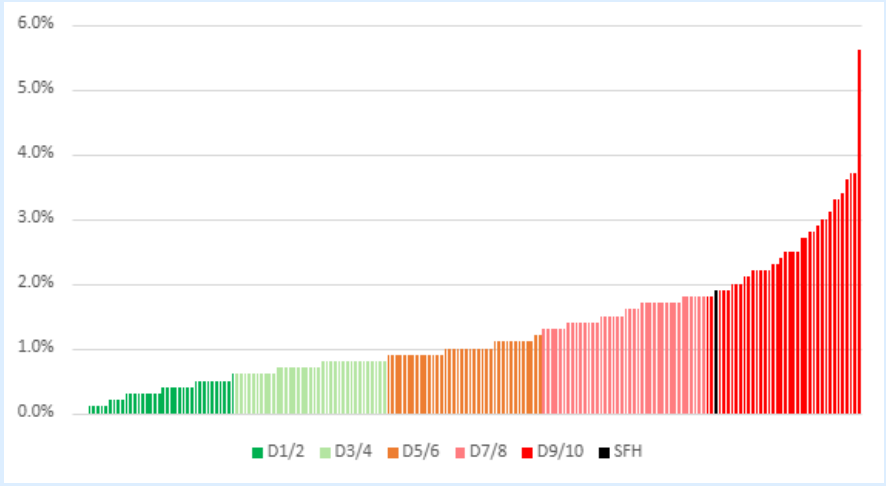
Actions and Timescale

There are ambitious agency reduction plans over 2026/27 that are aligned to the NHS England target. Our clinical divisions are focusing on the development of plans. We are engaging with Kendall Bluck Consultancy to support our overall reduction.

Impact

Target to reduce the agency level to 1.5%.

Benchmark Position (Feb-26)



Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Timely Care

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

Urgent and Emergency Care (UEC) performance remained challenged during the latest reported period of Jul-26 and Aug-26. This reflected a combination of factors, including the prolonged operational impact of the Nervecentre (NC) Electronic Patient Record (ERP) deployment within the Emergency Department (ED), increasing numbers of medically safe patients awaiting discharge, and exceptionally high non-elective attendances during Jul-26, particularly across type 1 and Newark type 3 services. These pressures significantly affected patient flow and contributed to us declaring business continuity incidents in Aug-26 and Sep-26. The impact of the NC implementation was greater and more sustained than anticipated, particularly in relation to system validation, interfaces and adoption. Learning from the implementation is being captured and will inform future EPR module deployments. The flow pressures also contribute to crowding which can result in corridor care. We began national reporting of the corridor care metric in Aug-26.

Despite these pressures, performance has shown encouraging signs of recovery following implementation of our improvement plan and associated remedial actions. Aug-26 delivered the strongest ED four-hour performance since NC went live in Apr-26 and exceeded performance observed in Aug-25. We also saw improvements in 12-hour length of stay and ambulance handover times. Further improvement was seen during the Sep-26 improvement week, where we enacted new processes. Lessons learnt will be collated and recommendations taken via our Emergency Care Steering Group. Hospital flow remains constrained by medically safe patient numbers, now at their highest level for more than two years, with limited availability of Pathway 1 packages of care, a key barrier to timely discharge. At King's Mill Hospital alone, the number of medically safe patients currently equates to approximately three wards of capacity. An internal discharge improvement programme is in place, alongside continued work with system partners to address capacity constraints and improve access to supported discharge.

In terms of planned care, the headline 18-week Referral to Treatment (RTT) performance has triggered a change in the control limits due to improvements observed since Mar-26. However, our position has deteriorated in the last two months and has fallen behind plan at 63.8% in Aug-26. Our 52-week wait backlog has also triggered special cause variation at 1.4% in the last two month which is worse than plan. Contamination issues in our Sterile Service department (CSSD) which caused a business continuity incident in Jul-26 and the asbestos removal programme in the Trauma theatre this summer have further impacted RTT performance. Positively, we have actions in place to recover performance, the impact of which is anticipated to be realised from Sep-26.

Our diagnostic DM01 position has improved significantly since the dip observed in Apr-26, and we have now achieved plan in the last two months. This recovery has been driven primarily by Ultrasound, which dipped following a significant increase in referrals, where we introduced outsourcing to increase activity and recover their position. Overall, we continue to increase Community Diagnostic Centre (CDC) activity and progressed in Jun-26 and Jul-26 to be above our NHS England agreed activity plan. We were 2% behind the CDC activity plan in Aug-26; however, above our income plan due to case mix.

Cancer 28-day faster diagnosis performance continues to perform strongly and within normal variation, while our cancer 31-day performance remains above plan despite the seasonally observed dip in performance relating to deterioration in the Skin tumour site. Cancer 62-day performance has improved to above 70% for the last two reported months, the first time since Apr-24 that this has happened, though we remain below plan. Our 62-day backlog deteriorated significantly during the summer holiday to a more severe degree than seen previously. We are committed to reducing this again, while acknowledging that the high backlog presents an elevated risk to 62-day performance over the coming months.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Timely Care

At a Glance	Indicator	Jul-26	Aug-26		Standard (Aug-26)	Benchmark (Jun-26)	STAR Data Quality
Urgent Care	Average ambulance handover time (mins)	24	24		≤19	4 / 15	
	Percentage of ambulance handovers within 15 minutes	25.9%	27.4%		≥73.5%	125 / 174	
	Percentage of ambulance handovers within 45 minutes	91.1%	91.4%		100%	5 / 15	
	ED 4-hour performance	71.2%	71.5%		≥83.3%	128 / 140	
	ED 12-hour length of stay performance	4.7%	5.7%		≤1.1%	83 / 177	
	ED 24-hour length of stay performance	0.3%	0.3%		0%		
	Number of ED patients cared for in corridors for over 45 minutes	-	824		0		
	Adult G&A bed occupancy	96.1%	96.5%		≤97.1%	80 /177	
	Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base	86	99		≤40		
	Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base	2,653	3,058		≤1240		
Electives	Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment	64.0%	63.8%		≥65.9%	94 / 148	
	Percentage of RTT waits over 52 weeks for incomplete pathways	1.4%	1.4%		≤1.0%	88 / 148	
Diagnostics	Diagnostic DM01 performance under 6-weeks	92.5%	92.1%		≥92.0%	39 / 135	
Cancer	Cancer 28-day faster diagnosis standard	81.6%	-		≥80.7%	47 / 130	
	Cancer 31-day treatment performance	90.8%	-		≥91.3%	69 / 130	
	Cancer 62-day treatment performance	70.4%	-		≥77.0%	76 / 134	

Summary Icon Key

Variation		Common cause - no significant change
		Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
		Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
Assurance		Variation indicates inconsistently hitting passing and falling short of the target
		Variation indicates consistently (P)assing the target
		Variation indicates consistently (F)alling short of the target

Benchmark Key

- Best performing 40%
- Middle performing 20%
- Worst performing 40%

STAR Data Quality Key

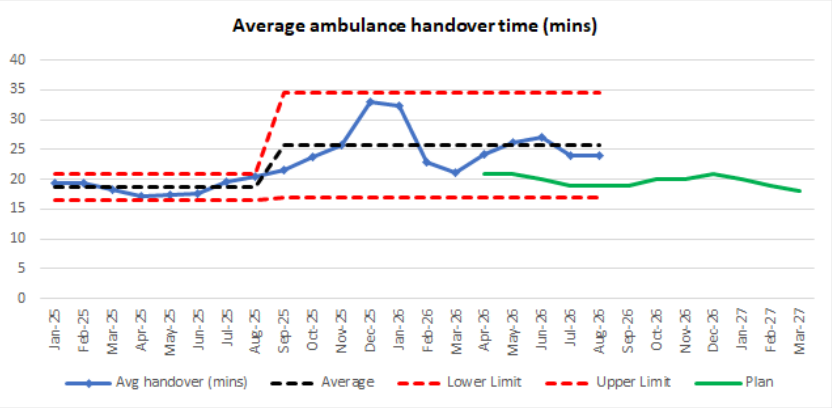
Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

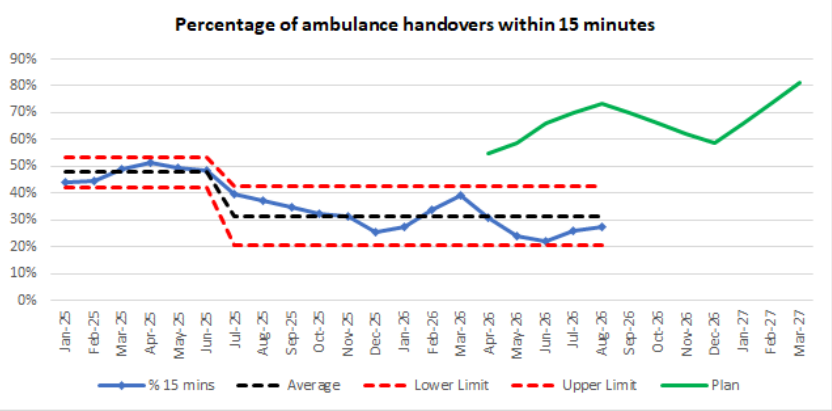
- Substantial assurance
- Limited assurance
- No assurance

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

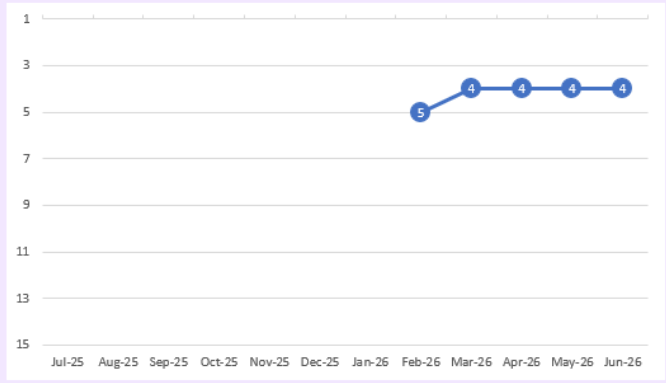
Sherwood Forest Hospitals NHS Foundation Trust

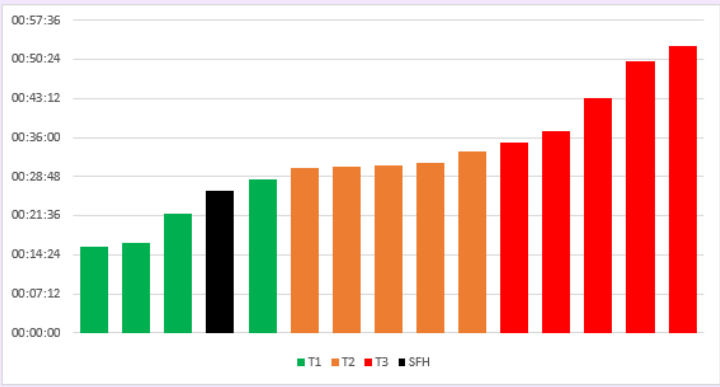
Local data (to Aug-26)

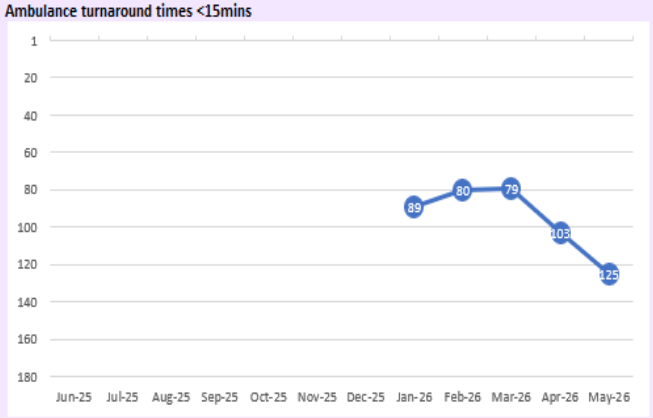


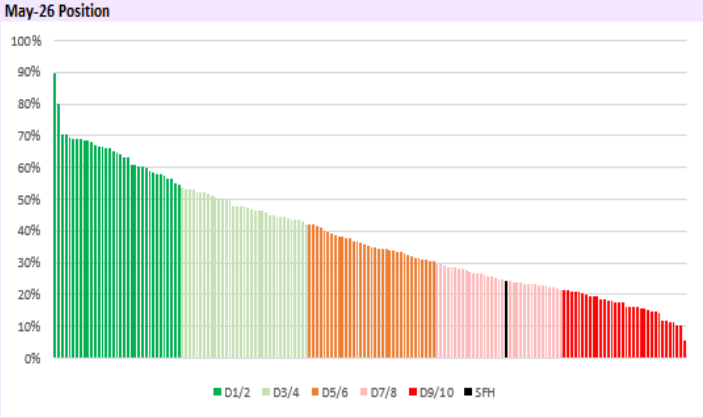


Benchmark position





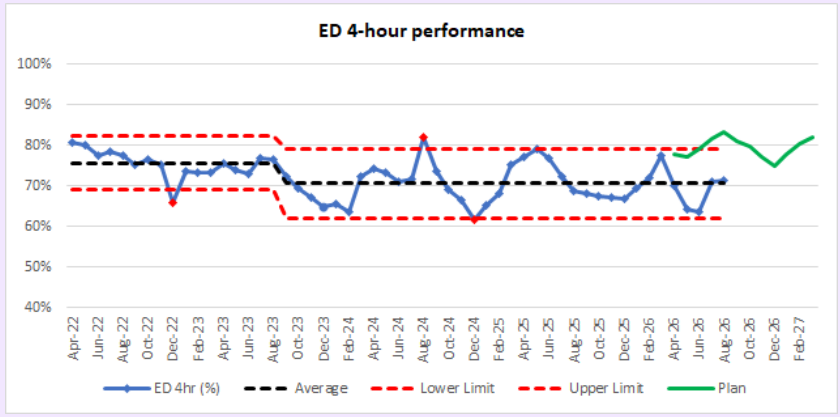


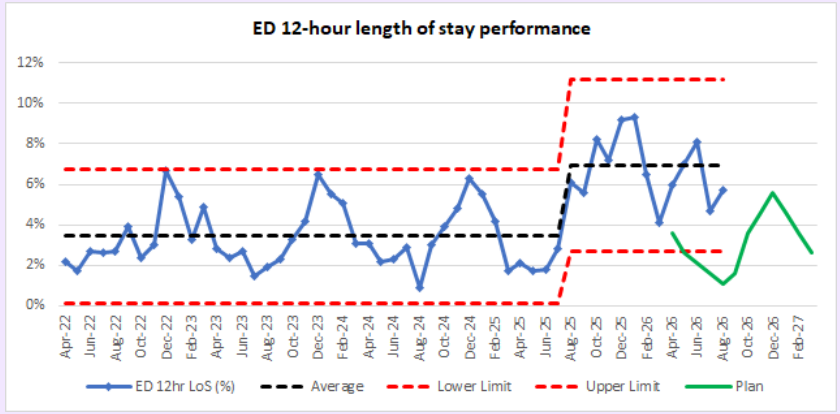


Indicators in Focus: Urgent Care – A&E (2/4)

Sherwood Forest Hospitals NHS Foundation Trust

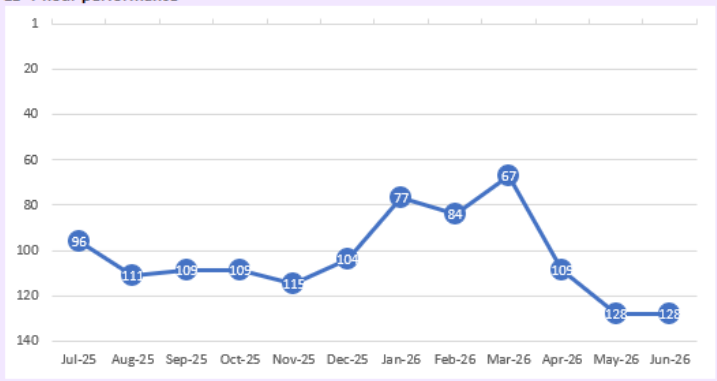
Local data (to Aug-26)



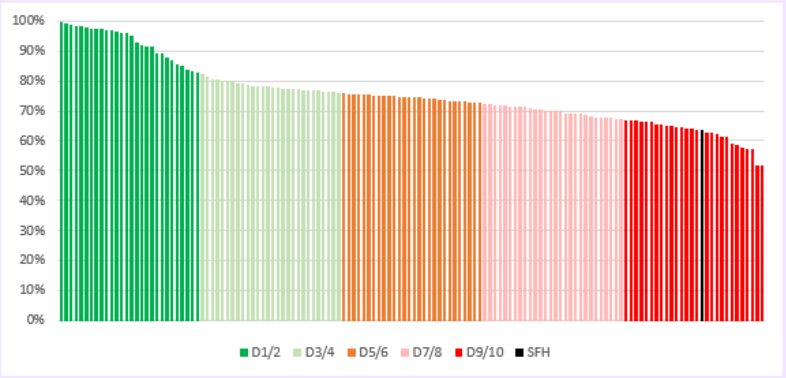


Benchmark position

ED 4-hour performance



Jun-26 Position



ED 12-hour length of stay performance

May-26 Position

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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

During the latest reporting period of Jul-26 and Aug-26, performance across several key Urgent and Emergency Care (UEC) metrics improved, although performance remains below both operational plan and the standards the Trust aspires to achieve.

Four-hour Emergency Department (ED) performance has recovered significantly after we experienced deteriorating performance following the deployment of Nervecentre in ED. In Jul-26 and Aug-26 we achieved circa 71% after falling into the mid-60% range immediately post-implementation. While this positions the Trust in the upper-middle quartile nationally, performance remains below plan. Improvements have also been seen in ED long waits, with reductions in both 12-hour and 24-hour length of stay. The proportion of patients experiencing a 24-hour ED stay reduced to 0.3% during the reporting period; however, this remains above the national expectation of zero.

The operational impact of the Nervecentre deployment was greater and more prolonged than anticipated, reflecting challenges associated with data validation, system interfaces and user adoption. Lessons learned from this implementation are being incorporated into future Electronic Patient Record (EPR) module deployments.

The Trust has commenced external reporting corridor care, recording 825 instances in Aug-26 for patients spending greater than 45 minutes in unconventional spaces. This is significantly above the expected standard of zero and is an area of concern. Current performance places the Trust in the lower-middle range nationally.

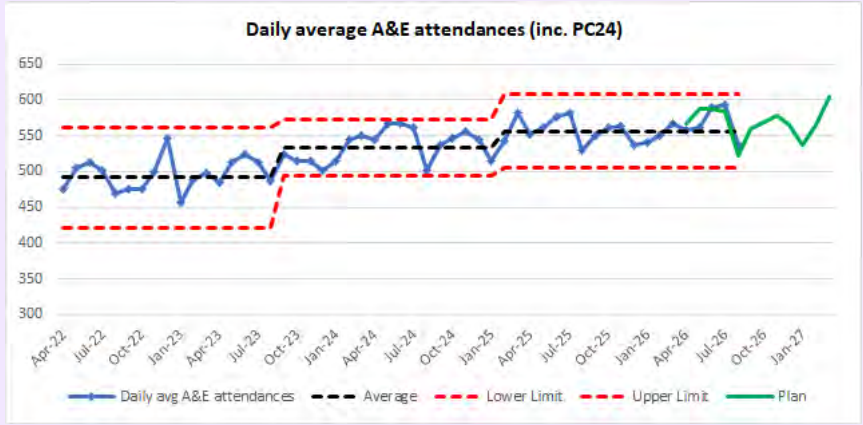
Patient demand remained exceptionally high throughout the reporting period. Jul-26 saw record attendance levels, averaging almost 600 patients per day. Although attendances reduced in August, consistent with seasonal patterns during school holidays, activity remained above historic August levels. Compared with the same period in 2025, type 1 attendances increased by 2% and Newark Type 3 attendances increased by approximately 6%, while activity within the Nottingham Emergency Medical Services (NEMS) Primary Care 24 service reduced by around 8%.

Ambulance handover performance also improved over the two-month reporting period, with average handover times reducing to approximately 24 minutes. Although this remains above plan, the Trust continues to perform favourably compared with regional peers for both average clinical handover times and the proportion of handovers completed within 45 minutes.

While performance remains below planned levels across several key UEC metrics, the improvements seen during the last two months demonstrate recovery following the Nervecentre implementation and provide a stronger foundation for further improvement through the second half of the year. In September, an improvement week took place across UEC pathway; learnings will be taken forward.

We have improvement initiatives in place across our UEC pathways with headline actions described in the subsequent pages.

Additional data (to Aug-26)



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

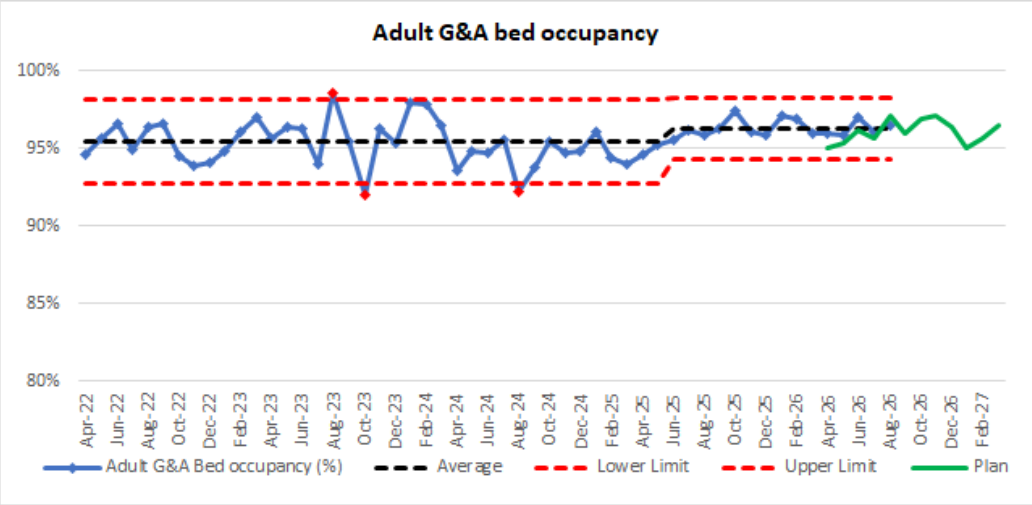
NHS Sherwood Forest Hospitals NHS Foundation Trust

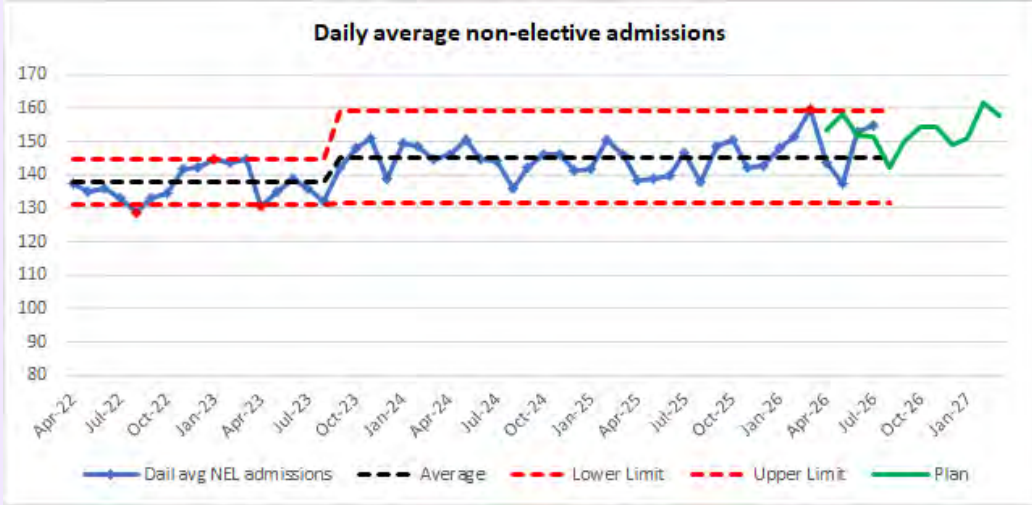
Root causes	Actions and timescale	Impact
High ED attendance demand, acuity and ambulance conveyance, including patients who could be managed through alternatives to ED.	• System demand avoidance: EMAS engaged on out-of-area conveyances; frailty "call before convey"; urgent community response; redirection to Urgent Treatment Centre (UTC) / PC24; NEMS interceptor pilot (complete and awaiting feedback); direct routing to Same Day Emergency Care (SDEC) where clinically appropriate. Improvement week took place week commencing 14-Sep to trial extended SDEC offering across Frailty / Gynaecology and Paediatrics.	• Fewer avoidable ED attendances and conveyances; more patients treated in type 3 / SDEC pathways; sustained UTC and PC24 performance above 95%.
	• Command, control and escalation workstream (including establishment of smaller working groups across ED 'time capsule' elements, and the programme for delivery of the new ED build is being developed through a dedicated working group. Programmes underway. Two hourly huddles between Consultant and Nurse in charge from 8am to 2am with extended Consultant hours until 2am.	• Increase the number of patients cared for in ambulatory pathways and via alternatives to ED.
Post-Nervecentre workflow instability, timestamp variation and validation burden affecting operational visibility and confidence in reported four-hour performance.	• Daily validation of breaches and missing departure / outcome times; timestamp definition review; configuration fixes; ED dashboard redevelopment; staff process guide, focused user support, supplier escalation and peer review. • All digital actions have now been completed to support recovery post-deployment.	• Improved data quality and transparent reporting; quicker identification of patients approaching four hours; reduced validation backlog and clearer operational focus.
A&E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Additional bed spaces created across our medical base wards over winter by installing additional curtain rails. These spaces are used during periods of local escalation to allow our wards to accommodate more patients earlier in the day to help improve hospital flow. Ongoing action deployed in line with our Managing Patient Flow Policy.	• Reduced ED crowding and 12-hour length of stay; fewer patients waiting in escalation areas; improved patient safety, experience and progress toward four-hour recovery.
	• Expand / optimise ambulatory pathways Clinical Decisions Unit (CDU) within ED footprint; reinforce specialty ownership and urgent review standards; use escalation bed spaces; maintain discharge focus and align admission / discharge demand. Trial of Zonal Nursing from 14-Sep to improve time to treatments and reduce non-admitted length of stay in Majors.	
Variable front-door grip, streaming and deployment, with delays to plans, disposition and use of ambulatory areas.	• Standardise and consistently implement the front-door operating model, ensuring senior clinical grip, effective streaming and dynamic workforce deployment throughout the day. Introduce regular operational reviews to identify and escalate delays in assessment, care planning and disposition, while maximising appropriate use of SDEC, CDU, frailty and other ambulatory pathways to reduce waits, crowding and avoidable admissions.	• Earlier clinical plans, faster decisions and fewer avoidable non-admitted breaches; improved mean time in department and better use of CDU capacity before four-hours.

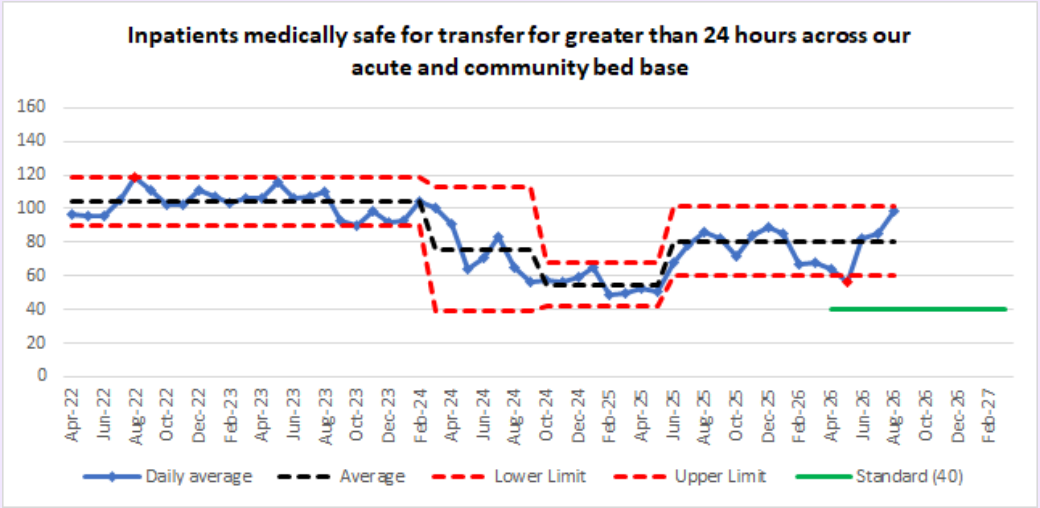
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

Data (to Aug-26)







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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

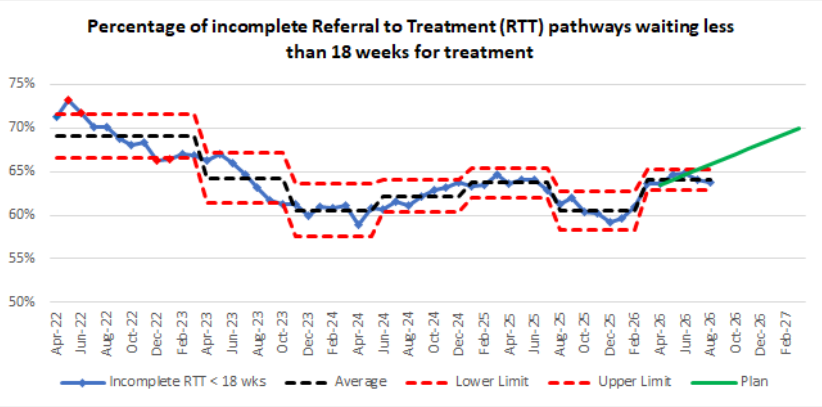
- General and Acute (G&A) bed occupancy was just over 96% for the last two months; during the year-to-date bed occupancy has generally been higher than our plan. We have had 22 more beds open across the Trust than we did during the same period last year and in Jul-26 we had on average three more non-elective admissions per day than our plan.
- The number of inpatients medically safe for transfer for greater than 24 hours have increased further during the last two months, rising to the highest levels since Apr-24 at 101 patients on average in Aug-26 (the equivalent of four acute inpatient wards). Package of Care availability has been a key constraint in recent weeks/months.

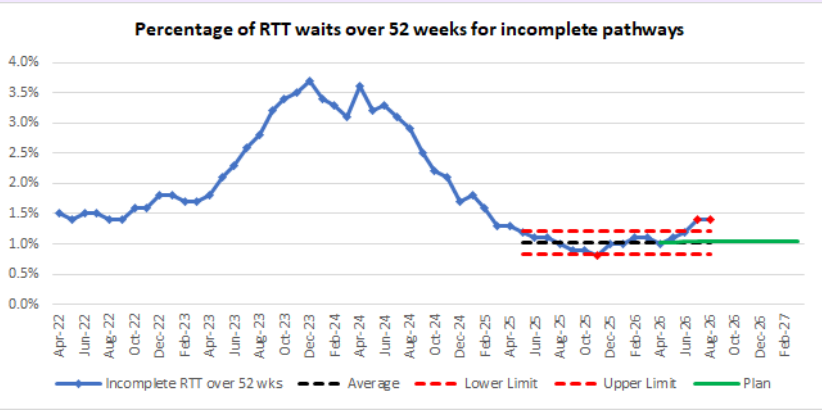
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards (flow through our hospitals).	• The ongoing 'Getting the Basics Right' programme championed by the Chief Operating Officer and Chief Medical Officer. Focus on effective board rounds, ward processes and weekend discharges to reduce delays and improve patient length of stay. Focus to date has been on Medicine Division wards; from Oct-26 we will commence work with Surgery Division wards. 360 assurance are in the process of completing board round audit to identify further improvement opportunities.	• Reduced delays and improved patient length of stay across all discharge pathways.
	• Weekday discharge targets remain in place and working well. There is increased focus on achieving weekend discharge targets through changing ward culture and practices.	
	• Progressing with the implementation of Optica platform to better manage flow for patients requiring discharge planning. Working toward a launch date in Oct-26.	
	• In line with national discharge sprint in Sep-26, we are increasing focus on all medically safe patients with daily scrutiny to identify early discharge opportunities.	
Delays to post-medically safe discharge processes (flow out of our hospitals).	• The Discharge Improvement Group, including internal colleagues and system partners, is focussing on all key areas of delayed discharge. At present, focus is on Package of Care waiters, TTO delays and planning and placements for fast-track patients. This focus is to be sustained over the next 12-months with fortnightly updates provided in our Integrated Remedial Action plan. Transport booking training is now complete. Early review of trusted assessor has shown it to work well and is now being extended to a wider cohort of patients.	• Improve length of stay (LOS) for complex discharges across our hospitals. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges.
	• A cost-neutral new flow and transfer team trial, which is operated from the flow room, and is managing bed bookings and the physical movement of patients through and out of the organisation, has been extended past the initial Aug-26 finish date. Feedback has been positive, and the flow aspect has been a success. We are considering how to eliminate the need to use a full transfer team through adjusting the usage of the portering system.	• Swifter bed bookings and patient movements from EAU to base ward, and base ward to Discharge Lounge.
Insufficient community capacity to meet supported discharge demand.	• There continues to be a significant shortage of Packages of Care across Nottinghamshire. SFH have implemented three-times weekly meetings with system partners to focus on delays and identify new ways of working to reduce demand and expedite discharge. New processes include review of Therapy ways of working to maximise capacity.	• Reduce the number of bed days lost due to patients with no criteria to reside.

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

Sherwood Forest Hospitals NHS Foundation Trust

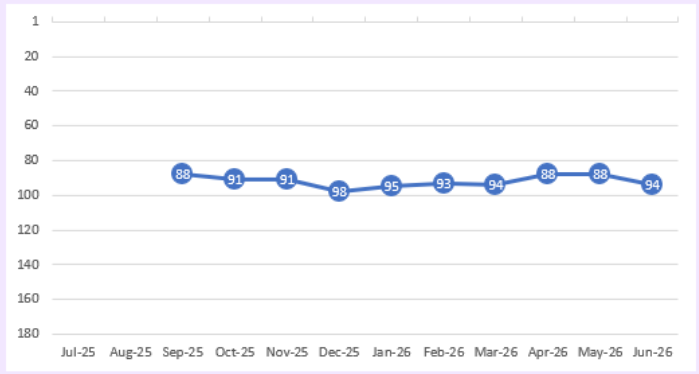
Local data (to Aug-26)



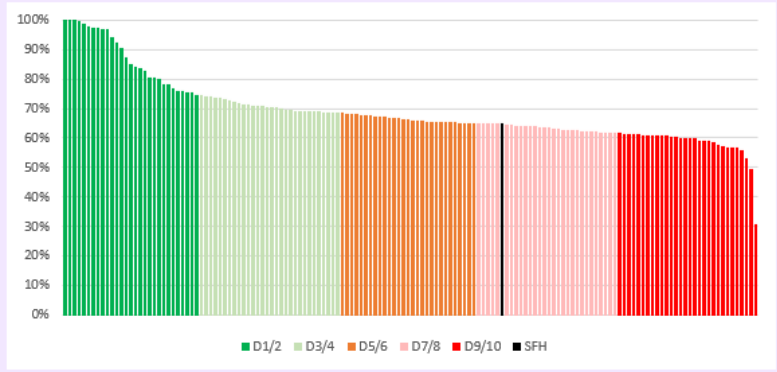


Benchmark position (to Jun-26)

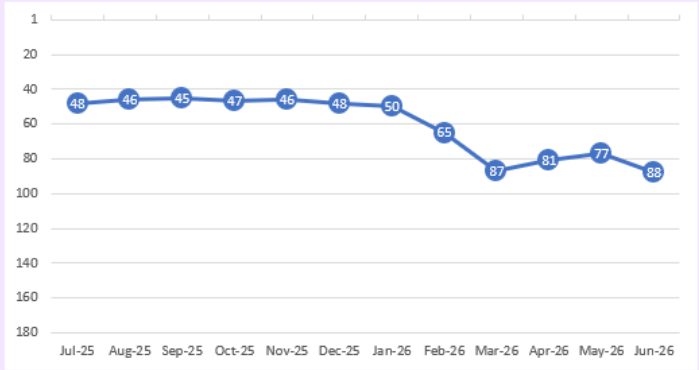
Elective RTT 18-Week Performance



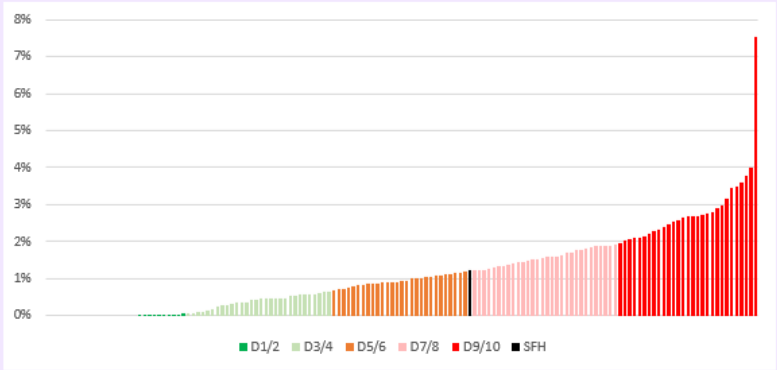
Jun-26 Position



Incomplete RTT pathways +52 weeks



Jun-26 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

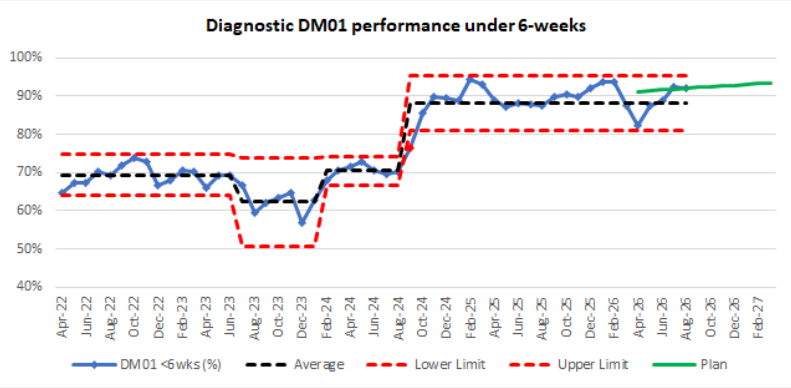
- Referral to Treatment (RTT) 18-week has triggered a change in the control limits due to improved performance since Mar-26, though our position has deteriorated over the last two months to 63.8% in Aug-26. This has been adversely impacted by contamination issues in CSSD and an asbestos removal programme requiring the closure of the trauma theatre. Performance was worse than our operational plan. Latest national benchmarking data places us in the seventh decile as a stable position.
- 52-week wait pathways was at 1.4% of the total Patient Tracking List (PTL) in Jul-26 and Aug-26 triggering as special cause variation. Our 52-week wait benchmark position put us in the sixth decile nationally.

Root causes	Actions and timescale	Impact
Insufficient anaesthetic capacity (deficit of seven Consultant vacancies) increasing the risk of list cancellation due to insufficient staffing cover.	• Strategy for anaesthetic staffing levels and recruitment plan in place for four Whole Time Equivalent (WTE) Consultant vacancies including: – Two appointments made from Jul-26 interviews (following no appointments in Mar-26). Start dates to be confirmed following ongoing recruitment processes. Further interviews planned in 2026/27 quarter three. – Interim escalated rates in place for Consultants extended to Sep-26.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations. • Sufficient and sustainable workforce.
Insufficient baseline capacity to reduce RTT backlogs and 52-week wait backlogs.	• New elective recovery and above plan schemes to improve year-end RTT position currently in the implementation phase, with impacts forecast from Sep-26 onwards.	• Improve Trust performance against first appointment trajectory. • Impact the Trust long wait position. • Reduce the number of patients waiting >18 weeks for treatment. • Reduction in 52-week waits.
	• GIRFT Further Faster speciality action plans for phased delivery throughout 2026/27.	
	• GIRFT clinic template restructure to increase new capacity underway with 14 specialties completed to date. All specialties are expected to be completed by end of Nov-26.	
	• Theatre template review underway with remit to generate more equitable distribution of resource based on waits and estate usage efficiency.	
Administrative capacity to deliver typing turnaround targets.	• Implementation of Artificial Intelligence (AI) solution for clinical correspondence in 2026/27 quarter three.	• Improve typing turnaround and patient experience.
PTL data quality and ability to sustain a 'clean' PTL and management of all failsafe reports due to insufficient validation resource.	• Federated Data Platform (FDP) to support validation and developments to manage patient pathways fully operational by end of Jun-26 as planned. Review and refinement of system functionality and standard operating procedure through 2026/27 quarter two based on user feedback following go-live.	• 'Clean' PTL. • Timely management of patient pathways and oversight of actions.
Insufficient live monitoring and historical performance reporting mechanisms.	• Operational oversight of clinic and theatre session and in-session utilisation being developed and explored within the FDP. Command centre tools being rolled out in theatres and demonstrated in outpatients by end of 2026/27 quarter three.	• More effective operational management and live arrangement of resource. • Increased oversight of resource utilisation.

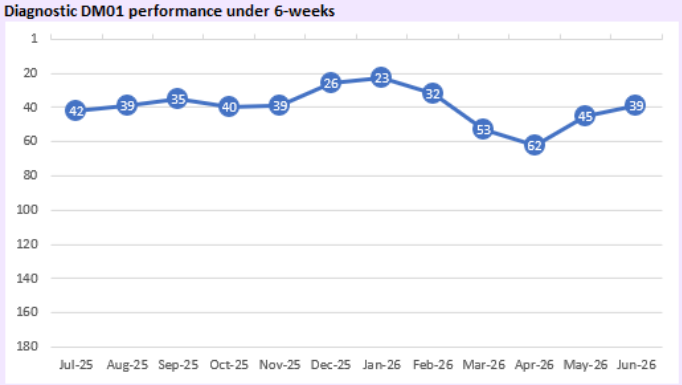
Indicators in Focus: Diagnostics

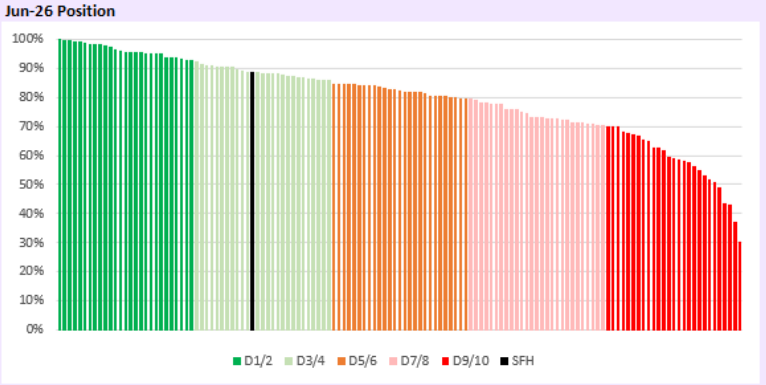
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Aug-26)



Benchmark position (to Jun-26)





Performance observations

- Our diagnostic DM01 performance improved in the last two months. We are now achieving plan, recovering from a variance to plan of circa 9% in Apr-26. Performance remains between the control limits of the statistical process chart. This performance improvement is reflected in our benchmarking position, where we have improved and risen into the third decile nationally.
- Our improvements in DM01 performance are being largely driven by recovery in our Ultrasound service, which saw a significant increase in referral demand that was identified and corrected as part of joint-working with system partners. We have also seen some challenges in DEXA.
- Echocardiography remains in a strong position, following the delivery of their recovery plans after their performance challenges in early to mid 2025/26.
- We continue to increase Community Diagnostic Centre (CDC) activity and expect that this will enable us to further drive improvements in DM01 performance and enable better access to care for patients.

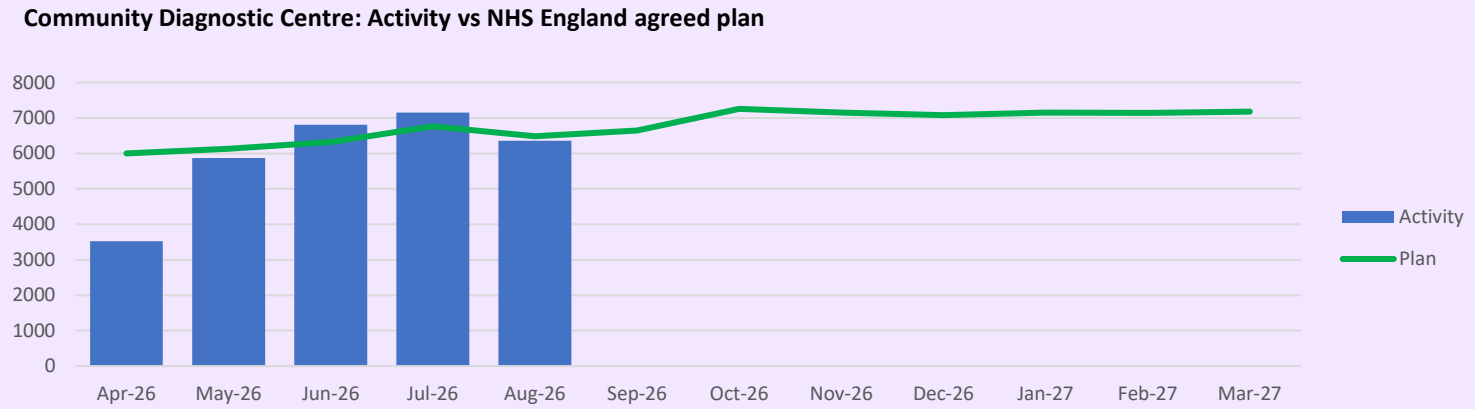
Community Diagnostic Centre (CDC)

Sherwood Forest Hospitals NHS Foundation Trust

Performance Observations

- Following the opening of the CDC in Apr-26, activity has increased monthly and exceeded plan in Jun-26 and Jul-26. We were 2% behind plan from an activity perspective in Aug-26, although income was above plan in Aug-26 due to the case mix.
- Cardiology ambulatory and Phlebotomy are behind plan which are partially offset by over-delivery in Respiratory and Endoscopy.

Activity vs Plan



Actions and timescale

Fibroscan to go live in 2026/27 quarter three. Delayed due to new equipment compatibility and training.

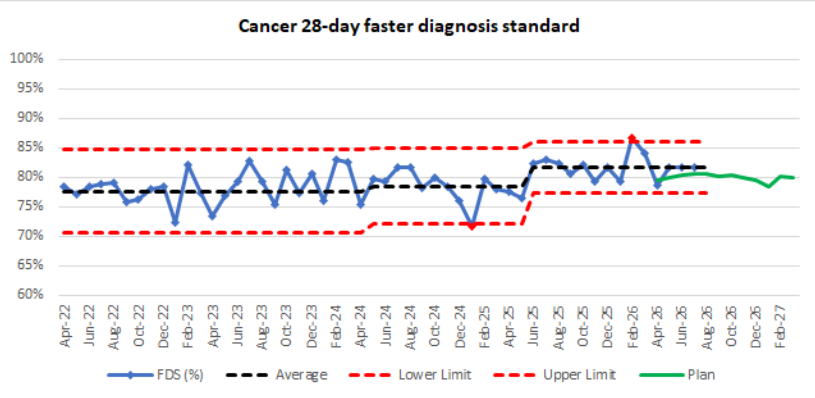
CT are introducing seven day working to become fully operational by end of 2026/27 quarter three, subject to recruitment and training.

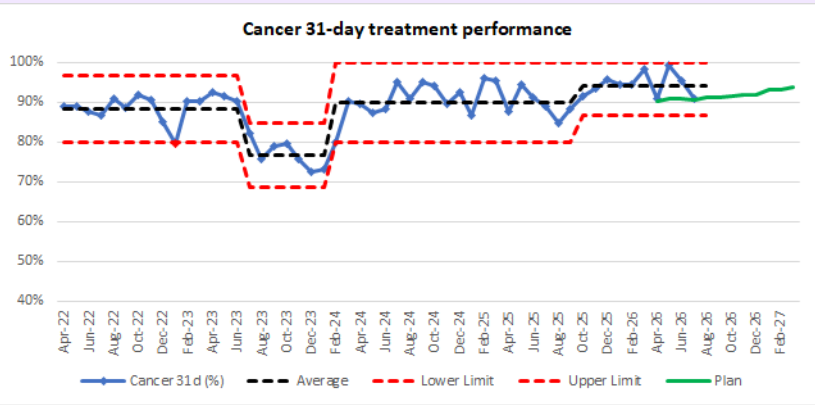
Phlebotomy have agreed with the Integrated Care Board (ICB) to cease King's Mill Hospital walk-in capacity and redirect to the CDC (specialist bloods excluded). This will commence at the end of 2026/27 quarter three. Ongoing review of walk-in and bookable capacity to maximise utilisation.

Indicators in Focus: Cancer (1/3)

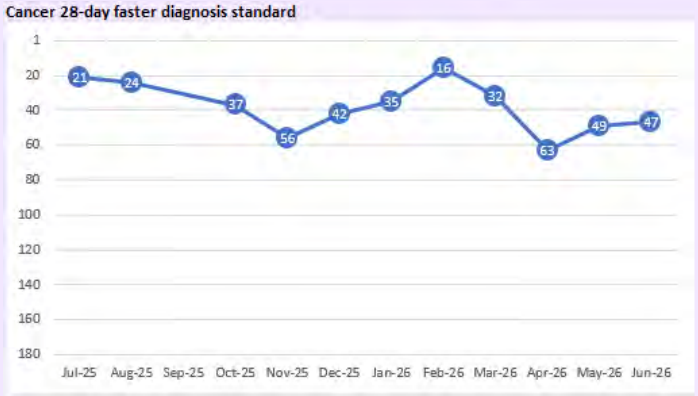
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

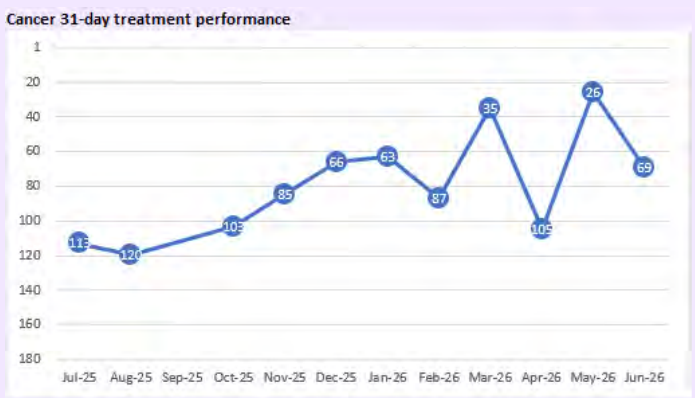
Local data (to Jul-26)

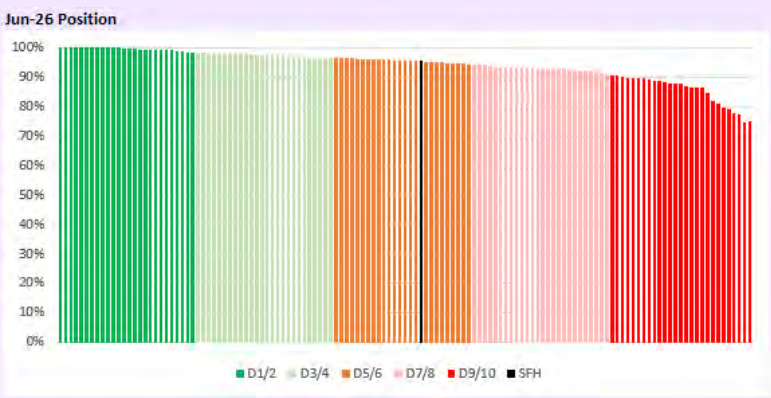




Benchmark position (to Jun-26)



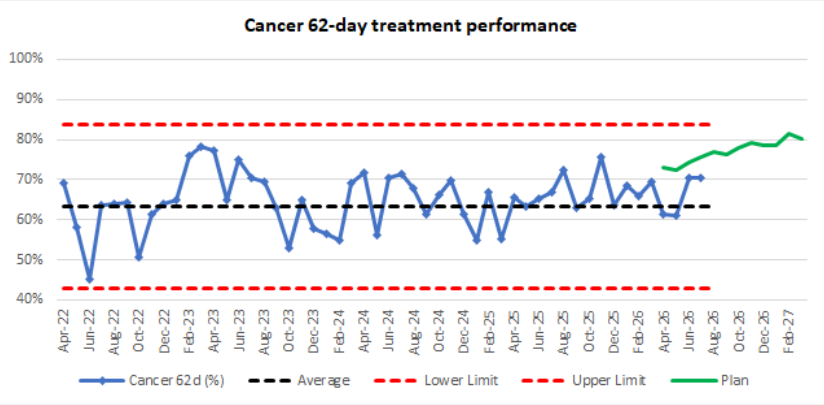




Indicators in Focus: Cancer (2/3)

Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Jul-26)



Benchmark position (to Jun-26)

Performance observations

- Cancer 28-day Faster Diagnosis Standard (FDS) continues to deliver above plan, closing at 81.6% for Jul-26. Our operational plan is set to deliver 80% on average during 2026/27. Our benchmarking position is currently in the fourth decile.
- Cancer 31-day treatment performance (first treatment) has deteriorated over the latest reporting period and closed at 90.8% for Jul-26. We have been better than operational plan throughout 2026/27. Deterioration through the summer is typically observed due to pressures in our Skin tumour site. Our benchmarking position deteriorated into decile six in Jun-26.
- Cancer 62-day treatment performance was 70.4% in Jul-26; this is our best position since Nov-25 but remains below our operational plan. The operational plan requires improvement to 80% by the end of 2026/27 as part of the national ambition. Our improved Jun-26 performance resulted in our benchmarking position rising into the sixth decile.

Indicators in Focus: Cancer (3/3)

Root causes	Actions and timescale	Impact
Insufficient capacity to meet Radiology reporting turnaround targets and specialist capacity.	• Recruitment to four Whole Time Equivalent (WTE) Consultant Radiologists for 2026/27. Recruitment process underway for the remaining three WTE commenced in Aug-26. • East Midlands Cancer Alliance (EMCA) funding additional sessions and increased outsourcing for reporting throughout 2026/27.	• Improve Radiology reporting turnaround.
Insufficient Histopathology capacity to deliver the 10-day turnaround standard of 98% across multiple tumour sites.	• Job planning to move from 5-day to 7-day reporting from Jan-27. • Estate work to create extra dissection capacity, timescales are awaiting confirmation from estates. • Use of agency to support specialist microtomy turnaround is ongoing. • Joint working with NUH is underway to ensure Nottingham and Nottinghamshire-wide solutions.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
Best Practice Timed Pathway (BPTP) guidance identifying opportunity to reduce pathway delays.	• Implementation of one-stop models, including the expansion of the Gynaecology see and treat capacity and a Haematuria pathway for Bladder Cancer in 2026/27 quarter three. • Implement a community-based Breast Pain pathway and explore self-referral pathways through NHS 111 in 2026/27 quarter three. • Cancer 360 implemented fully in 2026/27 quarter one. Through further development, this will provide the ability to track patients against BPTP in real time rather than retrospectively.	• Improved 28, 31 and 62-day performance. • Increased number of patients first seen within 7 days. • Reduced backlog.
Delays in patient pathways following MDT or delays to MDT due to volumes of patients being discussed.	• Implementation of approved clinical guidelines (Standards of Care) to be reviewed and implemented following East Midlands Cancer Alliance Clinical Expert Advisory Group development in 2026/27 quarter three. • Implementation of a Triage MDT for timely clinical decision making where a full MDT discussion is not required for completion by end of 2026/27 quarter three.	• Increase timeliness of clinical decision making to improve 62-day performance. • Improved patient experience. • Lung triage Multi Disciplinary Team (MDT) live reducing full MDT by circa 5-10 patients per week.
Manual administrative processes relied upon to ensure patients are upgraded to the cancer pathway following diagnostic test.	• Development of Infoflex, the cancer tracking system, to implement an automatic upgrade of patients to a cancer pathway where a diagnostic test shows suspicion of cancer by Oct-26.	• Release Cancer pathway tracking team capacity to progress patients along cancer pathways, improving 28-day FDS, 31-day and 62-day performance metrics

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Best Value Care

Outstanding Care,
Compassionate People,
Healthier Communities

Domain Summary: Best Value Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead: Chief Financial Officer

The financial plan for 2026/27 is break-even. The Trust has reported an in-month surplus position of £0.8m in Aug-26; this was £0.6m ahead of the £0.2m surplus plan with the inclusion of the impact of International Financial Reporting Standard 16 (IFRS16) on the Private Financial Initiative (PFI). Year-to-date position is a deficit of £9.7m, which is £6.3m behind the deficit plan of £3.4m. The reason for the year-to-date position being behind plan is due to several factors; these include Industrial Action in Apr-26, shortfalls in the delivery of our Financial Improvement Programme, patient demand and flow pressures, a shortfall on interest receivable and bank and agency expenditure being higher than our plan.

We are forecasting a break-even position to NHS England in line with the planning submission for 2026/27. A recovery plan was submitted to NHS England in Aug-26 on how we can achieve this.

The annual Financial Improvement Programme (FIP) target is £34.9m in 2026/27. Aug-26 saw an in-month delivery of £1.9m against an in-month plan of £3.1m, giving a shortfall of £1.2m. Year to date delivery is £8.9m against a plan of £13.1m, giving a shortfall of £4.2m.

Capital expenditure in-month was £1.36m against a plan of £1.46m. The variance relates to the rollout of the Electronic Patient Record system (EPR) in our Emergency Department, which has been phased in twelfths across the year. The full-year plan including PFI lifecycle is £22.01m.

Closing cash on 31 Aug-26 was £1.05m; a decrease of £1.57m in-month and £15.02m year-to-date. The large opening cash balance was due to the receipt of capital funding in 2025/26 quarter four, which has unwound as capital creditors were paid in Apr-26. There remains an underlying pressure on available revenue cash resource due to the requirement to deliver significant efficiency savings, and while this can be partly managed by extending creditors, working capital borrowing requests are being submitted.

The Trust's agency expenditure in Aug-26 was £0.9m against a plan of £0.5m, which is £0.4m over the limit; this is £1.8m over plan year-to-date. We have now used 76% of our agency cap. The largest proportion of our agency spend is on medical pay. Total agency expenditure as a proportion of our total pay spend is 2.6%.

The Trust's bank expenditure in Aug-26 was £1.9m against a plan of £1.5m, which is £0.3m over the limit; this is £1.9m over plan year-to-date. We have now used 53% of our bank cap. Total bank expenditure as a proportion of our total pay spend is 6.4%.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Best Value Care

At a Glance	Indicator	Jul-26	Aug-26		Standard (Aug-26)	STAR Data Quality
Financial Performance	Financial surplus / deficit	-£2.57	£0.84	F	≥0.21	STAR
	Variance YTD to financial plan	-£2.65	£0.62	F	≥£0.00m	STAR
Efficiency	Financial efficiency variance YTD to plan	-£0.47	-£1.21	F	≥£0.00m	STAR
	Risk adjusted efficiency forecast to plan (%)	67.0%	75.0%	F	100%	STAR
	Relative cost difference (National Cost Collection Index)	103	103		TBC	STAR
	Implied productivity growth (YTD compared to last year)	-	-		TBC	STAR
Variable Pay	Reported agency expenditure	£0.94	£0.86	H F	≤£0.45	STAR
	Reported bank expenditure	£1.99	£1.86	F	≤£1.53	STAR
	Temporary staffing cost relative band	TBC	TBC		≤6.7%	
Cash & Liquidity	BPPC - Number of bills paid within target (%)	7.1%	16.2%	F	≥95%	STAR
	BPPC - Value of bills paid within target (%)	57.4%	69.1%	F	≥95%	STAR
	Operating expenditure days	1	1	F	≥5	STAR
Capital	Capital expenditure against plan	£0.65	£1.36	P	≤1.46	STAR

Summary Icon Key

Variation		Common cause - no significant change
	H / L	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
	H / L	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
Assurance	?	Variation indicates inconsistently hitting passing and falling short of the target
	P	Variation indicates consistently (P)assing the target
	F	Variation indicates consistently (F)alling short of the target

Benchmark Key

- Best performing 40%
- Middle performing 20%
- Worst performing 40%

STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

- Substantial assurance
- Limited assurance
- No assurance

Indicator in Focus: Financial Performance

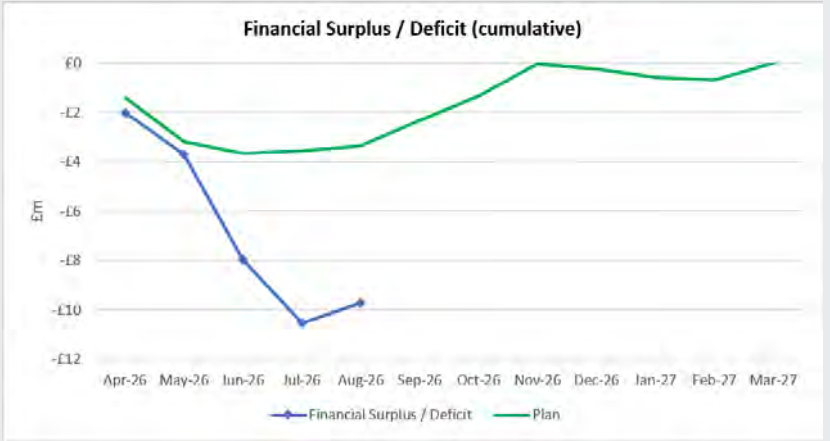
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the Trust financial plan, which is a break-even position for 2026/27.
- The Trust has a £0.8m deficit in Aug-26, which is £0.6m ahead of the planned surplus of £0.2m. The year-to-date position is a deficit of £9.7m, which is £6.3m behind the deficit plan of £3.4m.
- Forecast is currently break-even in line with plan, with a recovery plan submitted to NHS England in Aug-26.

Root Causes	Actions and timescale/areas of risk	Impact
Funding additional capacity.	• Additional capacity costs are being seen within the Trust to safely manage patient flow and operational demand. Whilst these measures have been necessary to maintain patient safety and performance, they are in part driven by constraints within the wider health and care system, particularly the availability of Packages of Care and timeliness of discharge pathways into community health services and social care. As a result, the Trust has incurred additional expenditure of £0.96m year to date associated with maintaining this additional capacity. This represents a contributor to the Trust's deficit position and is a cost pressure that is largely outside of the Trust's direct control, reflecting system-wide capacity constraints rather than operational inefficiency.	Deliver annual plan.
Non-delivery of the Financial Improvement Programme (FIP).	• At Aug-26, the Trust has delivered £8.9m of efficiency year-to-date, which is £4.2m behind the £13.1m plan. The full-year unweighted forecast of £34.9m is being reported to NHS England, with the weighted target being £25.9m, which is £9.0m behind plan. Divisional and corporate areas are continuously working towards this target and identifying opportunities for 2026/27.	
Variable activity plan.	• We need to ensure as a Trust that we maintain the variable elements of our activity to ensure we maintain the level of income associated with this.	
Industrial Action.	• Apr-26 saw six days of Industrial Action. This had a net impact of £0.6m driven by additional pay costs and lost income. We have not received funding to support this pressure.	

Data



Indicator in Focus: Efficiency

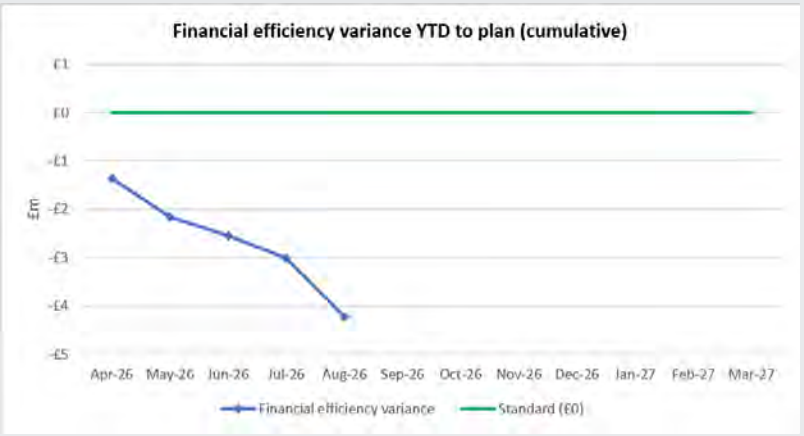
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is delivery of the Trust Financial Improvement Programme (FIP).
- The Trust has a £34.9m efficiency programme for 2026/27, which is currently £4.2m behind plan year-to-date (YTD).
- We are forecasting full delivery of our efficiency programme for 2026/27.

Root causes	Actions and timescale	Impact
Non-delivery of Financial Improvement Programme.	• Monthly Income, Pay and Non-Pay oversight groups have been set up to monitor the delivery of efficiency programmes.	Deliver annual plan.
	• Bi-weekly Divisional Delivery group meetings are in place to focus on progress against divisional FIP targets and focus on key lines of enquiry. These have currently been moved to weekly.	
	• Increased workforce controls that were established in 2025/26 are continuing. This includes a Vacancy Control Panel.	
	• Finance Recovery Cabinet (FRC) governance framework in place for 2026/27 with divisions and corporate progressing with efficiency ideas and their development for 2026/27.	
	• Enhanced oversight and grip strengthened further to support delivery within the financial year.	
Risk adjusted forecast.	• Currently, the weighted target at Aug-26 is £25.9m, which is 74% of the target. This value is expected to significantly increase as efficiency schemes progress to being implemented and in delivery.	

Data



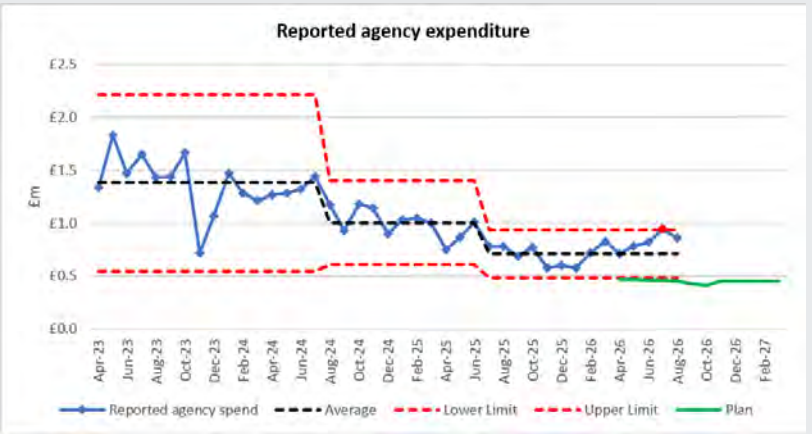
Indicator in Focus: Agency Pay

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the planned agency expenditure for 2026/27.
- The Trust reported agency expenditure of £0.9m in Aug-26 and £4.1m year to date
- Our Aug-26 plan was £0.4m; we were £0.4m over this plan. We are £1.8m over plan year-to-date.
- Agency expenditure accounted for 2.6% of our total pay bill in the 2026/27 position to date.

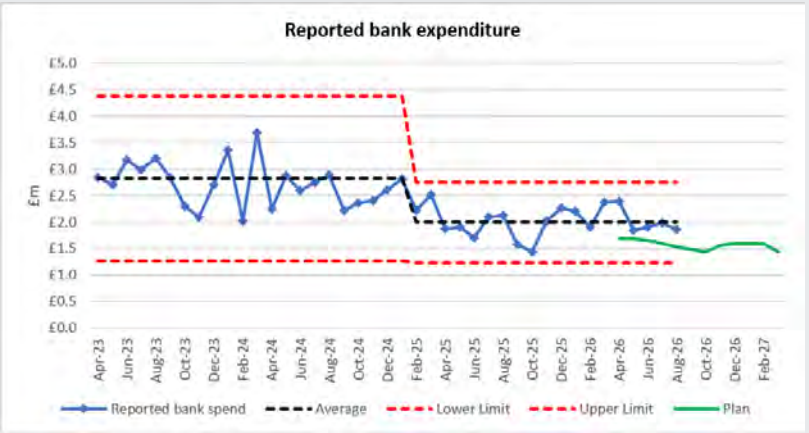
Data



Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Our Pay Oversight Group alongside Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required reduction in bank and agency expenditure. • Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews. • Divisional bi-weekly performance group is in place, which includes focus on bank and agency. • No new agency bookings. Any exceptions to be signed off by the Executive lead. • All medical agency bookings that are above cap are reviewed at bi-weekly Vacancy Control Panels. There are still shifts filled over-cap, but this has begun to reduce. • The use of off-framework agencies is not permitted. Any exceptions are to be approved by the Chief Executive Officer. All internal escalation forms have been updated to reflect this.	Reduced agency run rate to achieve financial plan.

Indicator in Focus: Bank Pay

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations	Data
• The standard is the planned bank expenditure for 2026/27. • The Trust reported bank expenditure of £1.9m in Aug-26 and £10m year-to-date. • Our Aug-26 plan was £1.5m; we were £0.3m over this plan. Year-to-date we are £1.9m over plan • Bank expenditure accounted for 6.4% of our total pay bill in our 2026/27 position to date.	

Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Our Pay Oversight Group alongside Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required reduction in bank and agency expenditure. • Enhanced financial governance focus on bank spend and compliance at Divisional Performance Reviews. • Divisional bi-weekly performance group is in place, which includes focus on bank and agency.	Reduced bank run rate to achieve financial plan.

Indicators in Focus: Cash and Liquidity

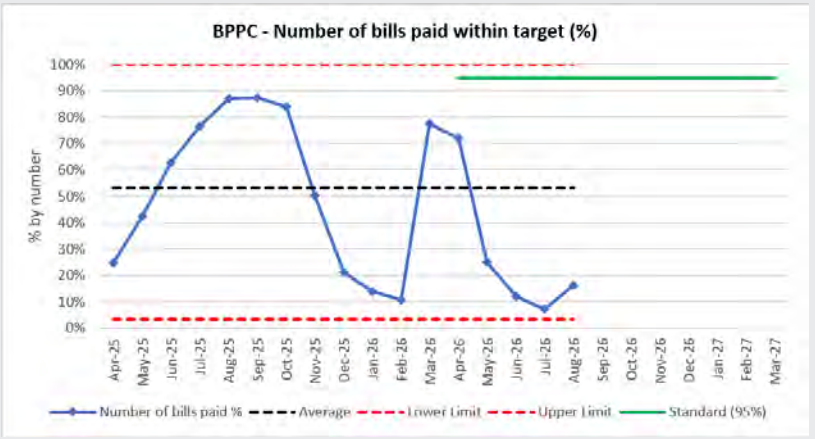
Sherwood Forest Hospitals NHS Foundation Trust

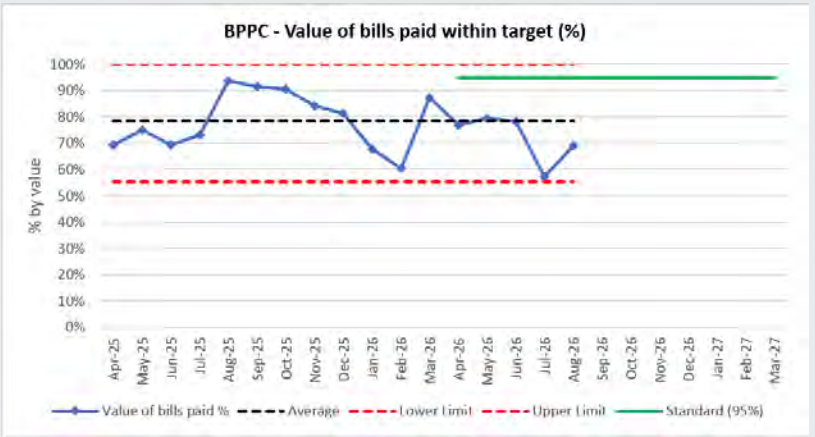
Performance observations

- The standard is the minimum cash balance (£2.8m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of Aug-26, cash in bank was £1.05m, which was below plan and the minimum cash balance.
- The submitted plan for 2026/27 does not require revenue borrowing Public Dividend Capital (PDC). However, the 12-month cash forecast indicates the need for working capital support. In addition, the plan requires £10.7m of PDC to support delivery of the capital programme.

Root causes	Actions and timescale	Impact
Standard is the plan and the minimum cash balance required by DHSC of £2.8m 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. • Submission of working capital PDC application in Sep-26 to support the available cash balance.	• Requirement to ensure minimum balance is met/ maintained. • Risk of disruption to services if suppliers cannot be paid in a timely manner.
Plan requires significant PDC in-year of £10.4m to support the 'business as usual' allocation and £0.3m of National Funding.	• Monthly capital PDC drawdowns to be submitted on receipt of the memorandum of understanding (MOU) from DHSC.	• Extended payment terms to suppliers. • Risk of failure to achieve Better Payment Practice code (BPPC). • Unsupportable capital plan.
Failure to deliver efficiency programme on a cash releasing basis.	• Delivery of efficiency improvement programme, which includes full-year savings in 2026/27 of £34.9m.	• Requirement to submit working capital applications to support payments.

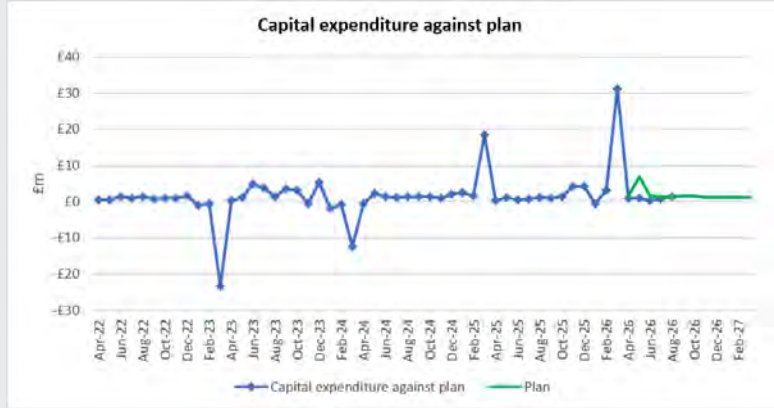
Data





Indicator in Focus: Capital

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Performance observations	Data
• The standard is the 2026/27 Capital Expenditure Plan. • The plan requires capital borrowing support from the Department of Health and Social Care (DHSC). • There are known risks due to the value of pre-commitments in the 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.	Delivery of Capital Expenditure Plan.
Requirement for Public Dividend Capital (PDC) to support the plan £10.7m.	• Monthly capital PDC drawdowns to be submitted on receipt of the MOU from DHSC.	Spend impacting available cash to meet revenue payments as drawdown are based on previous month reported spend.
		Overspends impacting other capital delivery requirements.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Activity Data and Trends (1/2)

Activity (for context)

Based on daily averages

At a Glance	Indicator	Jul-26	Aug-26		Standard (Aug-26)
Urgent Care	A&E attendances (inc. PC24)	593	537		≤523
	Non-elective admissions	155	-		≤142
Electives	Average daily elective referrals	373	299		No plan
	Outpatients - first appointment	343	-		≥320
	Outpatients - follow up	837	-		≤772
	Outpatients - procedures	320	-		≥280
	Day case	135	-		≥116
	Elective inpatient	12	-		≥13
Diagnostics	Diagnostics	511	498		≥465

Summary Icon Key

Variation
- Common cause - no significant change
- Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
- Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

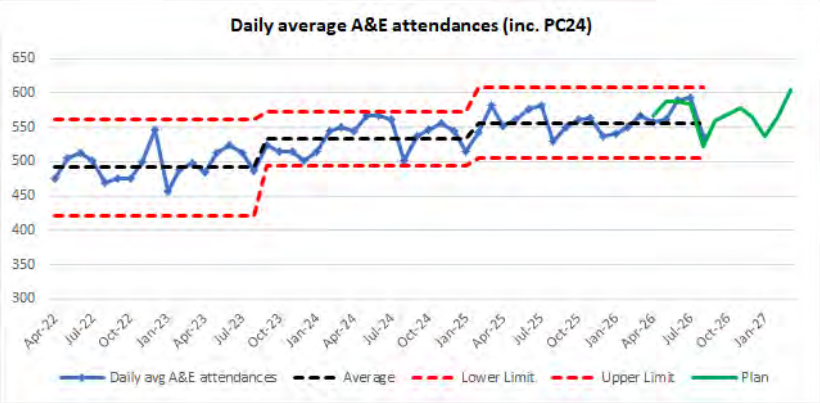
Assurance
- Variation indicates inconsistently hitting passing and falling short of the target
- Variation indicates consistently (P)assing the target
- Variation indicates consistently (F)alling short of the target

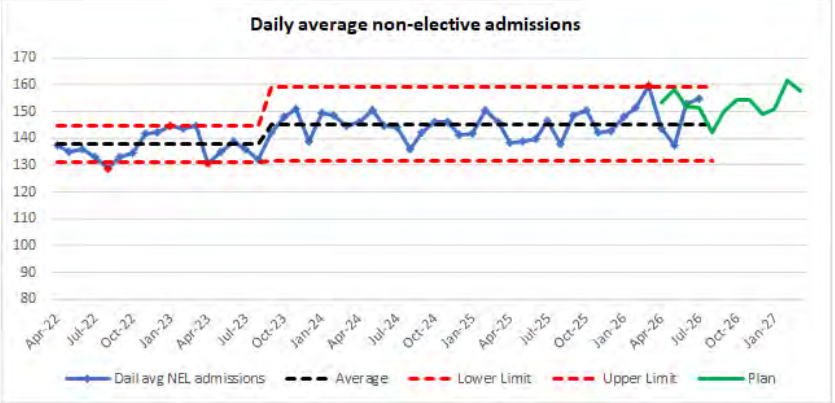
Benchmark Key
- Best performing 40%
- Middle performing 20%
- Worst performing 40%

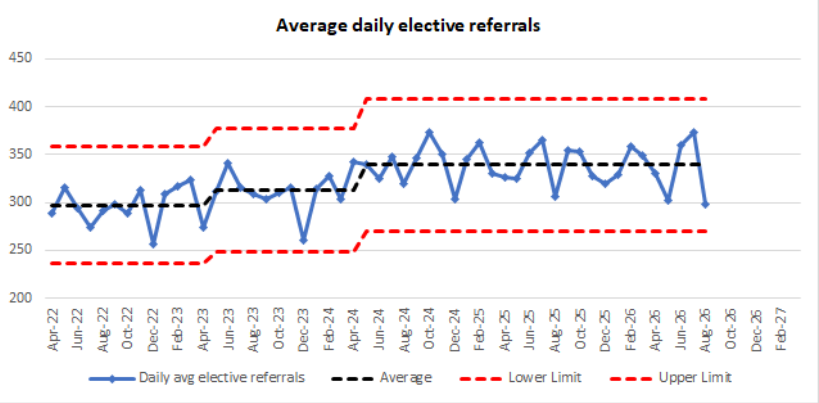
STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

- Substantial assurance
- Limited assurance



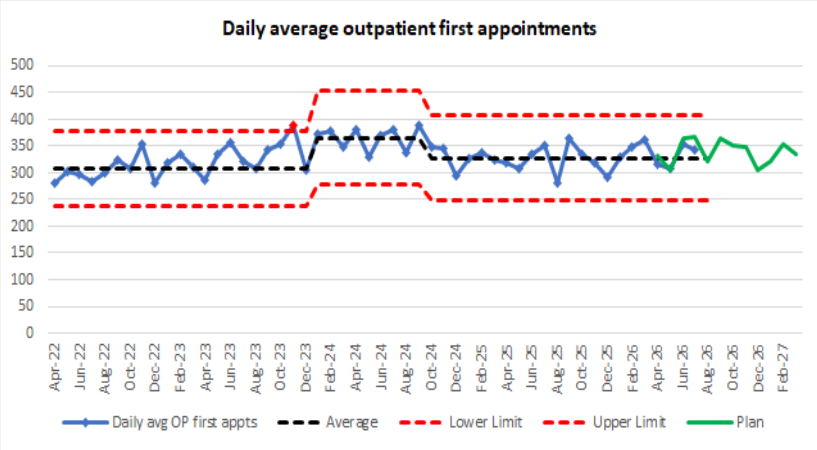


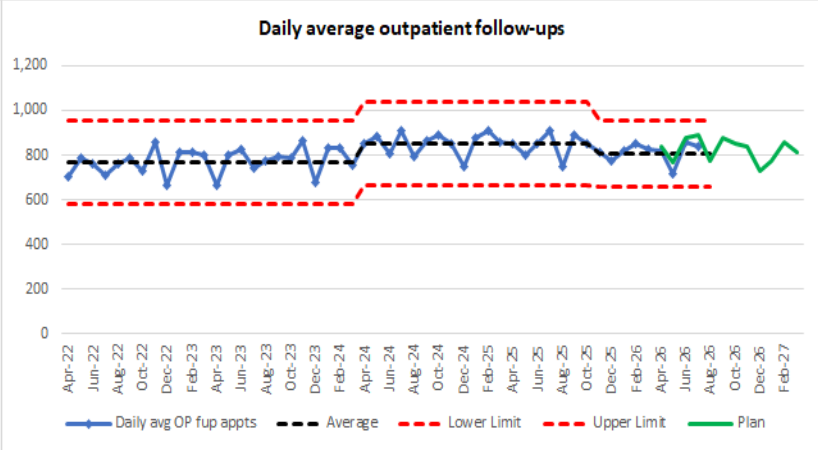


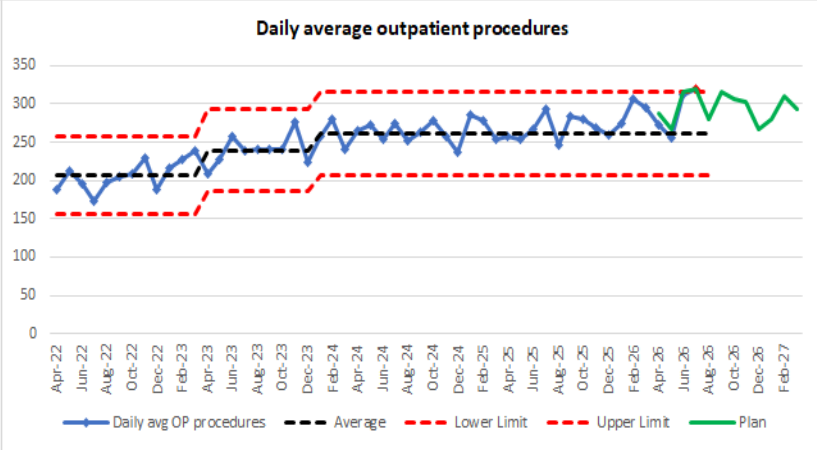
Outstanding Care,
Compassionate People,
Healthier Communities

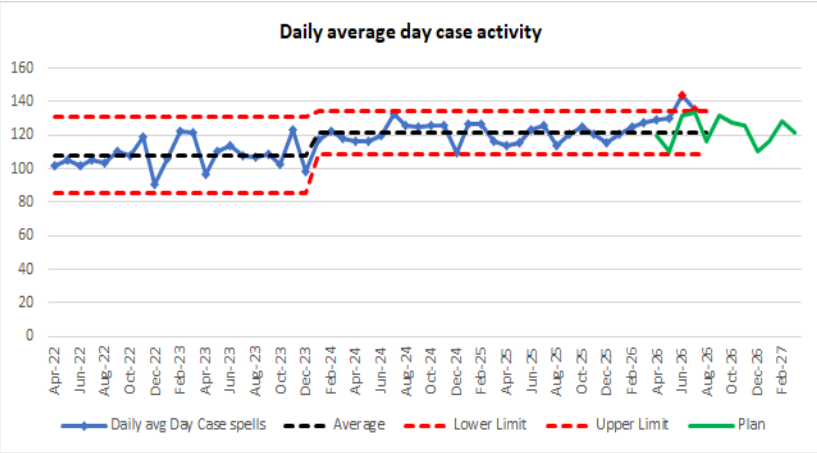
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

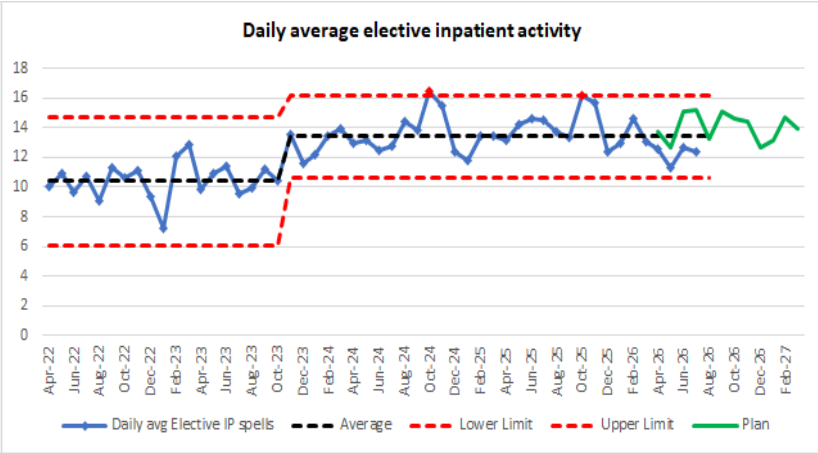
Activity Data and Trends (2/2)

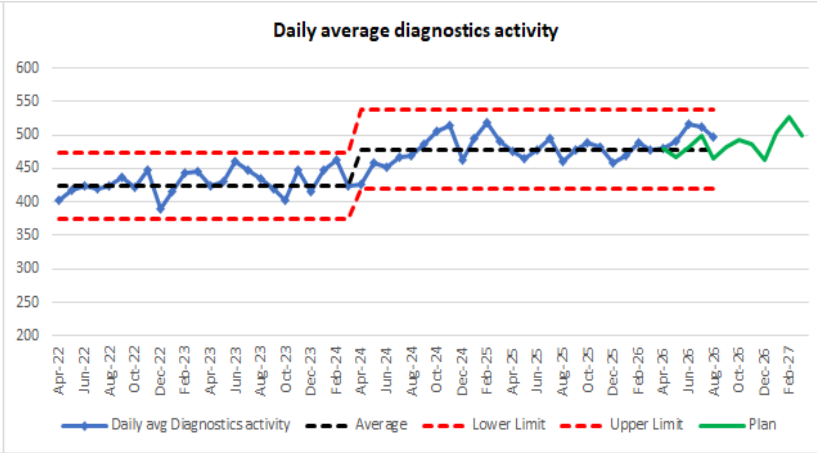












Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Appendix A: Integrated Scorecard & Graphs for each indicator

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

Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

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

How are we different?

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

Why are we different?

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

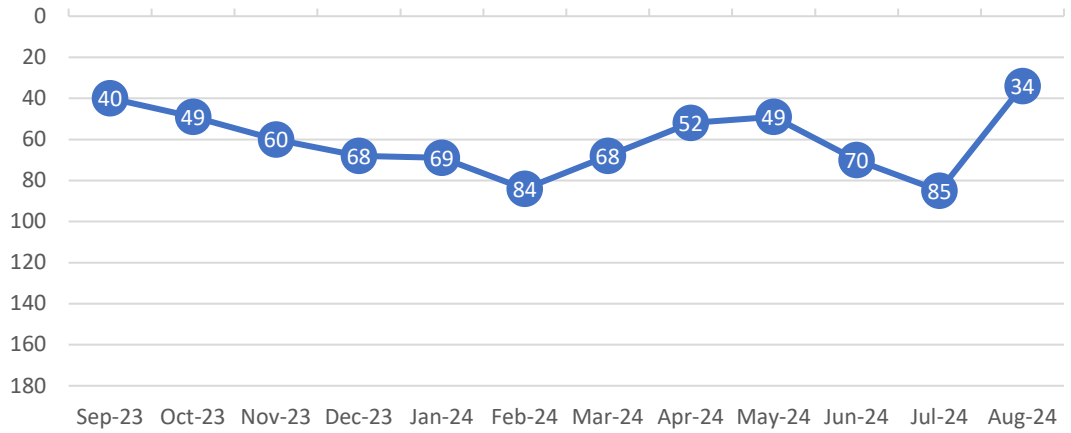
Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

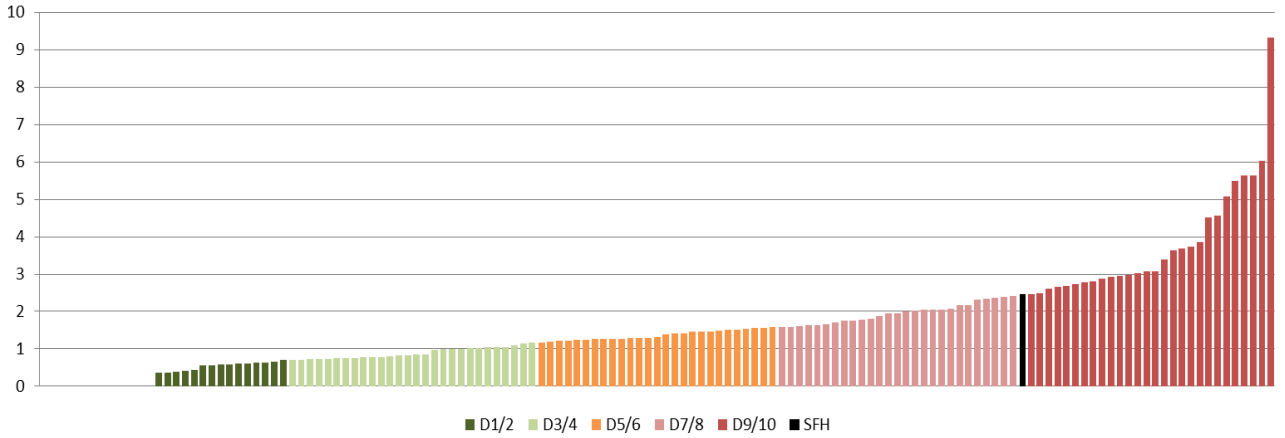
Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



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

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

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

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

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Appendix C: Data Quality Indicator Guidance

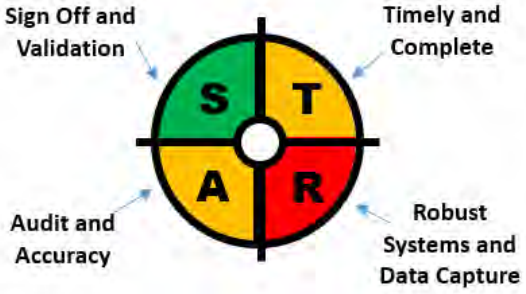
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

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

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

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

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



Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	NHS Oversight Framework 2026/27 Q1	**Date:**	1 October 2026
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Simon Illingworth, Chief Operating Officer		
Presented By:	Simon Illingworth, Chief Operating Officer		

Purpose

To update the Board of Director's on the NHS Oversight Framework reflecting on 2026/27 quarter one performance following national data being published in September 2026.	**Approval**	
	Assurance	✓
	Update	
	Consider	

Recommendation

Board of Director's is requested to:

1. Note the contents of this paper.
2. Agree to receive further reports on a quarterly basis.

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

None.

Acronyms

All acronyms are defined within the paper.

Executive Summary

The attached report describes the latest position on the NHS Oversight Framework reflecting on 2026/27 quarter one (Q1). The report opens with some context providing a summary of the evolutionary process of the framework and the main changes in 2026/27 from 2025/26. A segment breakdown is included together with details of the financial override and statements around how it is advised not to compare the outputs between financial years in terms of improvement and deterioration due to the changes in metrics and methodology.

Screenshots from the NHS England public data gateway are included showing an overview of acute provider scores with Sherwood Forest Hospitals (SFH) performance highlighted.

The headlines for 2026/27 Q1 include:

- SFH score was 2.44 and we were placed in segment three. Our position is capped in segment three due to our financial deficit.

- Our provider rank was 72nd (out of 134 providers).

- The domain summary segment position was as follows:

    - **Access to services:** Segment 2 (above average)
    - **Patient safety:** Segment 2 (above average)
    - **Finance, productivity and innovation:** Segment 4 (low performing)
    - **People:** Segment 2 (above average)
    - **Experience of care:** Segment 2 (above average)
    - **Effectiveness of care and population health:** Segment 4 (low performing)

- 32 acute trusts nationally are in segments one and two

- 10 of the top 12 hospitals are 'specialist' provider sub types

- We rank 8th (out of 20) in the 'medium' provider sub type.

The remainder of the main report provides an indicator-level overview that is provided for transparency and Board assurance.

Board of Director's is requested to:

1. Note the contents of this paper.
2. Agree to receive further reports on a quarterly basis with the next report reflecting on 2026/27 Q2 performance.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

NHS Oversight Framework

This document describes the latest position on the NHS Oversight Framework reflecting on 2026/27 quarter one following national data being published.

1 October 2026

Main changes in 2026/27 from 2025/26

Update for 2026/27 is intentionally evolutionary, retaining the core architecture and oversight approach from the 2025/26 Oversight Framework

- Alignment of the approach to delivery segmentation for ICBs and providers
- Clearer recognition of highly capable, high-performing providers, including those that are awarded advanced foundation trust status and benefit from lighter-touch oversight
- Update oversight metrics aligned to the NHS Medium Term Planning Framework, including new metrics for mental health, community and ambulance trusts
- Refinement of the delivery segmentation methodology, moving from a quartile-based approach to statistical thresholds, to make tracking of improvement easier
- Establishing a stronger link between the oversight response model and delivery segmentation, organisational capability, and other considerations around engagement intensity, support, potential incentives and consequences.

Source: NHS Oversight Framework 2026/27, sections 7 and 8

Segment breakdown

2025/26 was the first year in which we applied a calculation to determine segmentation under the NHS Oversight Framework. Initial segmentation was arrived at by taking each trust's average NOF metric score and using these to create four evenly sized groups (Highest scoring 25%, second highest scoring 25%, second lowest scoring 25% and lowest scoring 25%). Now as we have a full year of actual data, we have moved to a "threshold" based system in which segments are defined by comparing the trust's average metric score to fixed reference points e.g. anyone with an average metric score below 1.94 will be in segment one. Full details of the threshold values for each segment and how these were arrived at can be found in our methodology manual.

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Q1 2026/27
Segment 1	16.59%	19.02%	16.10%	20.00%	13.86%
Segment 2	34.15%	30.24%	33.66%	32.20%	21.29%
Segment 3	32.68%	34.15%	30.24%	34.63%	53.96%
Segment 4	16.59%	16.59%	20.00%	13.17%	10.89%

This change has several major advantages:

- Organisations have a clear threshold to aim for to reach each segment.
- Material improvement can more easily be tracked and understood.
- Segments no longer have a pre-defined size limiting the number of organisations that can qualify for them.

Because the segmentation model has changed, comparisons with segmentation spread in 2025/26 must not be made without first recalculating results using the new threshold values. The table above shows the breakdown of segmentation for the current and historic quarters, using the 2026/27 threshold values to calculate segments.

The Q1 2026/27 results are not precisely comparable with previous quarters because they are based on a revised set of metrics, but the trends should be noted. We are not seeing an increase in the size of segment 4, as might be expected between the end and the beginning of a performance year. This could indicate that organisations are maintaining higher baseline performance, in line with the ambitions of the NHS Oversight Framework.

Source: NHS England » NHS Oversight Framework – Q1 2026/27 segmentation summary

Further information

Financial override

- As in 2025/26, the revised NHS Oversight Framework continues to apply a financial override that stipulates that no organisation in financial deficit can be segmented higher than segment 3.
- The number of trusts classed as being in financial deficit continues to fall: from 119 to 108 trusts in Q4 2025/26 and from 108 to 99 trusts in Q1 2026/27.
- The financial override was applied for 21 of those 99 trusts, meaning those trusts would have been in a higher segment if they had not been in financial deficit. The override was applied to 38 trusts in Q4 2025/26.

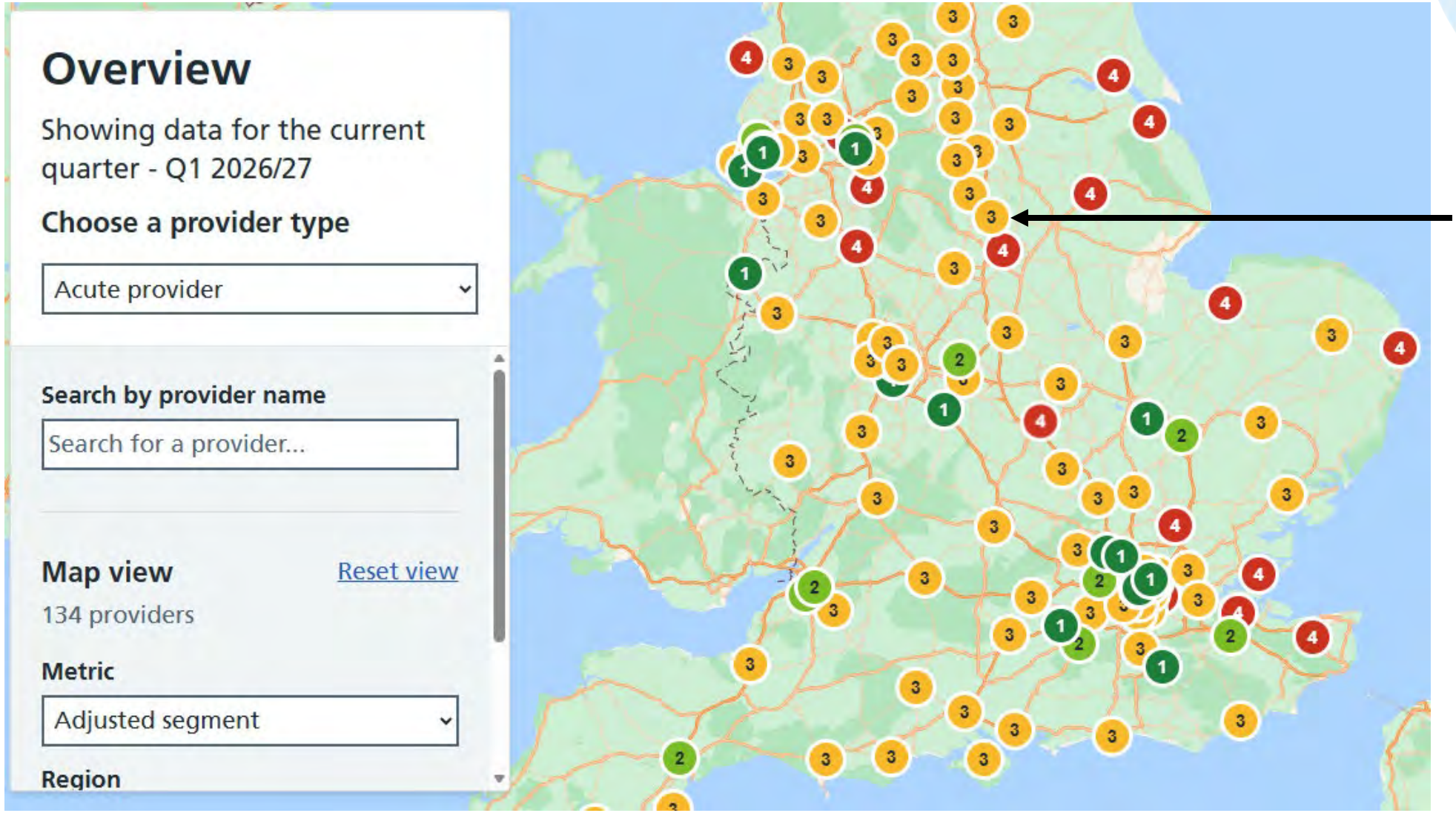
Improvement and deterioration

- Because of the changes to the metrics and methodology, it is not possible to identify improvement and deterioration from Q4 2025/26 accurately. From Q2 2026/27, we will provide a quarterly summary of significant performance changes compared with previous quarter.
- All providers in the Intensive Recovery Programme are currently within segment 4 and all providers participating in the Advanced Foundation Trust programme are in segment 1 or segment 2.

Source: NHS England » NHS Oversight Framework – Q1 2026/27 segmentation summary

NHS Oversight Framework: Q1 Summary

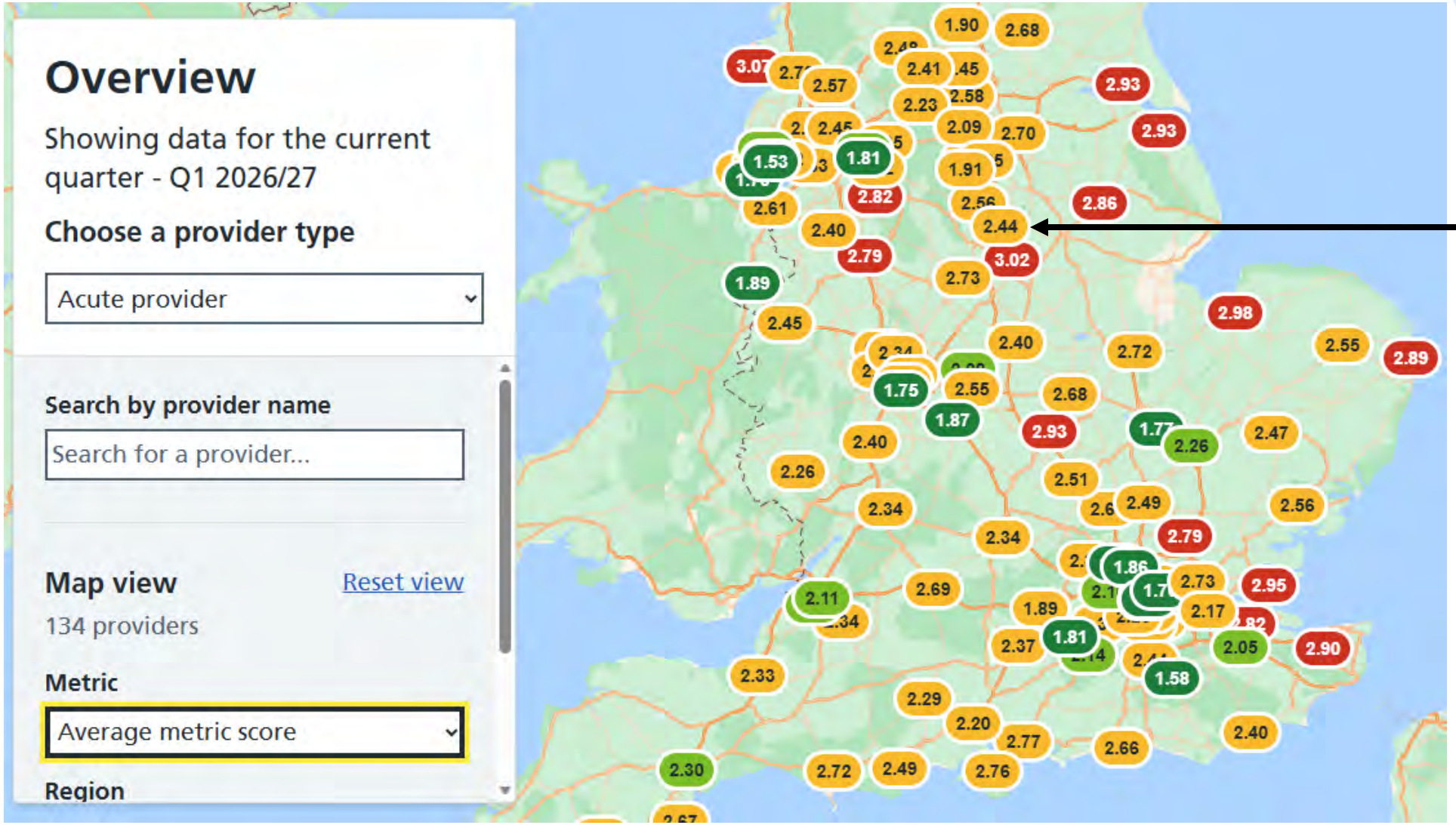
Sherwood Forest Hospitals NHS Foundation Trust



Overview – NHS Oversight Framework - NHS England public data gateway

NHS Oversight Framework: Q1 Summary

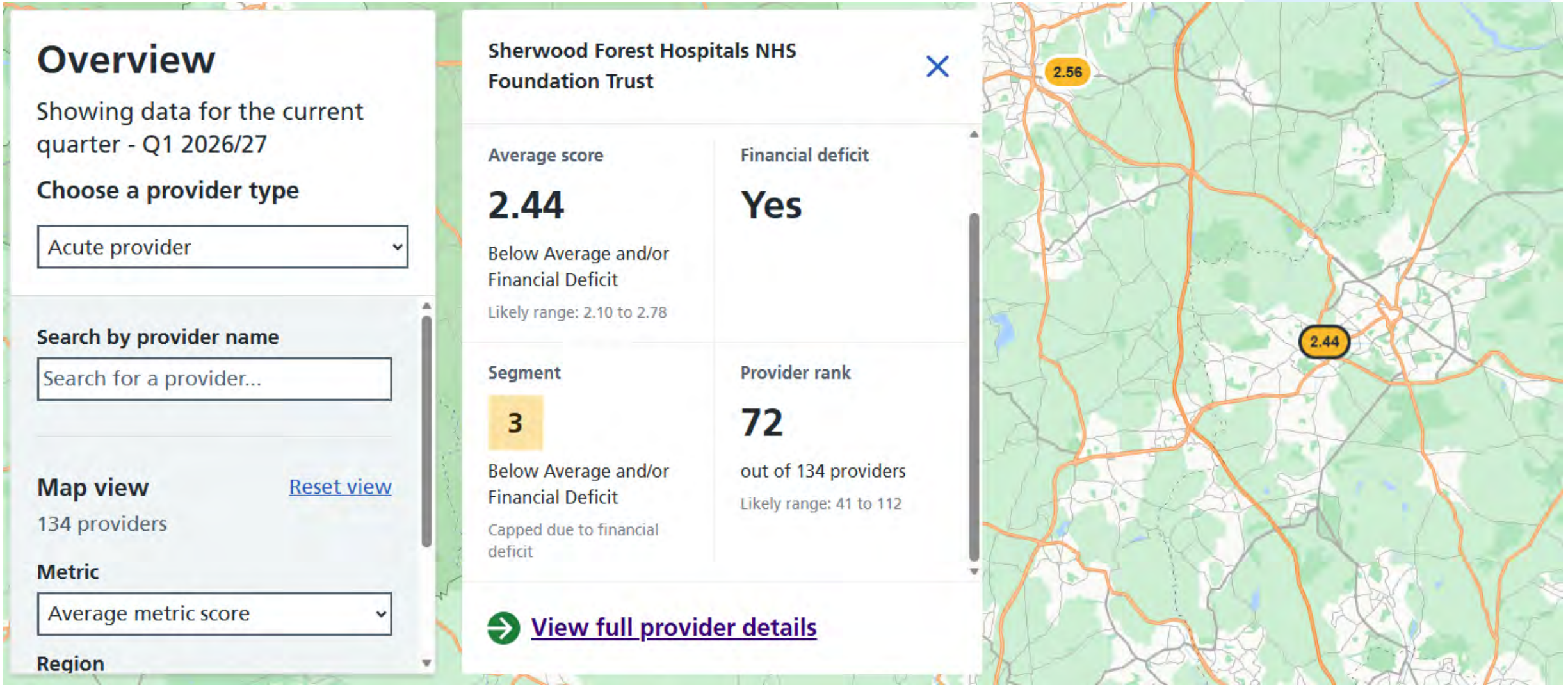
Sherwood Forest Hospitals NHS Foundation Trust



Overview – NHS Oversight Framework - NHS England public data gateway

NHS Oversight Framework: Q1 Summary

Sherwood Forest Hospitals NHS Foundation Trust



Overview – NHS Oversight Framework - NHS England public data gateway

NHS Oversight Framework: Q1 Summary

Sherwood Forest Hospitals NHS Foundation Trust

Domain quartiles

All metrics for this provider grouped by NOF domain. Each metric receives a score between 1 and 4, with 1 being the highest rating.

Access to services

Quartile

2 Second-highest-scoring 25%

Patient safety

Quartile

2 Second-highest-scoring 25%

Finance, productivity and innovation

Quartile

4 Lowest-scoring 25%

People

Quartile

2 Second-highest-scoring 25%

Experience of care

Quartile

2 Second-highest-scoring 25%

Effectiveness of care and population health

Quartile

4 Lowest-scoring 25%

Key

1 High performing
2 Above average
3 Below average and / or financial deficit
4 Low performing

Overview – NHS Oversight Framework - NHS England public data gateway

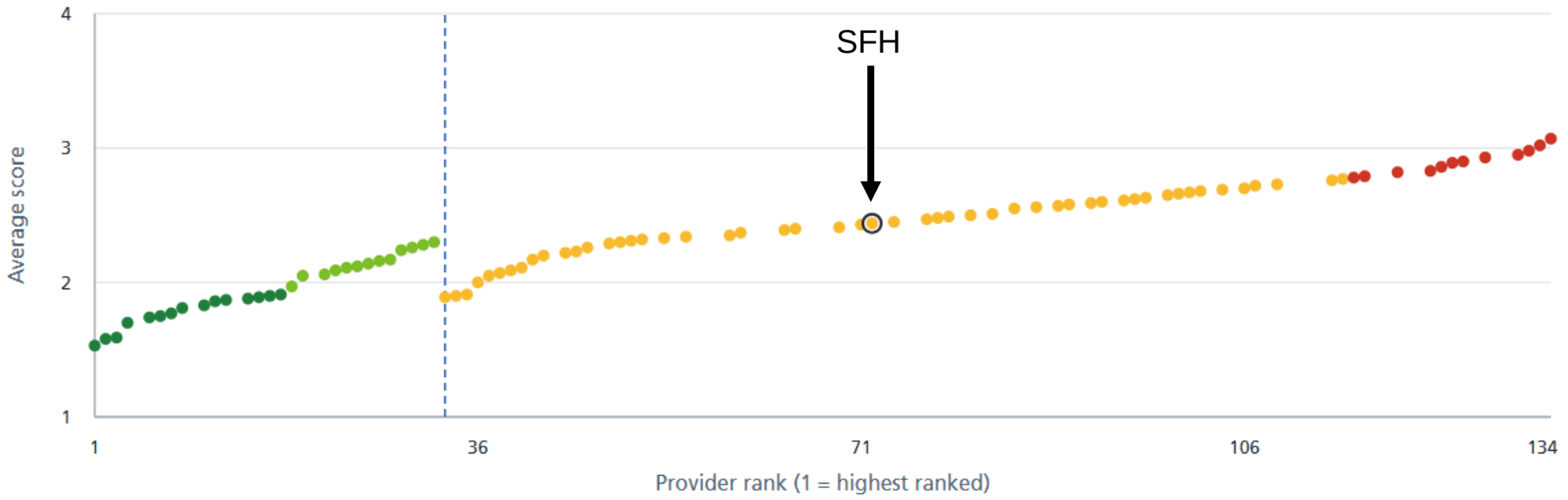
NHS Oversight Framework: Q1 Summary

Sherwood Forest Hospitals NHS Foundation Trust

Average score by provider rank placement

Each point represents a provider, plotted by rank and average score. This provider is highlighted to show where it sits relative to peers.

Chart | Data



Selected organisation is marked with its segment colour, a white gap, and a black outline.

32 Acute Trusts nationally are in segments 1 and 2 (have no financial deficit)

10 of the top 12 hospitals are ‘specialist’ provider sub types

We are 8th out of 20 ‘medium’ provider sub types.

Overview – NHS Oversight Framework - NHS England public data gateway

Access to services (1/3)

	Value	National Benchmark	Score	Rank
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	**64.80%**	**-**	**2.80**	**78**

- The reported performance is at the end of Jun-26 and represents our strongest performance month for several years. This performance was better than our plan which was 64.7% in Jun-26.
- Our operational plan trajectory for Mar-27 is 70% with an internal stretch plan to deliver 75%.
- Elective recovery plans are in place overseen by our Planned Care Steering Group.

Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	**1.22%**	**0%**	**3.08**	**72**

- This metric considers the number of long wait elective patients (over 52-weeks from referral) as a percentage of our overall referral to treatment (RTT) incomplete waiting list size at the end of Jun-26.
- Our ambition is to have no more than 1% of our waiting list over 52-weeks throughout 2026/27 which we have been slightly above due to two reasons: (1) our waiting list size (denominator) has been lower than our plan (which is good); (2) the absolute number of long waiting patients (numerator) has been higher than our plan with the specialty of greatest challenge being Gynaecology.
- Recovery plans for challenged specialties are in place overseen by our Planned Care Steering Group.

Percentage of patients waiting less than 18 weeks for community care	**98.85%**	**78%**	**1**	**3**

- The reported performance is at the end of Jun-26 and for us represents data for our Community Paediatric service. At the end of Jun-26, there were 436 patients on the waiting list with 5 patients being reported as being on the waiting list for over 18-weeks.
- In Jul-26 published data, our waiting list size was stable; although there were 19 patients over 18-weeks. This still represents performance of >95%.

Percentage of patients waiting over 52 weeks for community services	**0%**	**0%**	**1**	**1**

- This metric considers the number of long wait elective patients (over 52-weeks from referral) as a percentage of our overall Referral to Treatment (RTT) incomplete waiting list size for community services at the end of Jun-26.
- The SFH position is that we have no patients waiting over 52-week for community services.

Access to services (2/3)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Percentage of diagnostic referrals waiting over 6 weeks	**11.21%**	**-**	**1.88**	**39**

- The reported performance is for Jun-26. During 2026/27 Q1 we were recovering from referral issues experienced in Ultrasound.
- In Jun-26, we were behind our operational plan of 8.4% (91.6% within 6-weeks). We have recovered back ahead of plan in Jul-26 and Aug-26 with performance <8% (>92% within 6-weeks).
- Delivery is overseen by our Planned Care Steering Group.

Percentage of patients treated for cancer within 62 days of referral	**64.50%**	**80%**	**3.49**	**93**

- This performance is the quarterly average of our monthly reported performance during 2026/27 Q1. Our plan expressed as an average of the monthly position for Q1 was circa 73% which we did not deliver. Monthly performance remains behind our plan with recovery actions in place.
- The national operational planning ambition is to achieve 80% Mar-27.
- Specific tumour site recovery plans in place overseen by our Cancer Services Steering Group.

Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	**80.75%**	**80%**	**1**	**43**

- This performance is the quarterly average of our monthly reported performance during 2026/27 Q1.
- The national operational planning ambition is to achieve 80% throughout the three-year medium-term plan period (2026-2029).
- We have exceeded our plan every month this financial year since May-26.
- Delivery is overseen by our Cancer Services Steering Group.

Access to services (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Percentage of emergency department attendances admitted, transferred or discharged within four hours	**65.80%**	**82%**	**3.81**	**113**

- This performance is the quarterly average of our monthly reported performance during 2026/27 Q1.
- The national operational planning ambition is to achieve 82% by Mar-27.
- During 2026/27 Q1 our average plan position for the quarter was 78% which we missed.
- Our headline UEC metrics underperformance was driven primarily by our Nervecentre patient administration system deployment in ED in Apr-26 and compounded by high patient demand. The Nervecentre challenges relating to validation, system interfaces and use of the system were far greater and lasted longer than we anticipated.
- Performance has improved in Jul-26 and Aug-26 to greater than 71%; however, remains behind our operational plan.
- UEC recovery plan in place overseen by our Emergency Care Steering Group alongside a Remedial Action Plan between SFH and NHS England/ICB.

Percentage of emergency department attendances spending over 12 hours in the department	**9.85%**	**-**	**2.49**	**61**

- This performance is the quarterly average of our monthly reported performance during 2026/27 Q1.
- During 2026/27 Q1 our average plan position for the quarter was 2.8% which we missed.
- As detailed above, our UEC metrics were impacted primarily by Nervecentre deployment.
- Performance has improved in Jul-26 and Aug-26 to less than 6%; however, remains behind our operational plan.
- UEC recovery plan in place overseen by our Emergency Care Steering Group.

Patient safety (1/2)

	Value	National Benchmark	Score	Rank
Breadth and depth of clinical audit outliers Score	**-**	**-**	**1**	**-**

- SFH has no national clinical audit outliers, scoring 1 under the NOF patient safety domain. This reflects strong clinical governance, reliable audit processes and consistent delivery of evidence-based care.

NHS Staff survey - raising concerns sub-score	**6.40 out of 10**	**-**	**2.20**	**54**

- The reported performance is based on 2025 data.
- Scoring is out of 10, with 10 being the highest.
- The Trust rate (6.40) is higher than the Peer average (6.37) and the National Median (6.32).

Patient safety (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Number of MRSA bacteraemia cases	**3**	**0**	**2.64**	**-**

- This performance is based on reporting on a rolling 12-month period (Jul-25 to Jun-26).
- Current work is focused on reducing bacteraemia through education, surveillance and decolonisation.
- We remain on a zero-tolerance MRSA threshold, with regional and national increases being reported. Current monitoring and benchmarking are tracked through the IPR.
- Decolonisation training has been provided across sites to improve compliance and reduce infection rates.
- Recurrent infection control review themes have included missed wound swabbing during MRSA screening, with additional ward-level training and audits introduced where themes recur.

Rate of C. difficile	**-**	**-**	**3**	**-**

- This performance is based on reporting on a rolling 12-month reporting period (Jul-25 to Jun-26).
- A Trust-wide C. diff action plan is in place and continues to be expanded.
- Deep dives of C. diff cases are being undertaken, with expansion of the deep-dive methodology to include diagnostics and antibiotic usage.
- Work is being undertaken jointly with Antimicrobial Pharmacists and Consultant Microbiologists through the antimicrobial resistance action plan.

Rate of E. coli	**-**	**-**	**3**	**-**

- This performance is based on a rolling 12-month reporting period (Jul-25 to Jun-26).
- The current programme of work is focused on reducing urinary-tract-related bloodstream infections, more than 50% of gram-negative bloodstream infections originate from urinary tract infections (UTIs).
- Actions include raising awareness of hydration needs, improving cleansing and personal care, developing a UTI prevention campaign, delivering UTI training packages, undertaking deep dives of patients with UTIs to ensure correct treatment pathways and monitoring bloodstream infection sources and trends.

Finance, productivity and innovation (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Combined finance (National Oversight Framework)	**3.04**	**-**	**3**	**117th**

- The combined finance score is based on a combination of individual financial scores.
- This score is updated quarterly based on YTD performance.

Financial Override	**3**	**-**	**3**	**-**

- There is a 'Financial Override' where if an organisation receives deficit support funding, it can not be in a segment better than 3.
- SFH currently receive deficit support funding.

Productivity	**4.7%**	**2.5%**	**-**	**-**

- Implied Productivity Growth is calculated by comparing output growth (cost-weighted activity) to input growth (based on adjusted operating expenditure) against a baseline period.
- Implied productivity is up 4.7% year-to-date versus last year.

Finance, productivity and innovation (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Planned surplus/deficit	**(£3.4m)**	-	-	-

- The Trust has reported an in-month surplus position of £0.84m, this is £0.62m ahead of the £0.21m surplus plan. The YTD position is a deficit of £9.70m which is £6.34m behind the deficit plan of £3.36m.

Relative difference in costs	**103**	**100**	**103**	-

- The NCCI index for 2024/25 was released in November 2025 giving us an index of 103 which is a 3 point reduction compared to two years ago, the prior year (2023/24) NCCI had shown an increase to an index of 111 due to the inclusion of the IFRS16 adjustment (related to PFI).

Variance year-to-date to financial plan	**(£6.34m)**	-	-	-

- The Trust has reported an in-month surplus position of £0.84m, this is £0.62m ahead of the £0.21m surplus plan. The YTD position is a deficit of £9.70m which is £6.34m behind the deficit plan of £3.36m.
- The reason for the YTD position being behind plan is due to industrial action impact in month 1 of £0.60m, £4.23m efficiency miss, £0.96m demand and flow pressures and a shortfall on interest receivable of £0.4m.

People (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Healthcare Worker Flu Vaccination Rate	**56.80%**	**-**	**1.45**	**22**

- Flu vaccinations rank 22/134 and relates to the 2025/26 flu vaccination period.
- 2026/27 commences on the 1 October 2026.

NHS staff standards score	**7.40 out of 10**	**-**	**3.35**	**105**

- This is a new metric and is calculated and is a composite of national staff survey metrics.
- Questions include reducing violence and racism against staff, improving sexual safety, promoting flexible working, effective line management and health and wellbeing.
- The metrics are aligned to the 6-year people strategy.

NHS staff survey engagement theme sub-score	**6.72 out of 10**	**-**	**2.74**	**78**

- This performance is based on data from 2025. Scoring is out of 10, with 10 being the highest.
- The Trust rate (6.72) is above the peer average (6.67) but below the National median (6.80).
- There is a continued focus on creating a positive and inclusive working environment support by divisional plans aligned to feedback from the national staff survey.

National Education and Training Survey satisfaction rate	**78.53%**	**-**	**2.39**	**37**

- This metric is based on the response rate from the 2026 NETs survey.
- Shows a rank of 37/134, which sit in the upper quartile.

People (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Sickness absence rate	**5.43%**	**-**	**2.37**	**73**

- This performance is based on data from the previous quarter, was recorded at 5.43%.
- Shows an improvement from previous NOF score, with positive movement in rank score.

Temporary staffing agency	**-**	**-**	**2**	**-**

- Scored at level 2, 'bank spend above average and spending on track to meet target'.
- Rated from a banded score between 1-4, with 1 - 'bank spend below average and spending on track to meet target' to 4 - 'bank spend above average and spending off track to meet target'.

Temporary staffing bank	**-**	**-**	**2**	**-**

- Scored at level 2, 'agency spend above average and spending on track to meet target'.
- Rated from a banded score between 1-4, with 1 - 'agency spend below average and spending on track to meet target' to 4 - 'agency spend above average and spending off track to meet target'.

Temporary staffing cost relative band score	**-**	**-**	**2**	**-**

- Agency and Bank scores combined in a sixteen-box grid to determine overall temporary staffing score

Experience of care

	Value	National Benchmark	Score	Rank
CQC inpatient survey satisfaction rate	**-**	**-**	**2**	**-**

- The score is based on a 2024 reporting period. No values or rank are provided in the national tool.
- SFH continues to deliver a positive and compassionate inpatient experience. The trust performs better than many peers in key areas such as ward environment, communication, and dignity, with the remainder of domains performing broadly in line with national averages.

NHS staff survey advocacy rate Score	**6.69 out of 10**	**-**	**2.40**	**63**

- This performance is based on data from the 2025 NHS Staff Survey.
- Staff advocacy score reflects a stable position, with ongoing work to strengthen staff voice and inclusion.

Effectiveness or care and population health

Sherwood Forest Hospitals NHS Foundation Trust

	Value	National Benchmark	Score	Rank
Delayed inductions rate	**105.10 per 1000**	**-**	**3.77**	**110**

- This performance is based on data on a rolling 12-month period ending Jun-26.
- This remains an area of focus, with maternity improvement actions underway.

Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	**0%**	**0%**	**4**	**97**

- This performance is based on data on a rolling 12-month period ending Jun-26.
- SFH has a fully established in-house tobacco dependence service supporting inpatient quit attempts.
- Future NOF cycles are expected to better represent actual delivery once data capture is aligned.

Percentage of patients readmitted within 30 days of discharge – comparative band	**-**	**-**	**1**	**-**

- This performance is based on data from an annual data set 2025/26.
- Reflects strong discharge planning and post-discharge support.
- Performance aligns with wider effectiveness metrics (SHMI).
- Ongoing work in discharge optimisation and community coordination continues to maintain low readmission rates.

Summary Hospital-level Mortality Indicator	**-**	**-**	**2**	**-**

- This performance is based on data a rolling 12-month period ending Jun-26 for Q1.
- SHMI score of 2 indicates mortality outcomes in line with national expectations.

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

August 2026 (Qtr 2)

Integrated Report

Domain	At a Glance	Indicator	Jul-26	Aug-26	Standard (Aug-26)	Benchmark	STAR Data Quality
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	2.7	2.8	No standard		
		Never events reported in month	0	1	0		
		Hospital-onset MRSA reported in month	0	1	0		
		Rate of c-difficile	0.3	0.2	≤0.3		
		Rate of e-coli	0.1	0.2	≤0.3		
		Number of gram-negative bloodstream infections reported in month	4	7	≤8		
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0.0	0.1	No standard		
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	0		
		New category 3 or 4 pressure ulcers per 1000 occupied bed days	0.0	0.0	0		
		Patient Safety Incident Investigations (PSII) and Duty of Candour	11	10	No standard		
		Percentage of inpatient Service Users undergoing risk assessment for VTE	-	-	≥95%		
		Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)	49	41	TBC		
	Caring	Complaints per 1000 occupied bed days	2.2	1.9	≤1.9		
		Compliments received in month	120	99	No standard		
	Effective	SHMI	107	107	As expected		
		Still births per 1000 live births	3.3	3.6	≤4.4		
		Early neonatal deaths per 1000 live births	0.0	0.0	≤1		
		30 day readmission rate band	TBC	TBC	TBC		
		14 day readmission rate	9.6%	10.1%	TBC		
People and Culture	Belonging in the NHS	NHS staff survey engagement theme score	-	-	≥6.74	66 / 121	
		National Education and Training Survey satisfaction rate	TBC	TBC	TBC		
		NHS staff standards score	TBC	TBC	TBC		
	Growing the Future	Vacancy rate	9.3%	8.3%	≤9.0%		
		Time to hire	43	33	≤40		
		Turnover in month	0.4%	0.6%	≤0.9%	55 / 118	
		Appraisals	87.6%	88.9%	≥90%		
		Mandatory & statutory training	92.2%	92.3%	≥90%		
		Medical job plan compliance (Consultants)	99.7%	99.7%	≥95%		
		Medical job plan compliance (SAS Doctors)	100.0%	100.0%	≥95%		
	Looking after our People	Sickness absence	5.1%	5.0%	≤4.2%	52 / 118	
		Flu vaccinations uptake (front line staff)	-	-	≥56.9%		
		Employee relations management	19	20	<24		
	New Ways of Working	Bank usage	6.4%	6.0%	≤5.3%	119 / 195	
		Agency usage	3.0%	2.8%	<1.5%	158 / 193	
		Agency (off framework)	0.0%	0.0%	0%		
		Agency (over price cap)	39.7%	34.8%	≤40.0%		

Integrated Report

Domain	At a Glance	Indicator	Jul-26	Aug-26	Standard (Aug-26)	Benchmark	STAR Data Quality
Timely Care	Urgent Care	Average ambulance handover time (mins)	24	24	≤19	▲ 4 / 15	
		Percentage of ambulance handovers within 15 minutes	25.9%	27.4%	≥73.5%	▼ 125 / 174	
		Percentage of ambulance handovers within 45 minutes	91.1%	91.4%	100%	▲ 5 / 15	
		ED 4-hour performance	71.2%	71.5%	≥83.3%	▼ 128 / 140	
		ED 12-hour length of stay performance	4.7%	5.7%	≤1.1%	▬ 83 / 177	
		ED 24-hour length of stay performance	0.3%	0.3%	0%		
		Number of ED patients cared for in corridors for over 45 minutes	-	824	0%		
		Adult G&A bed occupancy	96.1%	96.5%	≤97.1%	▬ 80 /177	
		Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base	86	99	≤40		
		Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base	2653	3058	≤1240		
	Electives	Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment	64.0%	63.8%	≥65.9%	▼ 94 / 148	
		Percentage of RTT waits over 52 weeks for incomplete pathways	1.4%	1.4%	≤1.0%	▬ 88 / 148	
	Diagnostics	Diagnostic DM01 performance under 6-weeks	92.5%	92.1%	≥92.0%	▲ 39 / 135	
	Cancer	Cancer 28-day faster diagnosis standard	81.6%	-	≥80.7%	▲ 47 / 130	
		Cancer 31-day treatment performance	90.8%	-	≥91.3%	▬ 69 / 130	
		Cancer 62-day treatment performance	70.4%	-	≥77.0%	▬ 76 / 134	
Best Value Care	Financial Performance	Financial surplus / deficit	-£2.57	£0.84	≥0.21		
		Variance YTD to financial plan	-£2.65	£0.62	≥£0.00m		
	Efficiency	Financial efficiency variance YTD to plan	-£0.47	-£1.21	≥£0.00m		
		Risk adjusted efficiency forecast to plan (%)	67.0%	75.0%	100%		
		Relative cost difference (National Cost Collection Index)	103	103	TBC		
		Implied productivity growth (YTD compared to last year)	-	-	TBC		
	Variable Pay	Reported agency expenditure	£0.94	£0.86	≤£0.45		
		Reported bank expenditure	£1.99	£1.86	≤£1.53		
		Temporary staffing cost relative band	TBC	TBC	≤6.7%		
	Cash & Liquidity	BPPC - Number of bills paid within target (%)	7.1%	16.2%	≥95%		
		BPPC - Value of bills paid within target (%)	57.4%	69.1%	≥95%		
		Operating expenditure days	1	1	≥5		
	Capital	Capital expenditure against plan	£0.65	£1.36	≤1.46		
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	593	537	≤523		
		Non-elective admissions	155	-	≤142		
	Electives	Average daily elective referrals	373	299	No plan		
		Outpatients - first appointment	343	-	≥320		
		Outpatients - follow up	837	-	≤772		
		Outpatients - procedures	320	-	≥280		
		Day case	135	-	≥116		
		Elective inpatient	12	-	≥13		
	Diagnostics	Diagnostics	511	498	≥465		

Summary Icon Key

Variation		Common cause - no significant change
		Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
		Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
Assurance		Variation indicates inconsistently hitting passing and falling short of the target
		Variation indicates consistently (P)assing the target
		Variation indicates consistently (F)alling short of the target

Benchmark Key


Best performing 40%
Middle performing 20%

STAR Data Quality Key

Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

Substantial assurance
Limited assurance

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

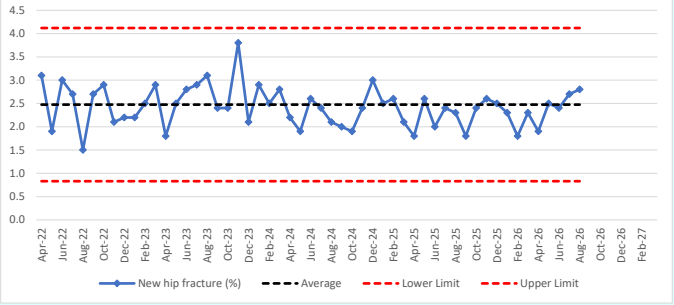
August 2026 (Qtr 2)

Cover Page | Definitions

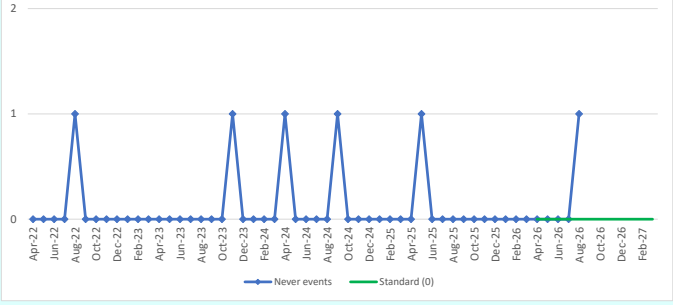
Charts

Quality of Care

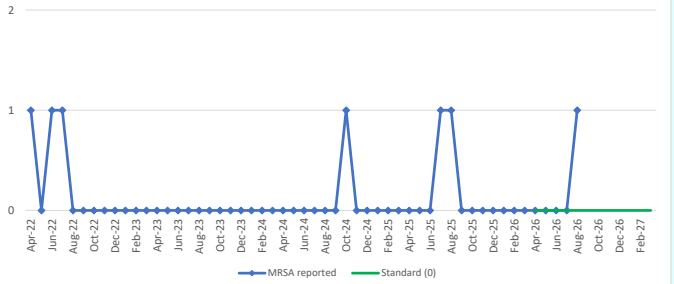
Rate of inpatients to suffer a new hip fracture



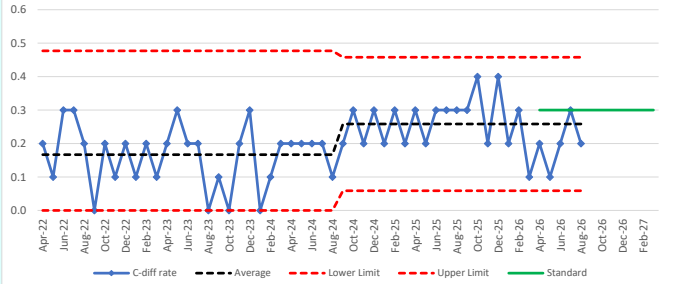
Never events reported in month



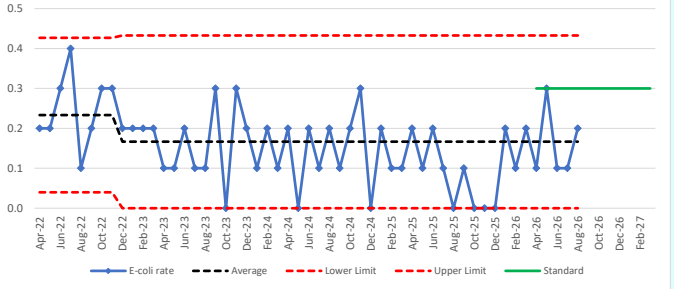
Hospital-onset MRSA reported in month



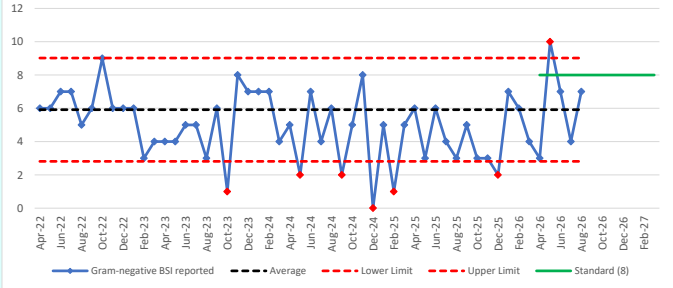
Rate of c-difficile



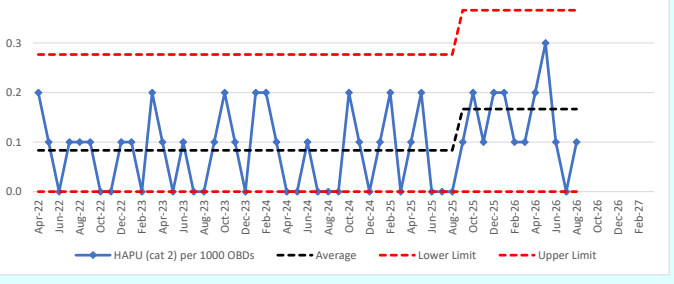
Rate of e-coli



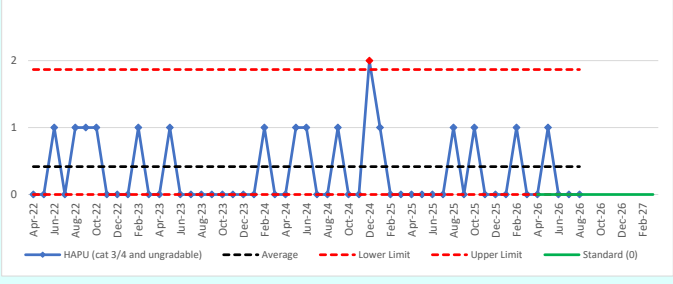
Number of gram-negative bloodstream infections reported in month



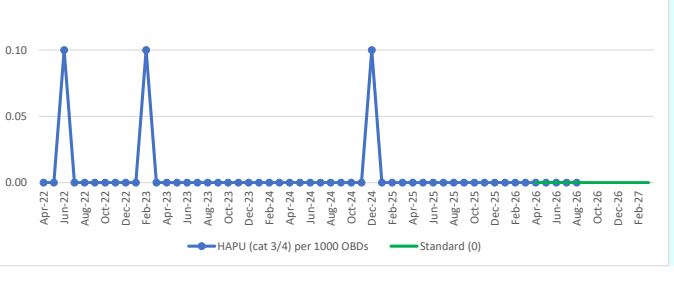
HAPU (cat 2) per 1000 occupied bed days with a lapse in care



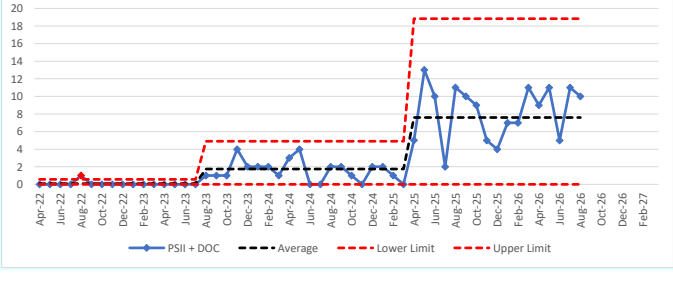
HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care

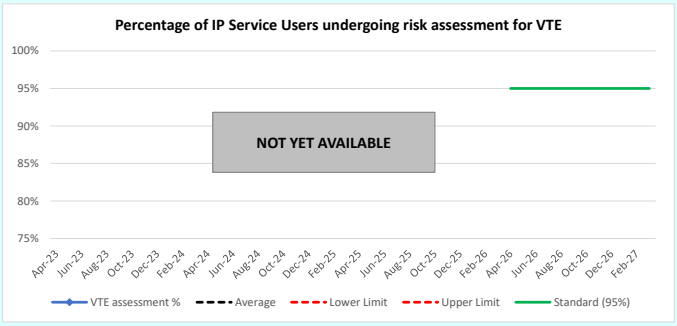


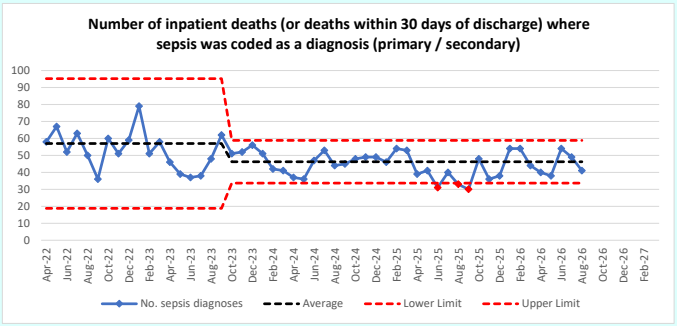
New category 3 or 4 pressure ulcers per 1000 occupied bed days

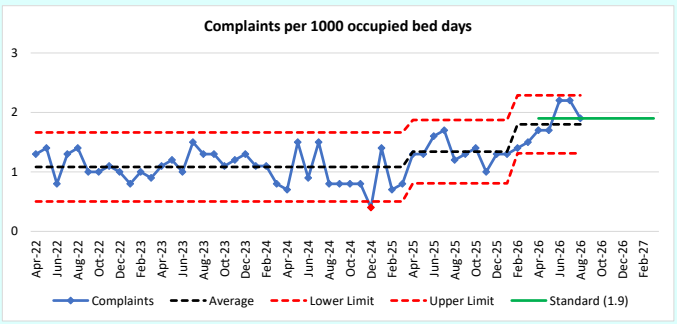


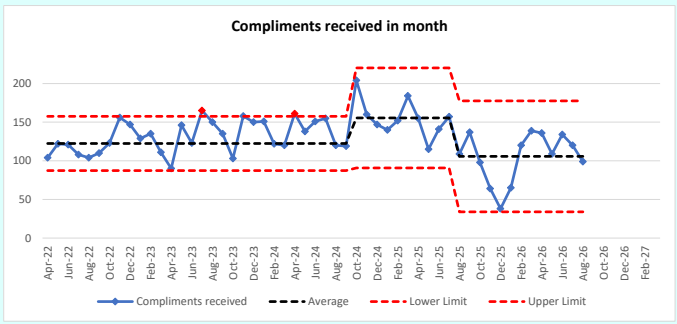
Patient Safety Incident Investigations (PSII) + Duty of Candour (from April 2025)

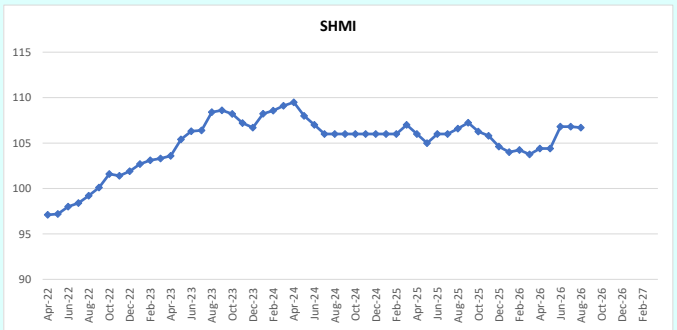


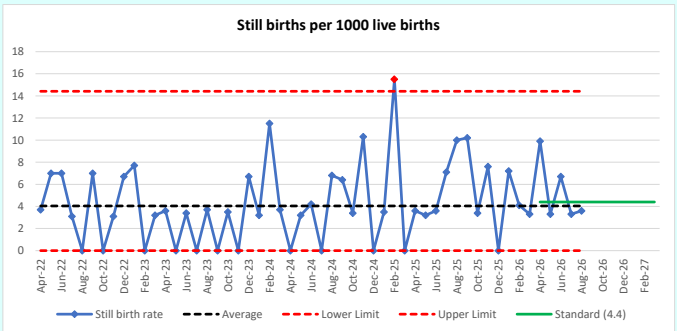

Percentage of IP Service Users undergoing risk assessment for VTE
NOT YET AVAILABLE
VTE assessment %
Average
Lower Limit
Upper Limit
Standard (95%)

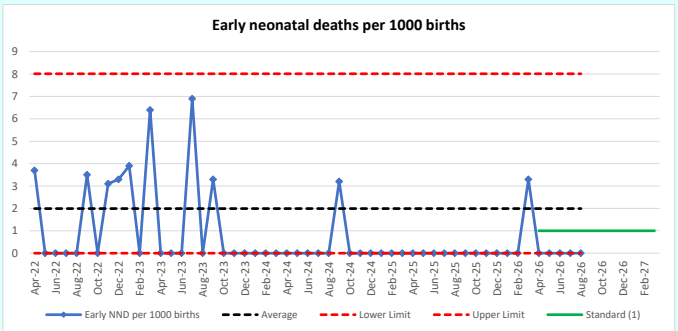

Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)
No. sepsis diagnoses
Average
Lower Limit
Upper Limit

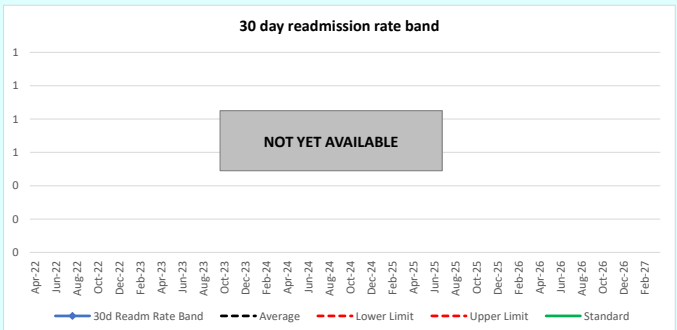

Complaints per 1000 occupied bed days
Complaints
Average
Lower Limit
Upper Limit
Standard (1.9)

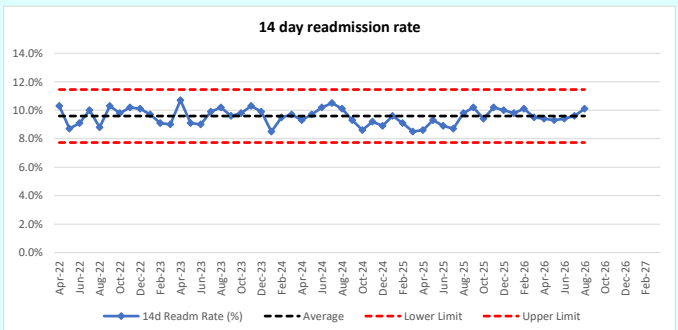

Compliments received in month
Compliments received
Average
Lower Limit
Upper Limit


SHMI


Still births per 1000 live births
Still birth rate
Average
Lower Limit
Upper Limit
Standard (4.4)

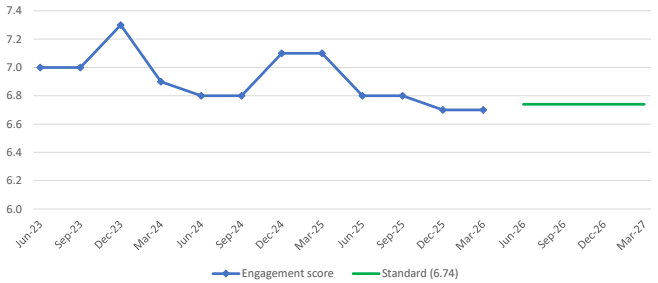

Early neonatal deaths per 1000 births
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard (1)


30 day readmission rate band
NOT YET AVAILABLE
30d Readm Rate Band
Average
Lower Limit
Upper Limit
Standard

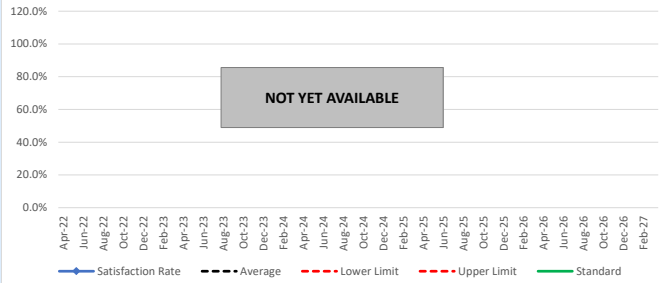

14 day readmission rate
14d Readm Rate (%)
Average
Lower Limit
Upper Limit

People and Culture

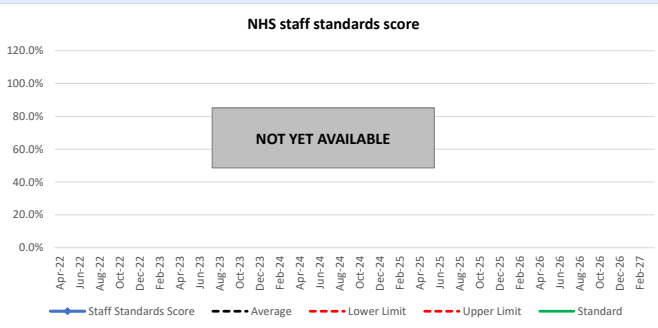
NHS staff survey engagement theme score



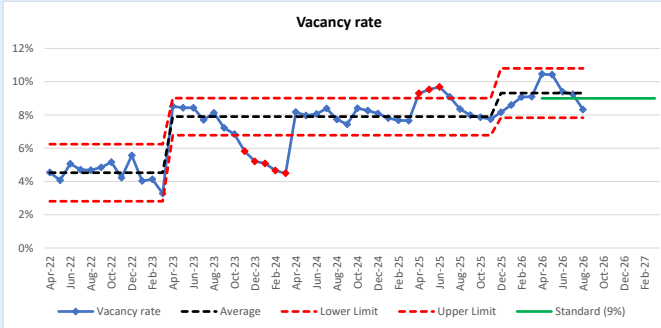
National Education and Training Survey satisfaction rate



NHS staff standards score

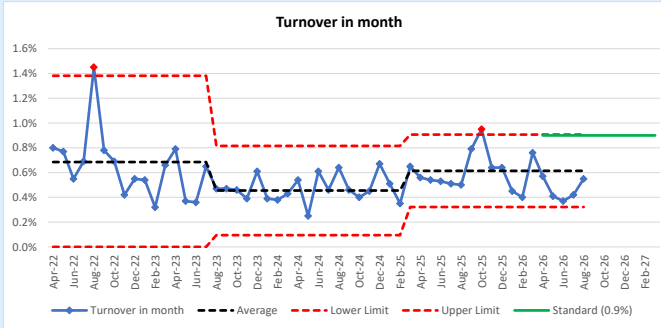


Vacancy rate

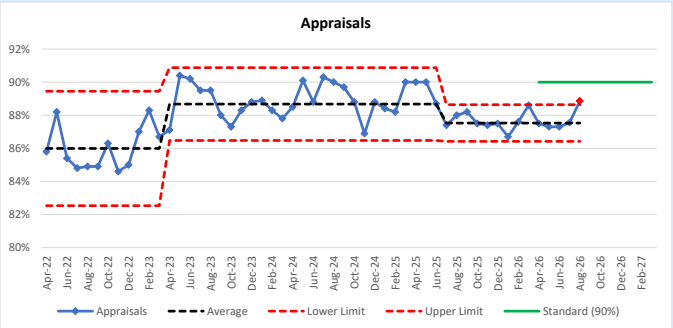


Time to hire

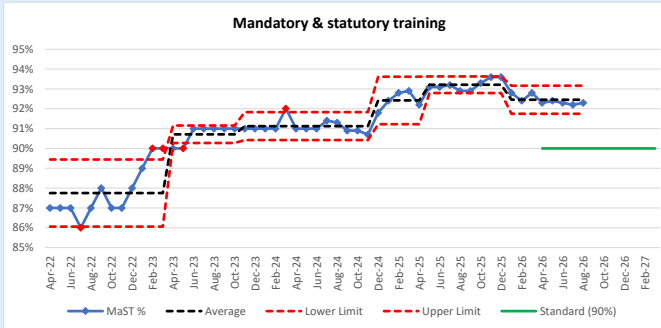
Turnover in month



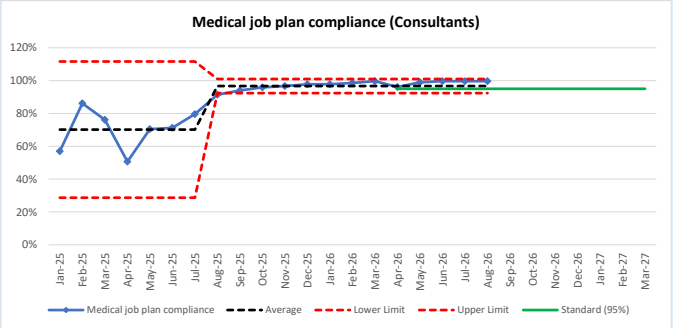
Appraisals



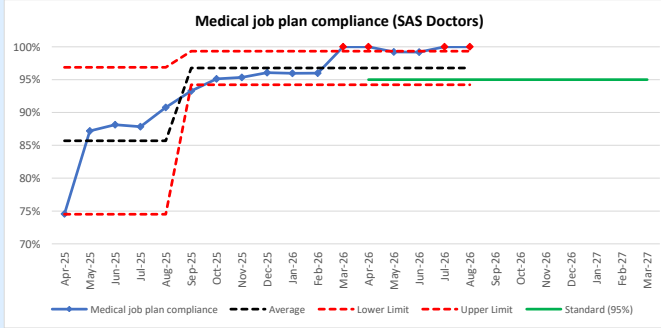
Mandatory & statutory training

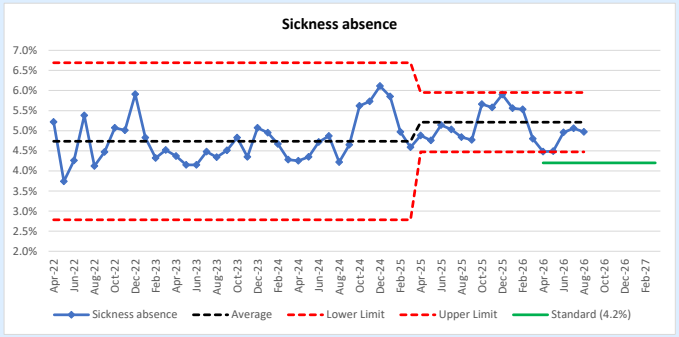


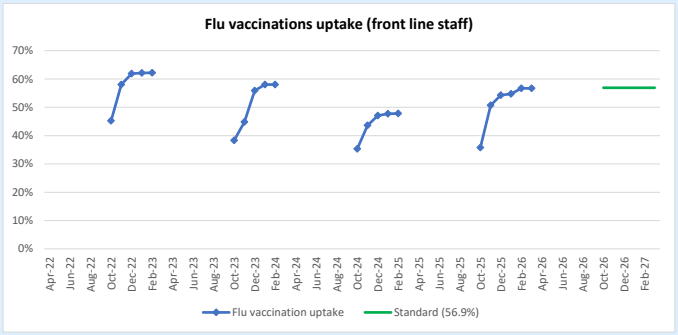
Medical job plan compliance (Consultants)

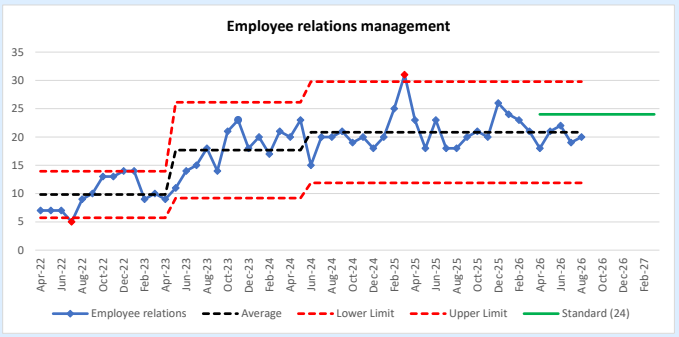


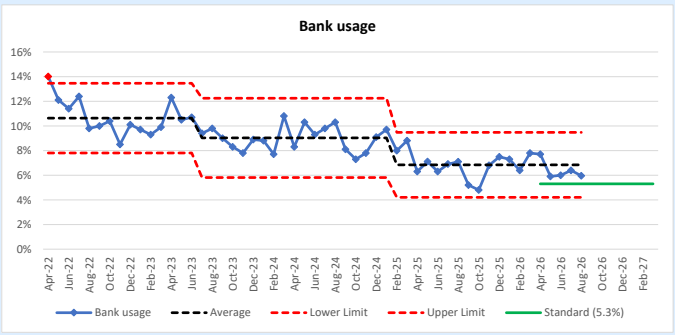
Medical job plan compliance (SAS Doctors)

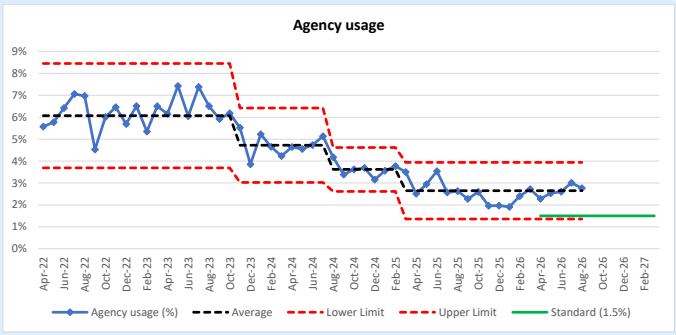


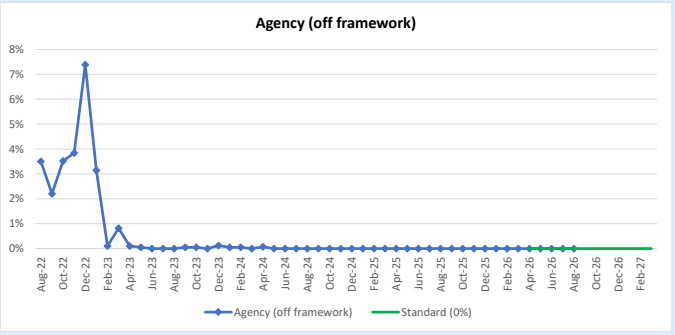

Sickness absence
Sickness absence
Average
Lower Limit
Upper Limit
Standard (4.2%)

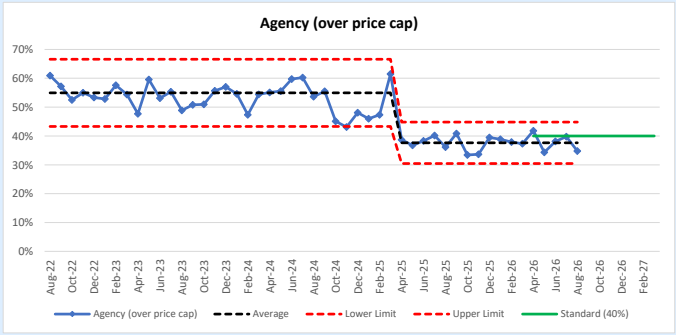

Flu vaccinations uptake (front line staff)
Flu vaccination uptake
Standard (56.9%)


Employee relations management
Employee relations
Average
Lower Limit
Upper Limit
Standard (24)


Bank usage
Bank usage
Average
Lower Limit
Upper Limit
Standard (5.3%)

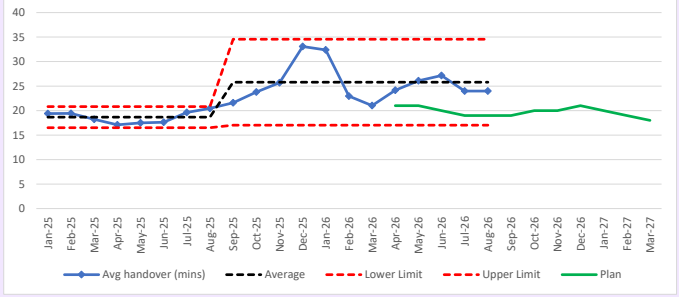

Agency usage
Agency usage (%)
Average
Lower Limit
Upper Limit
Standard (1.5%)


Agency (off framework)
Agency (off framework)
Standard (0%)

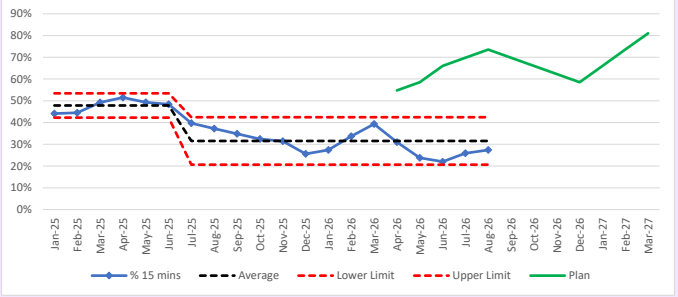

Agency (over price cap)
Agency (over price cap)
Average
Lower Limit
Upper Limit
Standard (40%)

Timely Care

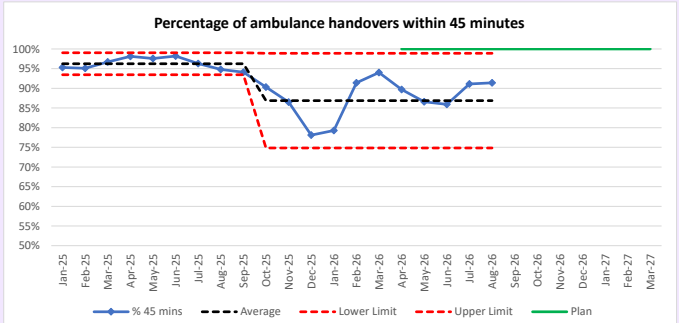
Average ambulance handover time (mins)



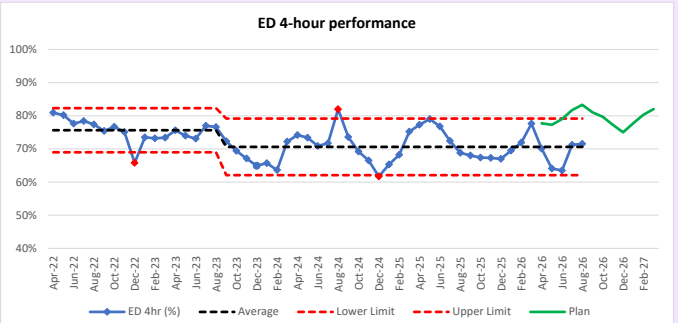
Percentage of ambulance handovers within 15 minutes



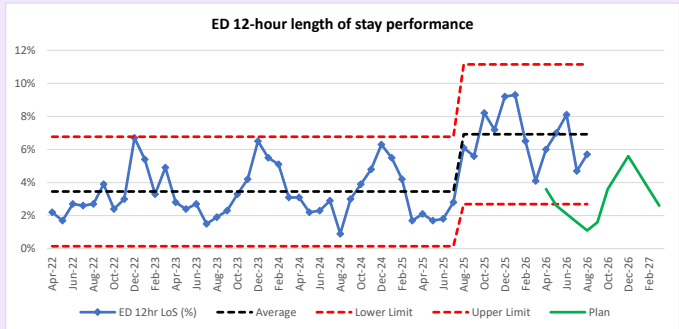
Percentage of ambulance handovers within 45 minutes



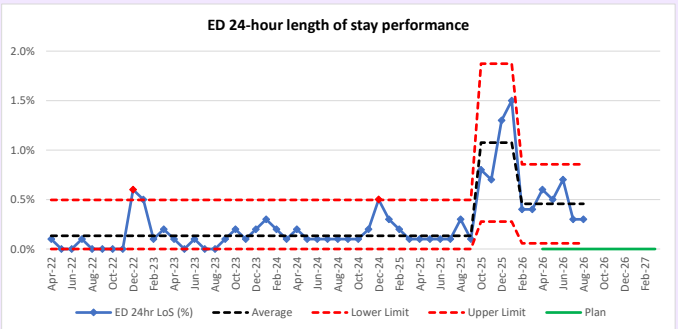
ED 4-hour performance



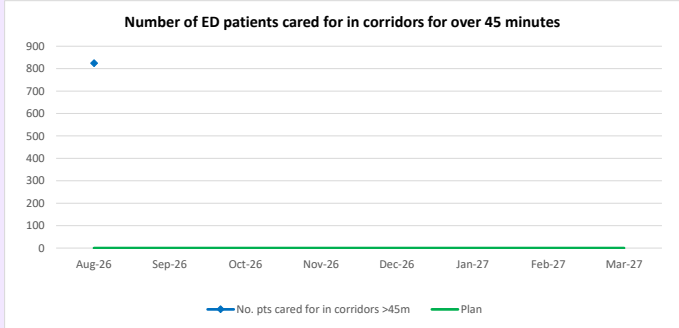
ED 12-hour length of stay performance



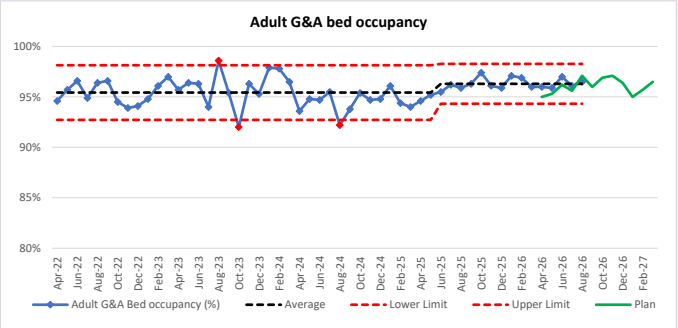
ED 24-hour length of stay performance



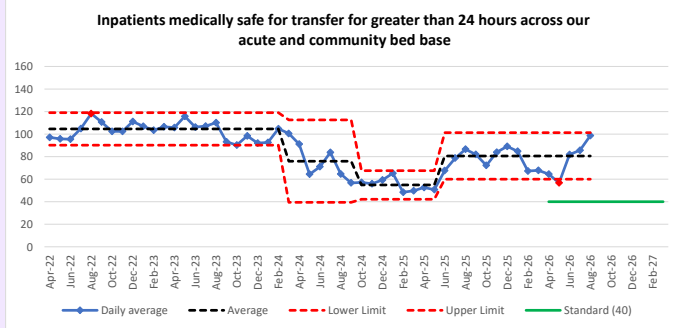
Number of ED patients cared for in corridors for over 45 minutes



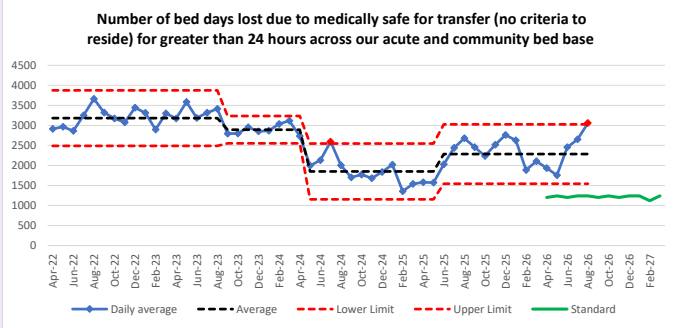
Adult G&A bed occupancy

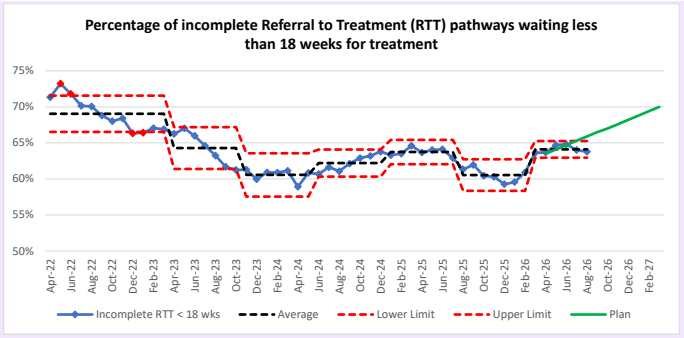


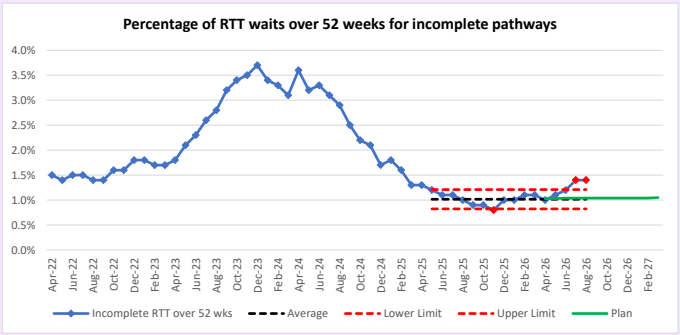
Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base

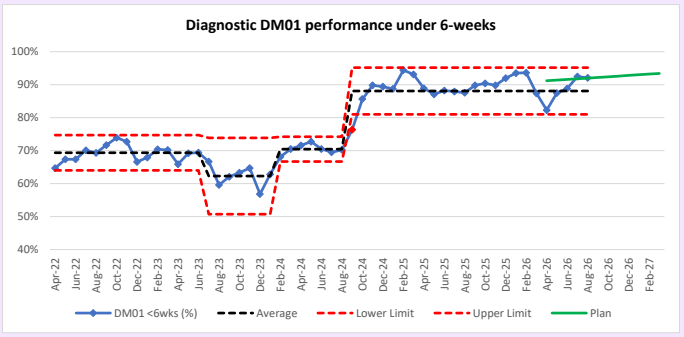


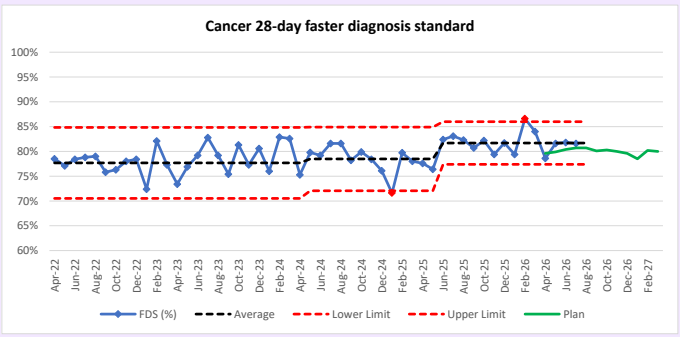
Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base

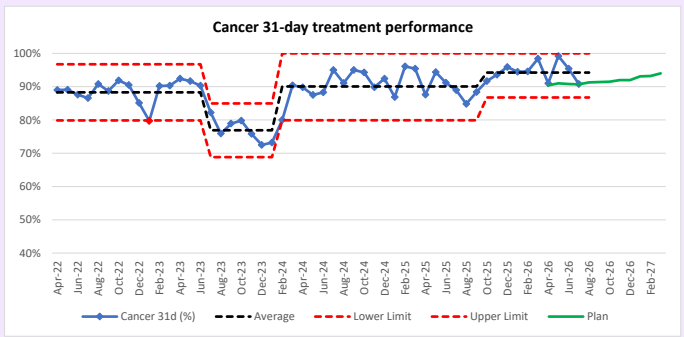


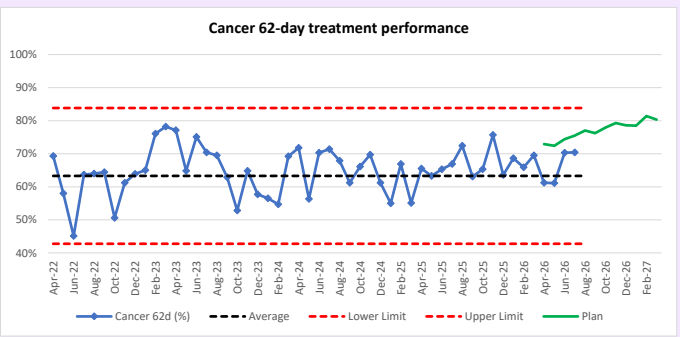

Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment
Incomplete RTT < 18 wks
Average
Lower Limit
Upper Limit
Plan


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


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

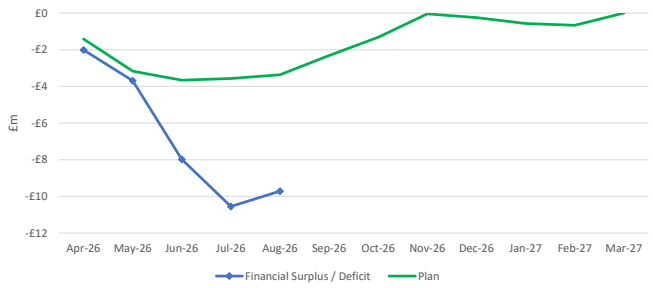

Cancer 28-day faster diagnosis standard
FDS (%)
Average
Lower Limit
Upper Limit
Plan


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

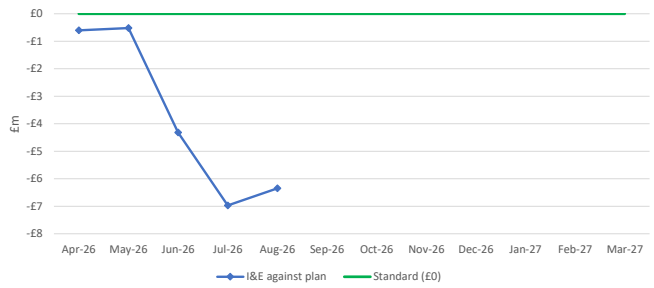

Cancer 62-day treatment performance
Cancer 62d (%)
Average
Lower Limit
Upper Limit
Plan

Best Value Care

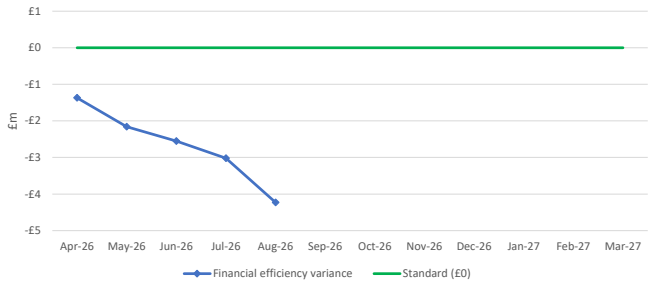
Financial Surplus / Deficit (cumulative)



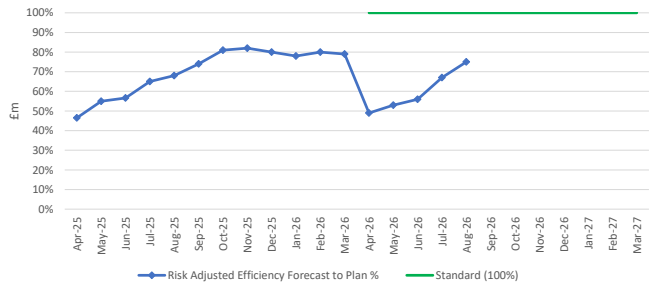
Variance YTD to financial plan (cumulative)



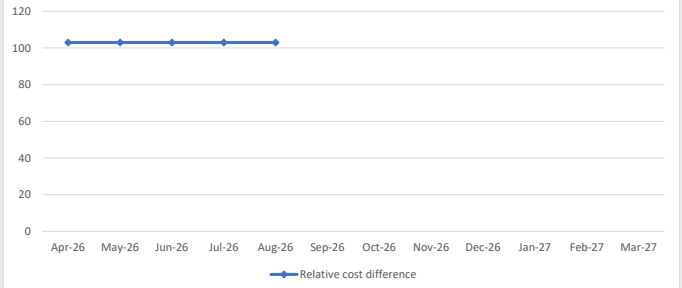
Financial efficiency variance YTD to plan (cumulative)



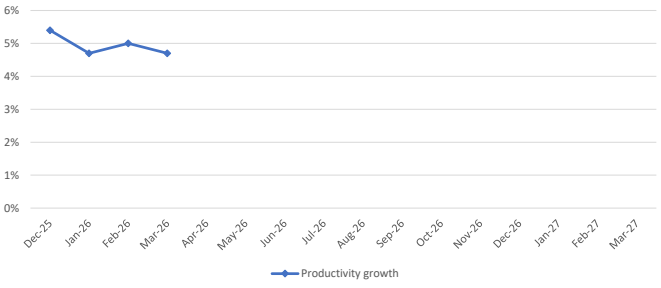
Risk adjusted efficiency forecast to plan (%)



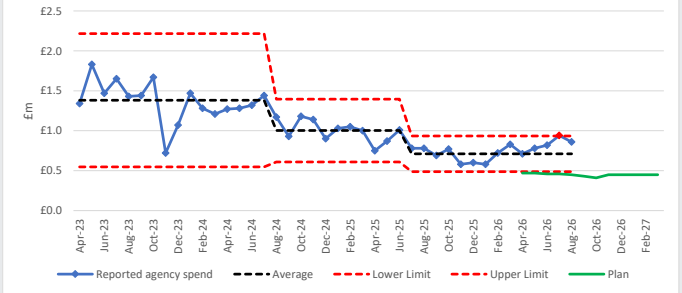
Relative cost difference (National Cost Collection Index)



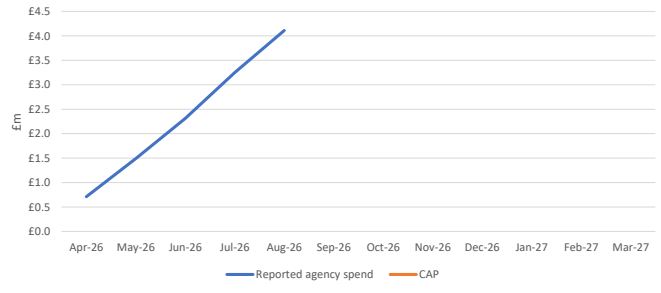
Implied productivity growth (YTD compared to last year)

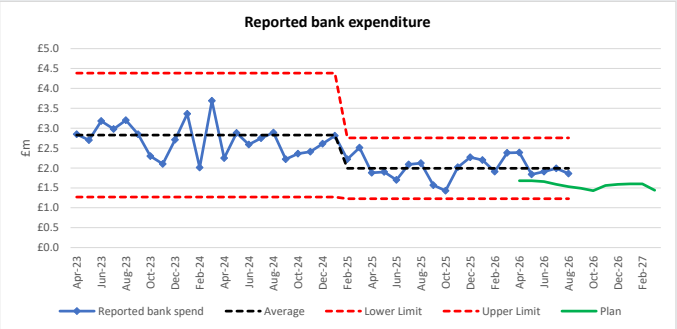


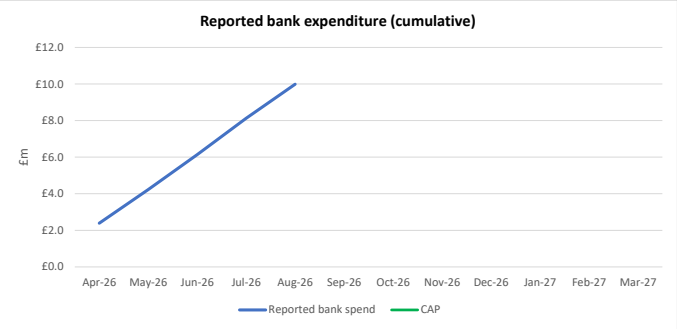
Reported agency expenditure

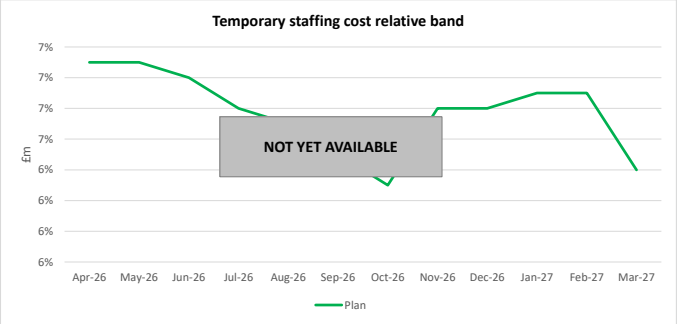


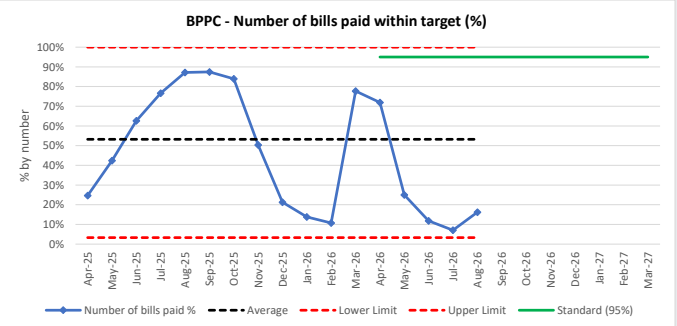
Reported agency expenditure (cumulative)

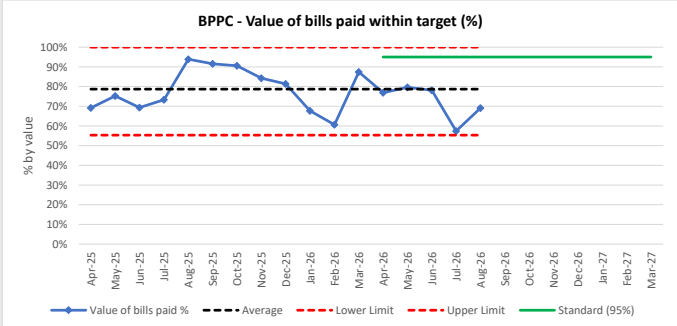


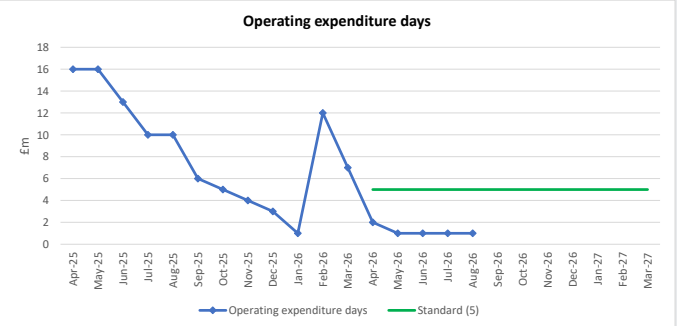

Reported bank expenditure
£m
Reported bank spend
Average
Lower Limit
Upper Limit
Plan

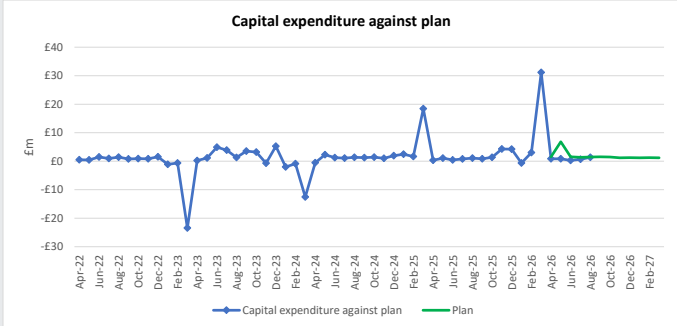

Reported bank expenditure (cumulative)
£m
Reported bank spend
CAP


Temporary staffing cost relative band
£m
NOT YET AVAILABLE
Plan


BPPC - Number of bills paid within target (%)
% by number
Number of bills paid %
Average
Lower Limit
Upper Limit
Standard (95%)

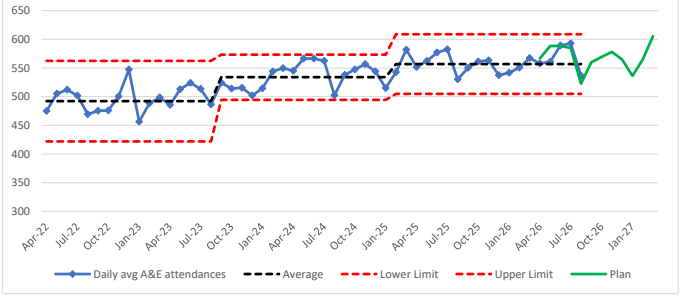

BPPC - Value of bills paid within target (%)
% by value
Value of bills paid %
Average
Lower Limit
Upper Limit
Standard (95%)


Operating expenditure days
£m
Operating expenditure days
Standard (5)

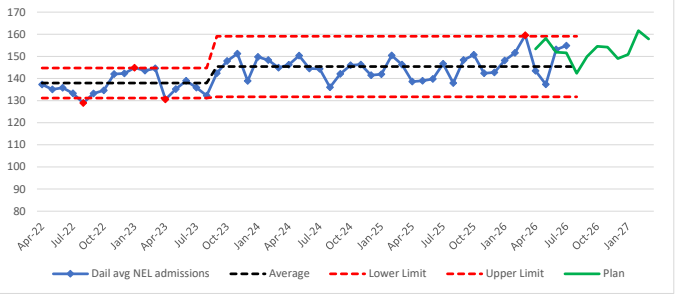

Capital expenditure against plan
£m
Capital expenditure against plan
Plan

Activity (for context)

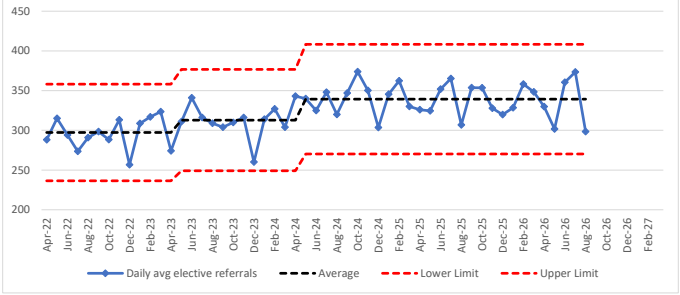
Daily average A&E attendances (inc. PC24)



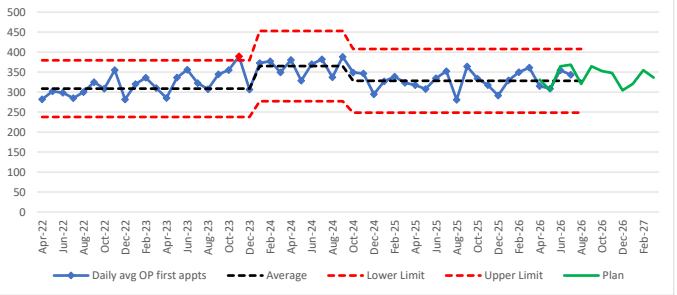
Daily average non-elective admissions



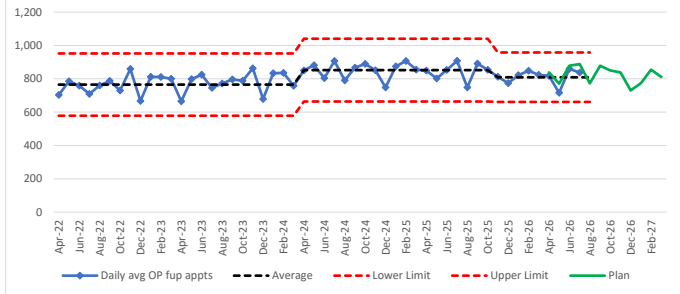
Average daily elective referrals



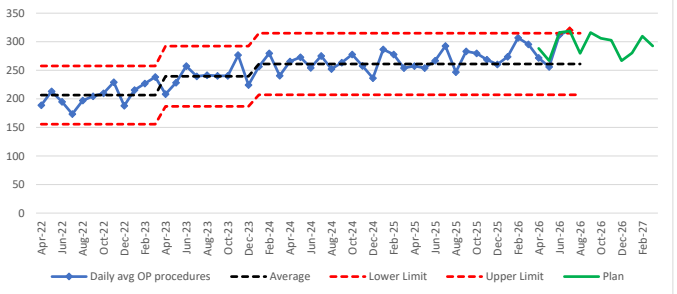
Daily average outpatient first appointments



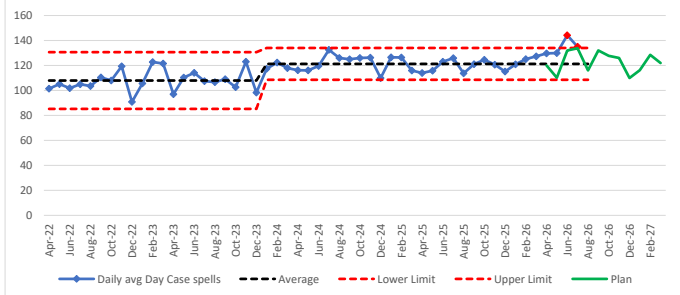
Daily average outpatient follow-ups



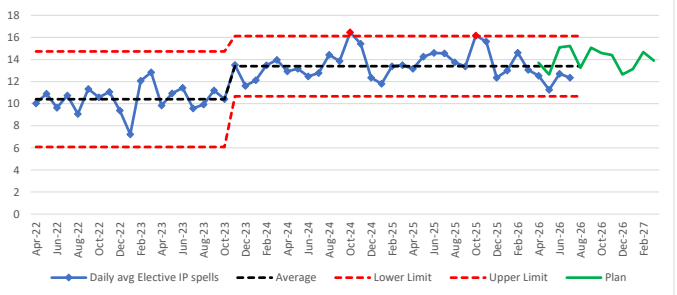
Daily average outpatient procedures



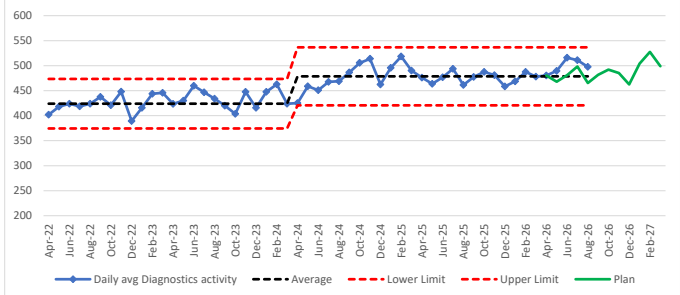
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

August 2026 (Qtr 2)

People & Culture Benchmarking

Apr-26

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period
Belonging	Engagement Score	NHS Staff Survey	6.7	66	121	6	2025
Growing the future	Turnover in month	NHS Hospital and Community Health Services (HCHS) monthly workforce statistics	0.9%	55	118	5	Apr-26
Looking after our People	Sickness absence	NHS Sickness Absence Rates	4.9%	52	118	5	Mar-26
New Ways of Working	Bank usage	Model Hospital	7.3%	119	195	7	Feb-26
	Agency usage	Model Hospital	1.9%	158	193	9	Feb-26

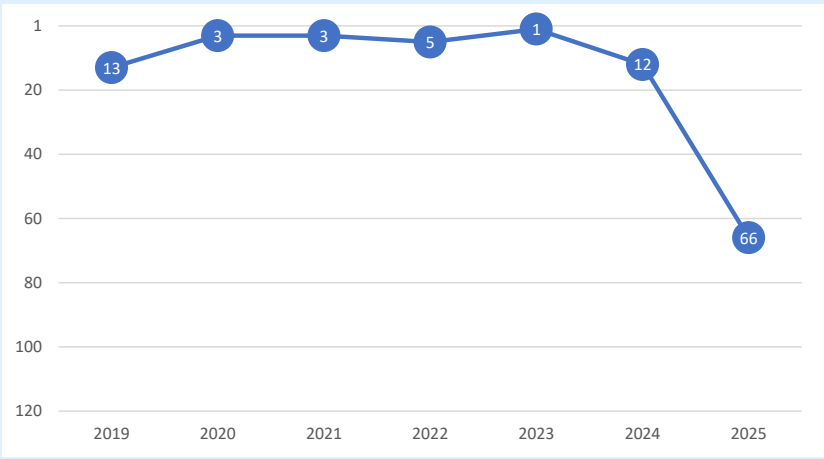
Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

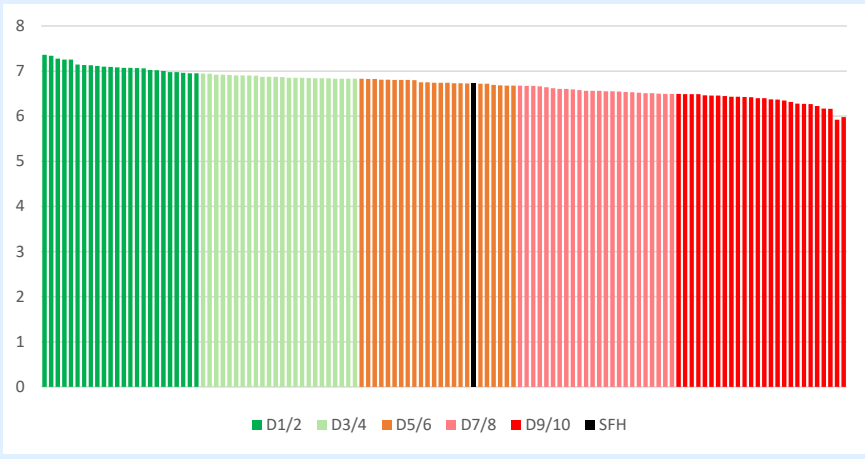
August 2026 (Qtr 2)

People + Culture Benchmarking

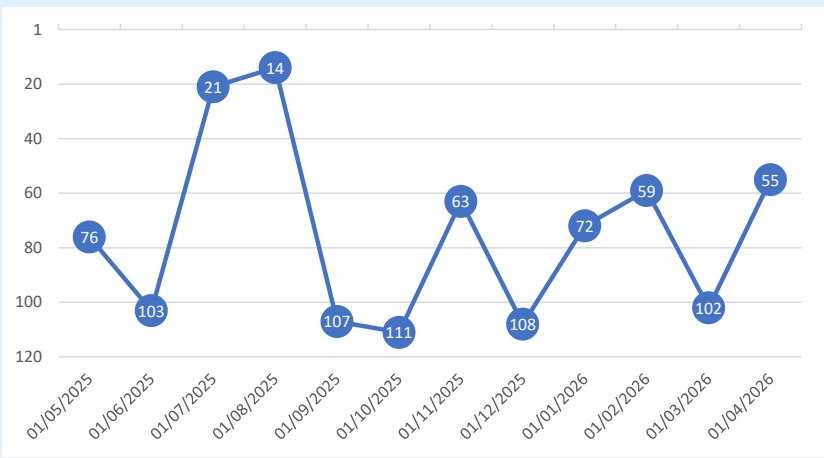
Overall Staff Engagement (NSS)



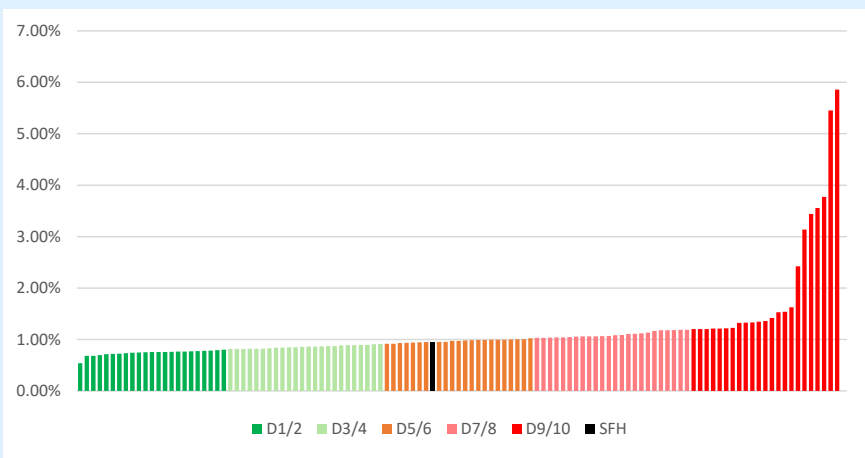
2025 Position



Turnover in month

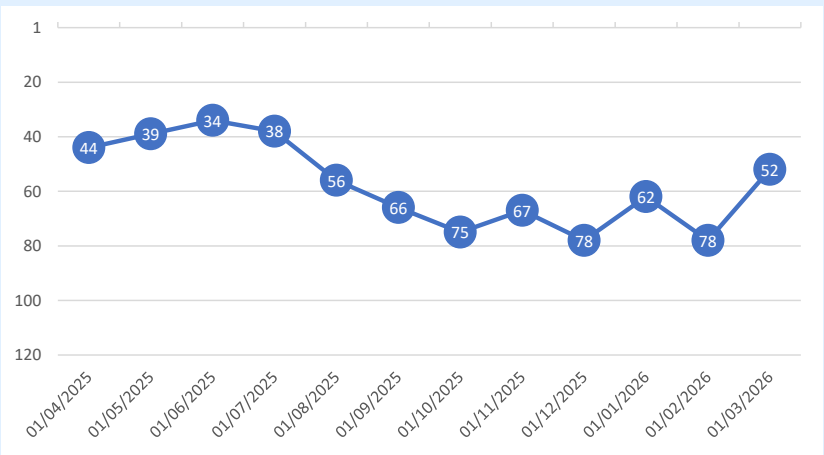


Apr-26 Position

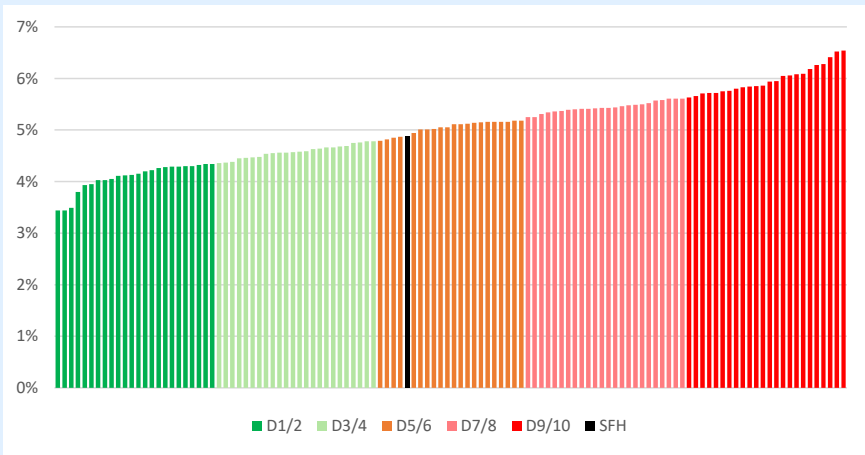


NB: Benchmark not published for March 25

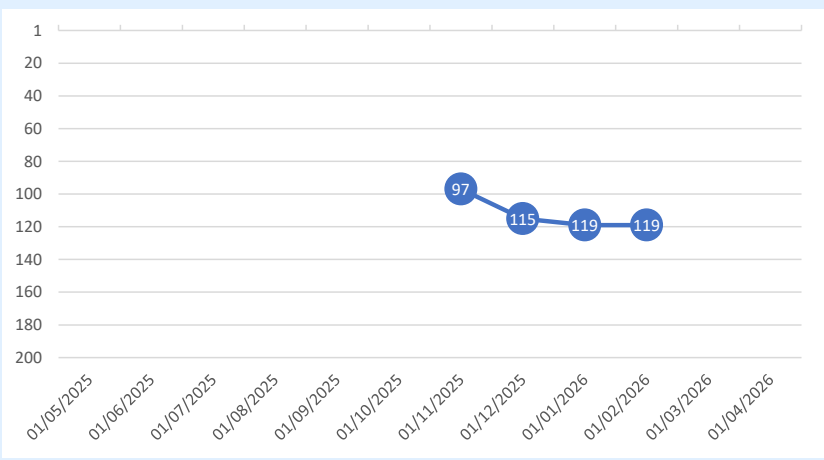
Sickness Absence



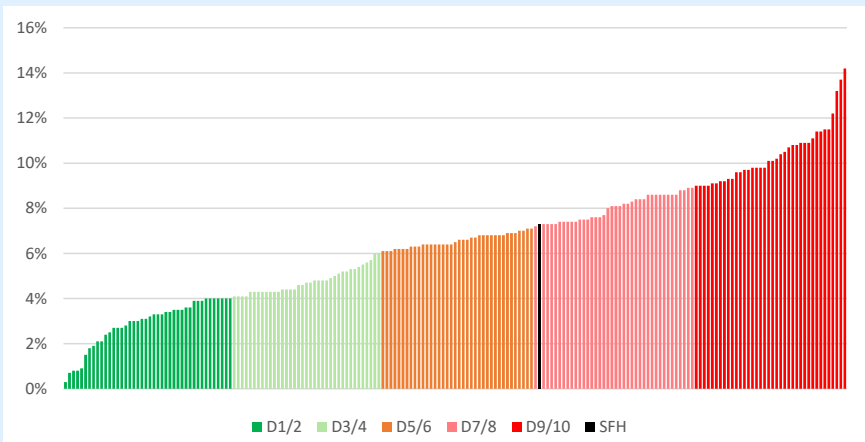
Mar-26 Position



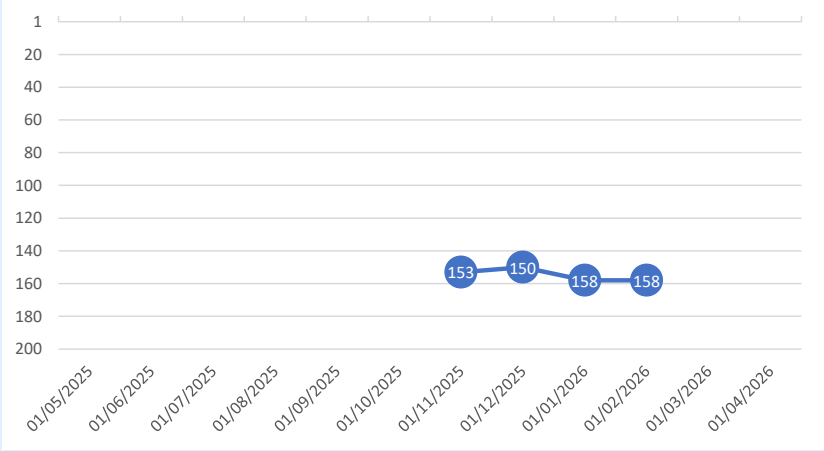
Bank usage



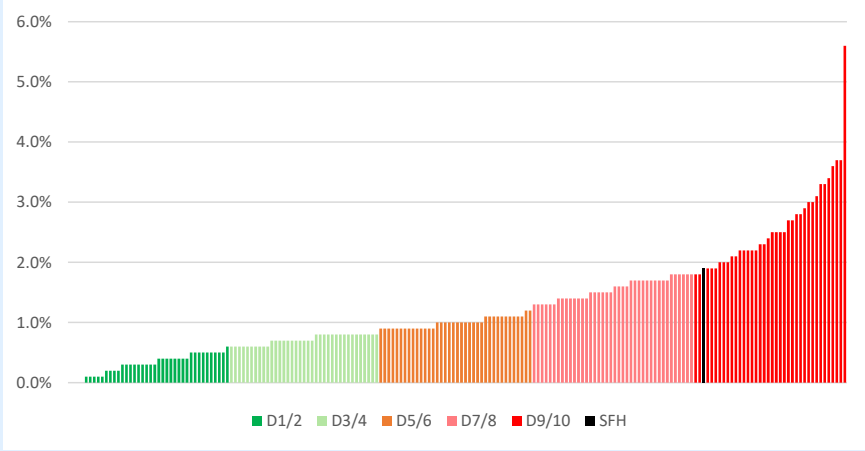
Feb-26 position



Agency usage



Feb-26 position



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

August 2026 (Qtr 2)

Timely Care Benchmarking

Jun-26

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period	
Urgent Care	Ambulance turnaround times <15 mins	Summary Emergency Department Indicator Table (SEDIT)	24.1%	125	174	8	May-26	
	Average ambulance handover time (mins)	EMAS Handover and Turnaround Report	00:27:10	4	15	1	Jun-26	NB: Local benchmarks only
	Percentage of ambulance handovers within 45 minutes	EMAS Handover and Turnaround Report	85.9%	5	15	1	Jun-26	NB: Local benchmarks only
	ED 4-hour performance	A&E Attendances & Emergency Admission monthly statistics	63.5%	128	140	10	Jun-26	
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	10.1%	83	177	5	May-26	
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	94.2%	80	177	5	May-26	
Electives	Elective RTT 18-Week Performance	RTT waiting times data	64.8%	94	148	7	Jun-26	
	Incomplete RTT pathways +52 weeks	RTT waiting times data	1.2%	88	148	6	Jun-26	
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	88.8%	39	135	3	Jun-26	
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	81.8%	47	130	4	Jun-26	
	Cancer 31-day treatment performance	Cancer Waiting Times standards	95.4%	69	130	6	Jun-26	
	Cancer 62-day treatment performance	Cancer Waiting Times standards	70.3%	76	134	6	Jun-26	

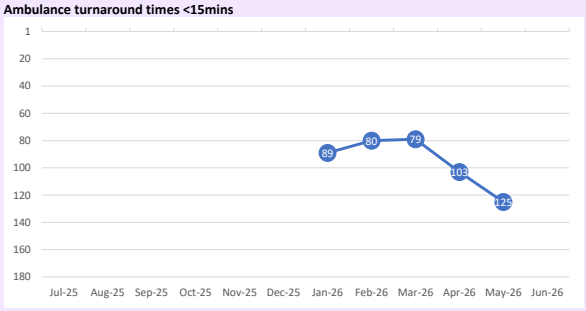
Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

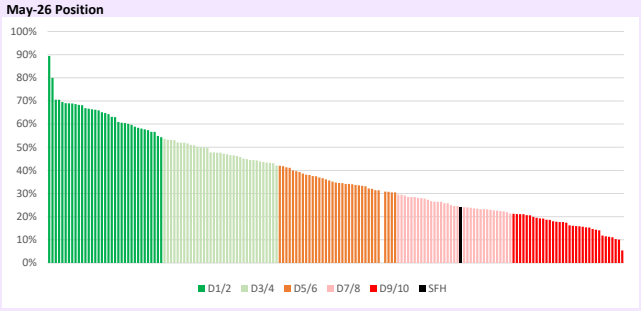
August 2026 (Qtr 2)

Timely Care Benchmarking

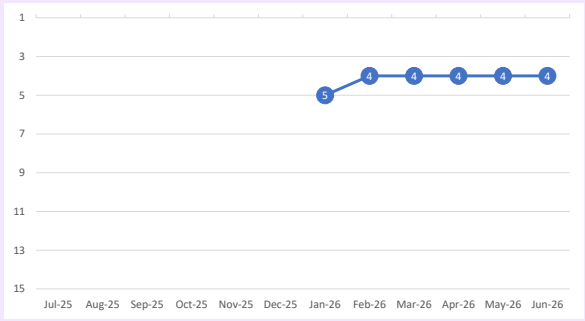
Ambulance turnaround times <15mins



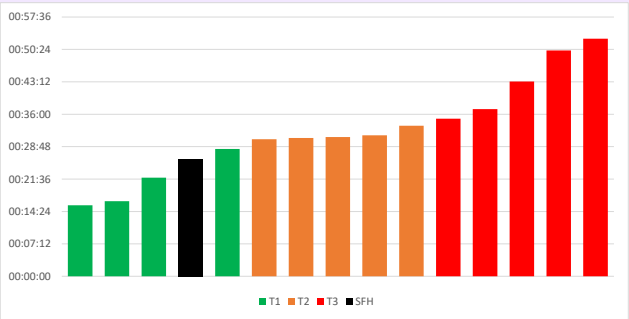
May-26 Position



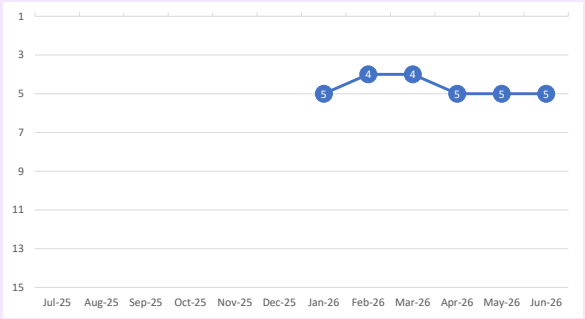
Average ambulance handover time (mins) - Local Benchmarks only



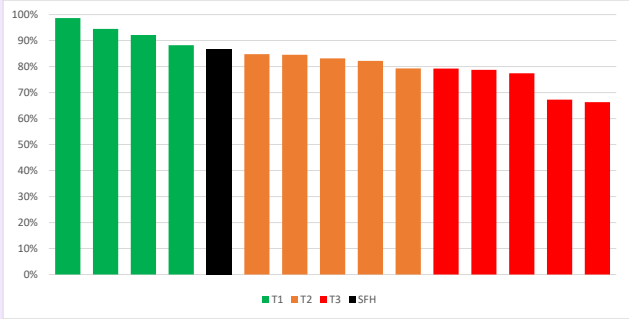
Jun-26 Position



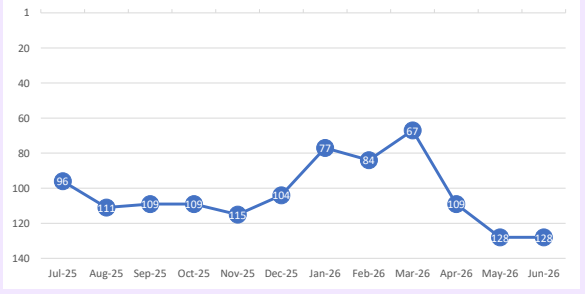
Percentage of ambulance handovers within 45 minutes - Local Benchmarks only



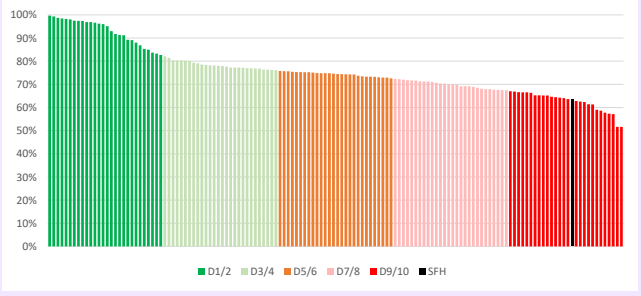
Jun-26 Position



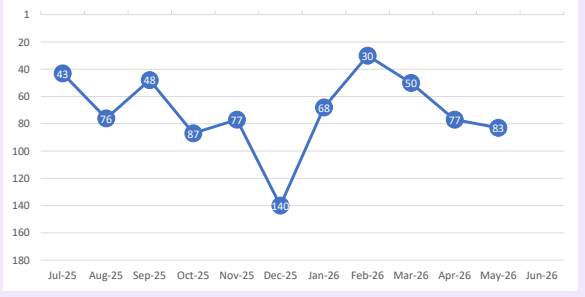
ED 4-hour performance



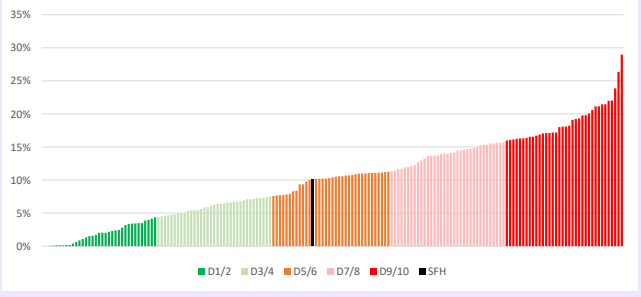
Jun-26 Position



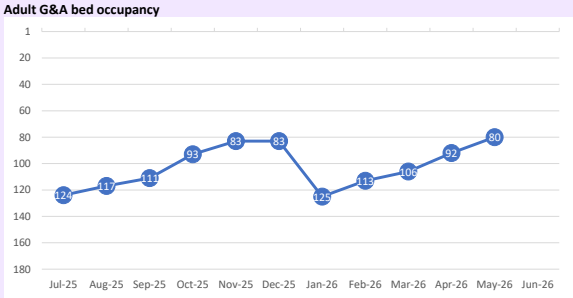
ED 12-hour length of stay performance



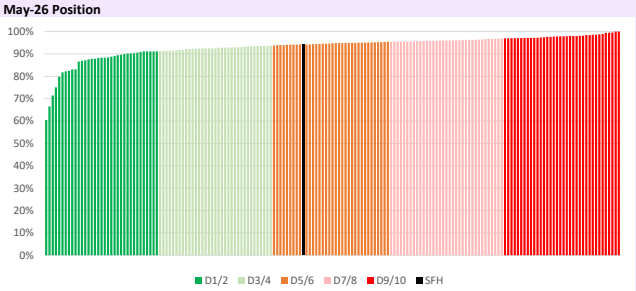
May-26 Position



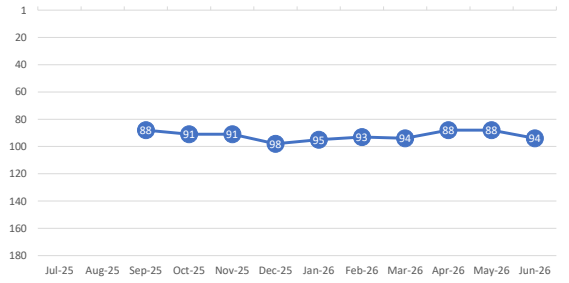
Adult G&A bed occupancy



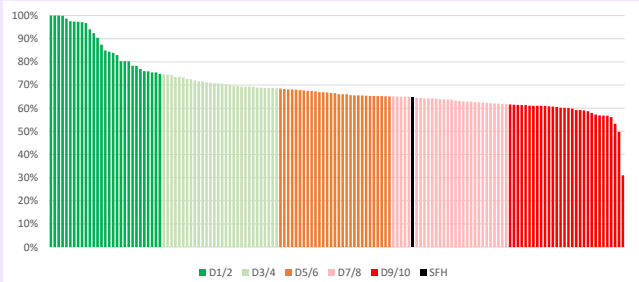
May-26 Position



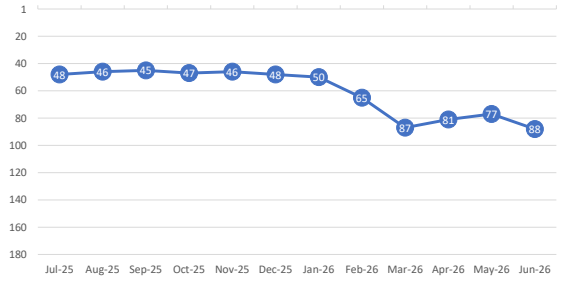
Elective RTT 18-Week Performance



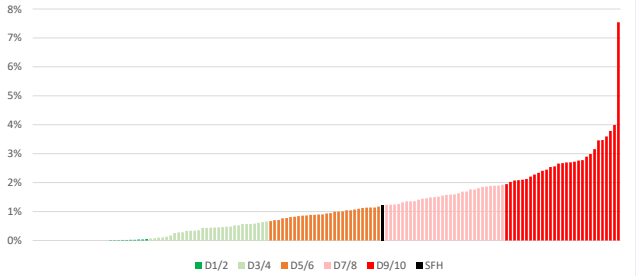
Jun-26 Position



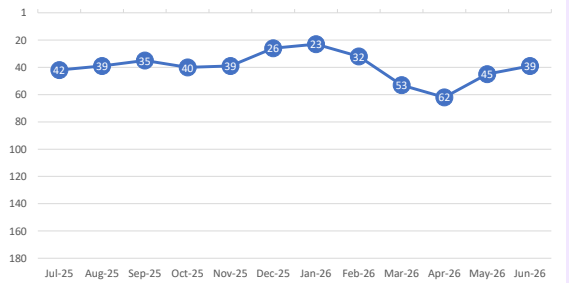
Incomplete RTT pathways +52 weeks



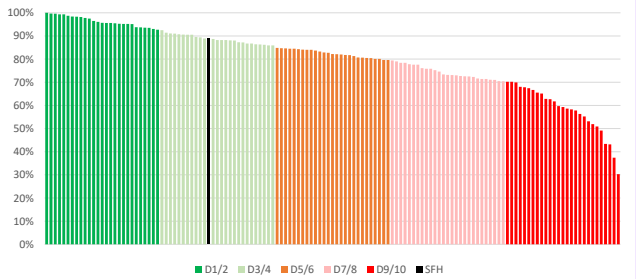
Jun-26 Position



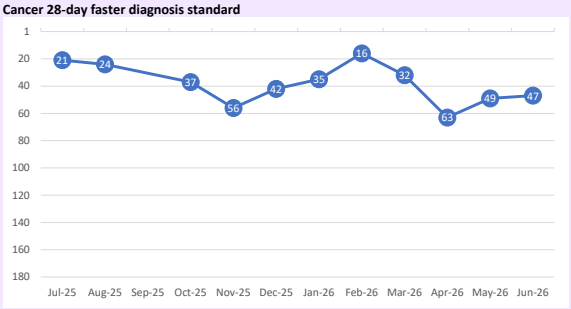
Diagnostic DM01 performance under 6-weeks



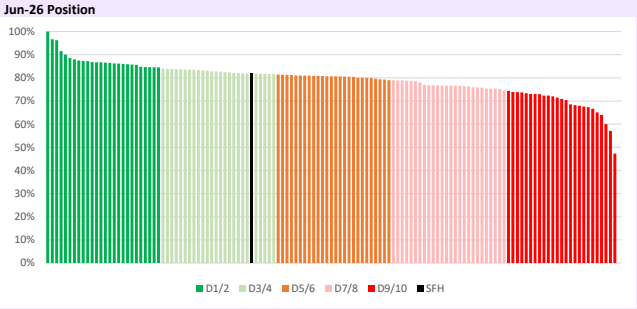
Jun-26 Position



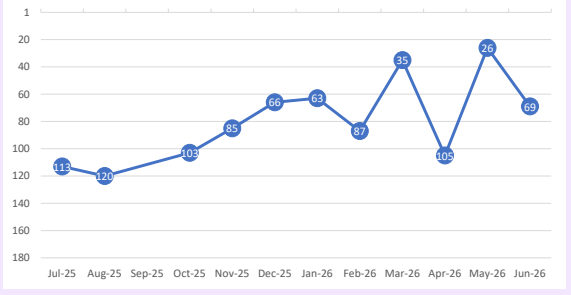
Cancer 28-day faster diagnosis standard



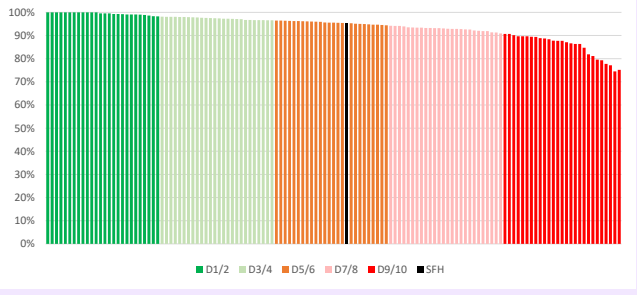
Jun-26 Position



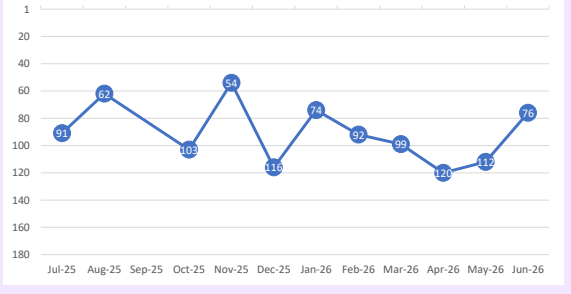
Cancer 31-day treatment performance



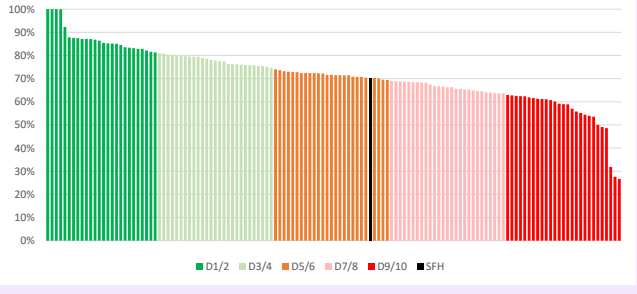
Jun-26 Position



Cancer 62-day treatment performance



Jun-26 Position



Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Winter Plan – 2026/27	**Date:**	1 October 2026
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Simon Illingworth, Chief Operating Officer		
Presented By:	Simon Illingworth, Chief Operating Officer		

Purpose

Winter Plan shared for review and approval by Trust Board.	**Approval**	✓
	Assurance	
	Update	
	Consider	

Recommendation

To approve our 2026/27 Winter Plan and Board Assurance Statement.

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

- Constructed under the oversight of the Winter Group.
- Reviewed in draft by Trust Management Team on 19 August 2026
- Considered in draft by Executives and Non-Executives on 3 September 2026.

Acronyms

All acronyms are defined within the paper.

Executive Summary

The attached presentation describes our key principles and approach to Winter Planning at SFH in 2026/27 and is based on the Integrated Emergency Management approach structured under the four headings:

1. Anticipate and assess
2. Prevent
3. Prepare
4. Respond and recover.

We have learnt from previous years and started the planning process early in 2026/27 with engagement across corporate and divisional teams. Outputs of the annual bed modelling exercise and proposed priority mitigations over winter within the allocated financial envelope (both bedded and non-bedded) are presented.

The proposed schemes represent the ‘best offer’ available and leave us with a peak bed gap of 25 beds in January 2027 (assuming modelling assumptions are correct and schemes deliver as planned).

Summary information is also presented around vaccination plans, our communications approach, areas of system focus, and escalation and contingency plans.

Our Winter Plan forms part of a wider process across the Integrated Care System (ICS). Our draft plan has been shared with Integrated Care Board (ICB) colleagues to support a system submission, and the final Trust Board approved plan will also be shared. We have also participated in a Nottingham and Nottinghamshire stress test exercise on 18 August, a national stress test exercise on 10 September and an NHS England winter assurance visit on 22 September.

We have completed and submitted to the ICS (on the 30 September) a Board Assurance Statement. This is included in appendix A.

The timescales for next steps include:

- **7 October:** NHS England Board Assurance Statement deadline (extended from 30 September). The ICS are collating and submitting the statements for all system partners together.
- **10 November:** Winter Plan update to the Council of Governors.

Work will continue to operationalise, communicate and monitor the plan. Specific Christmas and New Year plans will be developed in November 2026.

Trust Board are requested to review and approve our 2026/27 Winter Plan and our Board Assurance Statement.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Winter Plan 2026/27

This document describes the SFH winter plan for 2026/27

Trust Board: 1 October 2026

Key Principles for Winter Planning

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place, at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised, and quality of care is maintained. Patients are not exposed to unnecessary clinical risk
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised.
  Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment due to infectious disease outbreaks e.g. Influenza, Covid-19, Strep A, Norovirus, Carbapenem-resistant Enterobacterales (CRE) etc.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Approach to Winter Planning

The SFH winter plan is based on the Integrated Emergency Management approach:

1. **Anticipate and assess** issues in maintaining resilient services:
    - Key winter pressure drivers identified – likely epidemiology of winter 2026/27
    - Lessons learned from 2025/26
    - Demand modelled
    - Risks identified
2. **Prevent** the likelihood of occurrence and effects of any such issues:
    - Prevent and manage infection including vaccination
    - Effective population, patient and staff communications (system approach)
3. **Prepare** by having appropriate mitigating actions, plans and management structures in place:
    - Mitigating actions and flow priorities including staff and support service plans; staff well-being
    - Extent to which elective activity is protected, and patient outlying is reduced
    - Specific plans for the Christmas and New Year period
4. **Respond and recover** by enacting plans and contingencies as required:
    - Escalation triggers and actions
    - Contingency plans for surges in demand beyond anticipated levels in our ‘nominal’ state.

Outstanding Care,
Compassionate People,
Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Key Winter Pressure Drivers

Traditionally, key drivers for our winter pressures relate to:

- Higher acuity as evidenced by National Early Warning Scores (NEWS2) leading to longer hospital average length of stay
- High prevalence of influenza
- Increase in attendance/admissions in Respiratory (including Respiratory Syncytial Virus) and Healthcare of the Elderly
- Increase instances of infection (norovirus, D&V, CRE etc)
- Increase in number of beds occupied for patients that have been medically safe for transfer (MSFT) for greater than 24 hours awaiting discharge

We will learn from the Southern Hemisphere regarding the likely epidemiology of winter.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Performance Observations from 2025/26

Headline performance observations include:

- **Ambulance handover** performance deteriorated through 2025/26, dropping to particularly low levels during the peak winter months of Dec-25 and Jan-26
- Year-on-year growth in **Emergency Department (ED) attendances.** Although during winter, levels have been closer to 2024/25 apart from in Jan-26 when we did not see the usual ease. There is growth in King's Mill type one and Newark type three attendances. PC24 has observed very low attendance levels in recent months
- **4-hour performance** dropped significantly from Aug-25 driven by constrained outflow from ED for admitted patients. The bed pressures were, in part, driven by **increases in the number of medically safe patients**. 4-hour performance since Nov-25 has been higher than in the previous two years, despite the significant flow challenges and the Jan-26 critical incident. Type one 4-hour performance has improved since we opened the expanded Clinical Decisions Unit (CDU) in Feb-26
- **12-hour length of stay** deteriorated significantly to unprecedented levels during the winter period aligned to the high number of patients waiting in ED for a bed
- The **average wait in ED for a hospital bed** has deteriorated through 2025/26. In Oct-25 bed waits surpassed the peak levels seen in 2024/25 and peaked in Jan-26 at an unprecedented average wait of nine hours, the point at which the critical incident was declared. The average wait for a bed has reduced following delivery of the critical incident actions
- Wards across King's Mill Hospital have been **using additional bed spaces** (one, two and three over spaces). This has been in addition to opening all escalation beds to generate capacity and reduce waits in ED, thereby limiting delay-related patient harm. We have seen a record high number of patients occupying hospital beds. The proportion of wards going at least one-over during winter 2025/26 has increased significantly compared to the previous year
- NEWS2 scores indicate an expected **seasonal rise in acuity**. Winter 2025/26 saw a later but steeper rise in acuity than in previous years
- **Elective and day case activity has been strong** during Winter 2025/26, though often not quite at levels seen last year. However, we maintained more activity than in previous years during Dec-25 and we treated more elective inpatients in Jan-26 and Feb-26 than the previous year (as we only converted our elective ward to care for medical patients for a two-day period over Winter 2025/26)

Further detail (graphs and evidence) supporting the performance observations above is available on request.

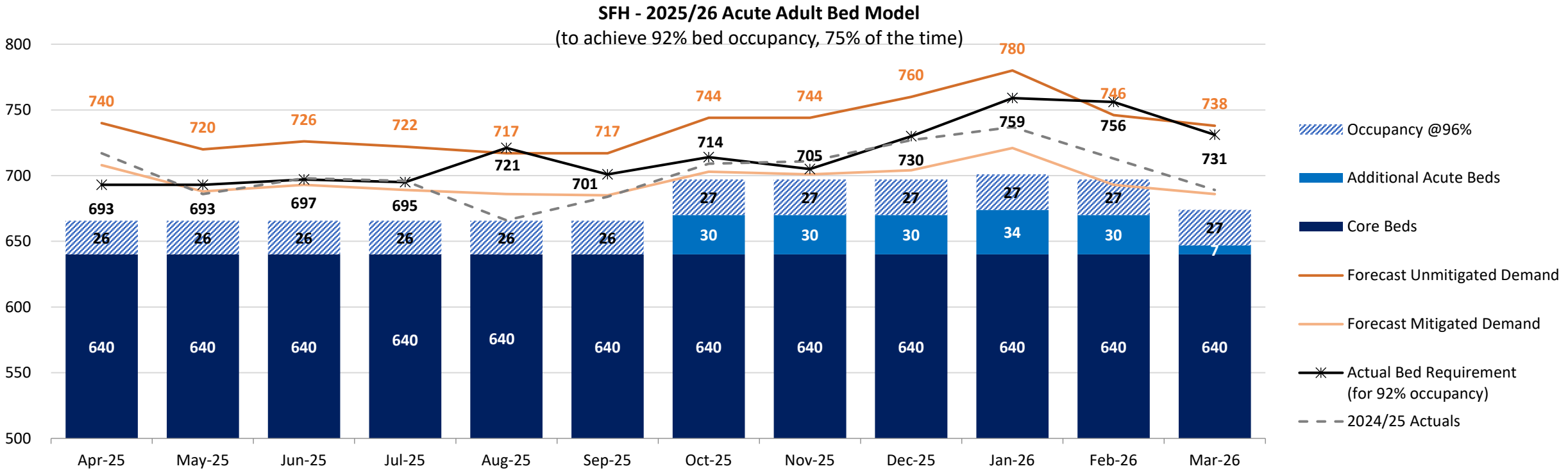
Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess | Prevent | Prepare | Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2025/26 Bed Model (1/2)



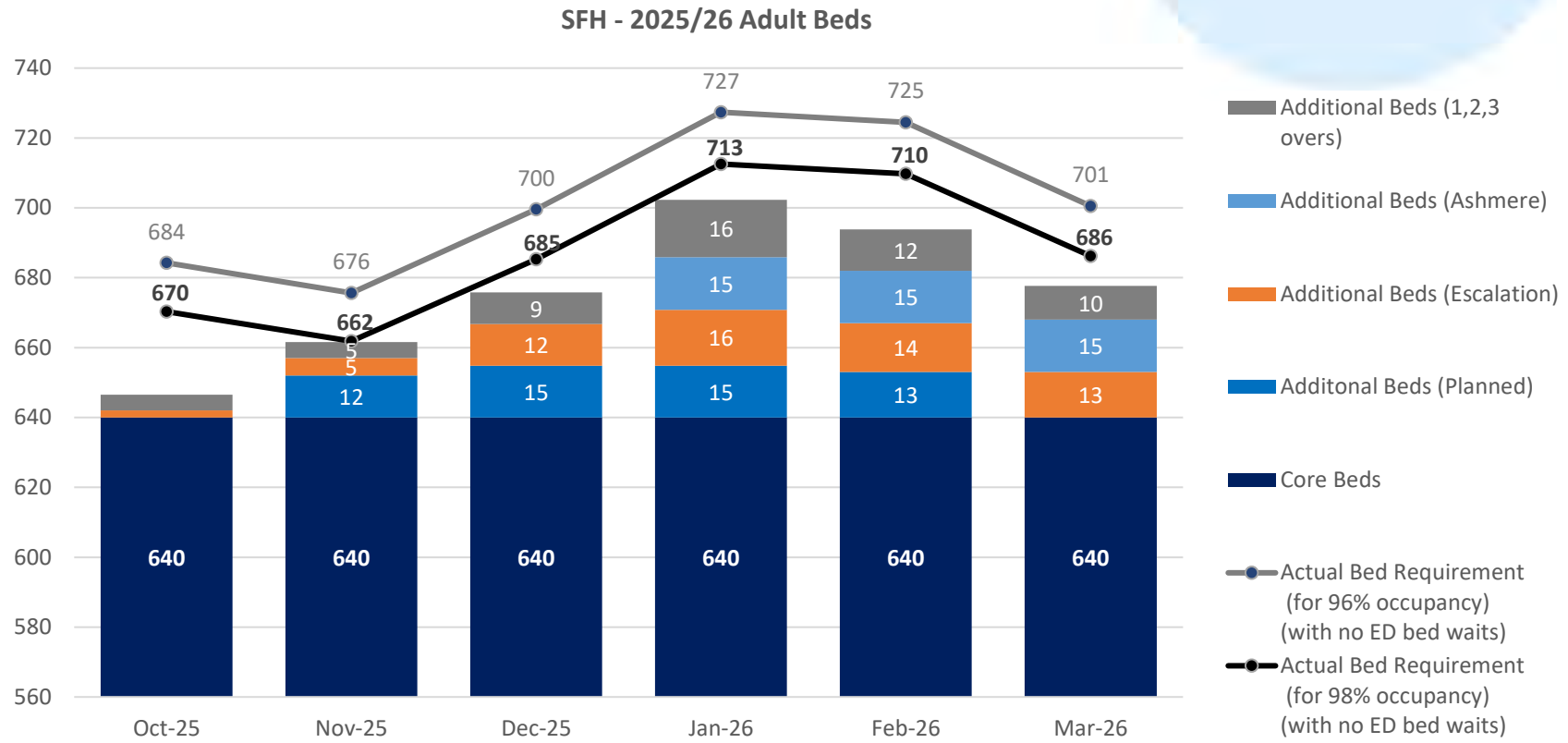
Actual bed requirement (black line) tracked closely to forecast mitigated demand (light amber line) during seven of the first eight months of the year. Variance in Aug-25 was driven by increased numbers of pathway one to three medically safe patients remaining in hospital. From Dec-25, the bed pressures were greater than the modelled scenario and, in Jan to Mar-26, a step higher than the previous year. We saw a higher level of medically safe patients in hospital over the winter period compared to 2024/25.

Reflecting on our 2025/26 Bed Model (2/2)

Our winter plan was initially based on mitigating the bed gap at 96% bed occupancy.

We also tracked running at 98% bed occupancy, recognising that while it represents a high-risk operational threshold, it is not unusual to be running at this level of bed occupancy.

It was necessary to open escalation beds (EAU, ward 53/54, Lindhurst) and use additional bed spaces (over spaces) across many of our King's Mill Hospital (KMH) wards.



We also commissioned capacity at Ashmere Care Home Group to support with the care of medically safe patients previously cared for at Mansfield Community Hospital (MCH). The released capacity at MCH was occupied by Stroke Rehabilitation to release acute beds at KMH which remained open for the remainder of the winter period. From Dec-25, and especially from Jan-26, we consistently had more beds occupied than the previous year and circa 30 more beds open than our original plan.

Reflecting on our 2025/26 Spend

- The Winter reserve for 2025/26 was £2.495m. We were initially working to an allocation of £1.8m to allow £695k cost avoidance (a similar level of spend to 2024/25 on official schemes; additional monies were spent on exceptional actions). In early September, we moved to a revised spend cap of £700k to provide a further £1.1m cost avoidance to support the Trust financial position

- We spent £563k on the approved winter schemes (underspend of £137k driven by the early closure of the Transitional Care Unit). A further £1.25m was spent on additional mitigations in response to patient demand (including the critical incident in Jan-26). These were:

  - Medical and nurse staffing in our Emergency Department
  - Additional medical beds on ward 53 following the transfer of Stroke Rehabilitation to Chatsworth ward at Mansfield Community Hospital
  - Additional beds on Lindhurst and Stroke wards
  - Medical bank and agency within the Medicine Division
  - Additional beds open on our assessment and admissions unit EAU
  - Additional discharge lounge opening
  - Additional beds at Ashmere
  - Additional patient transport services
  - Additional use of surgical Same Day Emergency Care (SDEC) spaces for overnight bed capacity
  - Additional orthopedic trauma list

Please note: *Some of the additional schemes were part of our 2024/25 winter plan and in our original 2025/26 winter plan before the revised spend cap was applied.*

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2025/26 Schemes and Mitigations

Seek to mainstream as business as usual

- **Enhancements to our Virtual Ward offer.** Our virtual ward offer requires some review in terms of year-round delivery. Use of virtual wards is an important component of our business-as-usual clinical offer
- **Discharge lounge enhanced overnight use.** We should maximise the use of the discharge lounge throughout the year. Opening additional space on the discharge lounge should be part of our actions within our Patient Flow and Escalation Policy for year-round deployment

Modify for Winter 2026/27

- **Acute Frailty Service.** We wish to implement an ambulatory frailty service/frailty SDEC instead of a frailty unit within our short stay bed base in alignment with GIRFT recommendations
- **Bridging capacity for pathway one discharges.** Reflections were positive with the view that this scheme could be expanded in scope to transfer more medically safe patients out of acute beds and to a community setting. The scheme supported the transfer of approximately 15 patients per week. The scope could be increased if we could support patients with a requirement for more than one visit per day

Desire to repeat in Winter 2026/27

- **Doubling of respiratory physicians at weekends.** Mobilised for the past four-years and supports increased seasonal demand in this specialty
- **Children's Assessment Unit (CAU) increased opening hours.** Mobilised for the past three-years and supported increased admissions to CAU from both GPs and ED with good clinical feedback
- **Orthopedic 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 reducing length of stay. Maintaining trauma operating allows elective operating to continue (generating income)
- **Bedded schemes.** Our bed base was fully utilised over winter. This included all escalation beds and one, two and, at times, three over spaces. Capital works were completed in Dec-25 to create a fifth bed space in most of our King's Mill Hospital ward bays

Do not repeat or modify

- **Transitional Care Unit.** Whilst this unit provided patients with a safer and more appropriate place to wait for admission, it did not provide a sustainable solution to resolve the patient flow challenges through and out of our medical base ward beds. We could not deliver against the anticipated impact of a 30-bed mitigation; instead, the unit cared for a maximum of 16 patients
- **Surgical SDEC overnight use.** Preference is to not repeat as overnight use can adversely impact on next day activities. Focus should be to right-size the medical bed base over the winter period
- **Medical and nurse staffing in ED**. Enhanced ED staffing was required to care for the high number of patients waiting for admission. It is not driven by the number of attends (which do not increase over winter). Whilst acuity is higher over winter, the existing ED staffing rotas would be sufficient if there was not significant increases in the number of patients waiting for admission. If we can solve the admission problem, this additional ED staffing would not be required.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

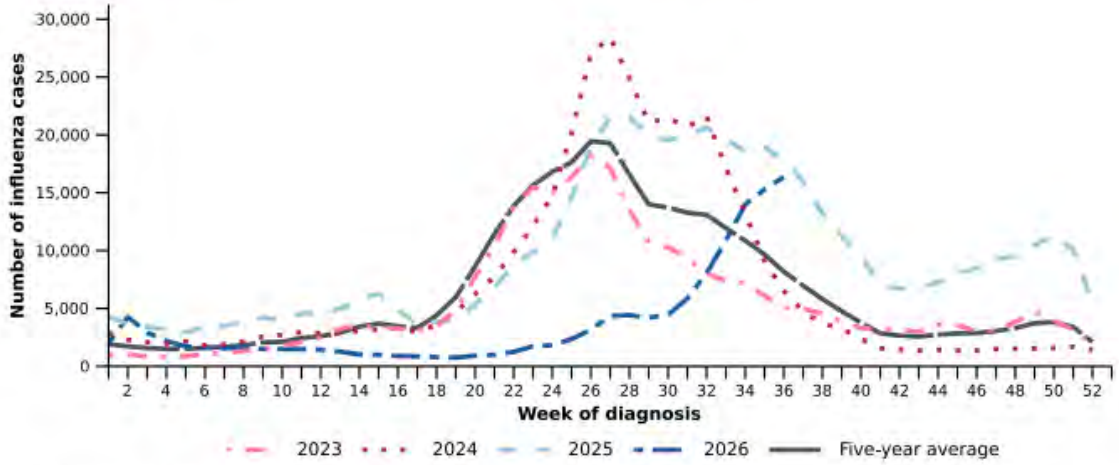
NHS Sherwood Forest Hospitals NHS Foundation Trust

Lessons Learned from 2025/26

What worked well	Areas for improvement
▪ **Bed model was accurate** and should be regarded as reliable for future planning. The months with variance to the modelled scenario related to the **unexpected increase in the number of medically safe patients** across our hospitals ▪ **Approved schemes commenced as planned** ▪ The capital works to create **additional bed spaces** (fifth bed) in the bays across our wards at King's Mill Hospital (KMH) completed and the spaces **were used providing patients with better privacy and dignity** than before ▪ We **kept our elective ward running** for most of the winter period (except for two days during the critical incident in Jan-26). This is the first winter period we have been able to maintain our inpatient elective ward for several years ▪ **Surge and escalation plans** (including full capacity protocol [FCP]), when enacted, **supported de-escalation.** The actions taken during the critical incident supported a rapid de-escalation ▪ **Hospital flow pressures began to ease** as we exited winter and as **discharge delays reduced.** This, together with the opening of an **expanded Clinical Decisions Unit** (CDU) supported **improved 4-hour performance**	▪ Due to bed constraints during peak winter periods, our **wards** at times were **required to go 'one, two and three-over'.** We require space to be able to flex our bed base up and down at KMH to meet patient needs during peak periods ▪ **Medical** patients were placed as **outliers on surgical wards** impacting on planned care and emergency surgical pathways ▪ Some of our people worked **additional hours** over and above contract, including clinical bank shifts and overtime adversely impacting on work-life balance ▪ **Actions** that have historically been part of our winter plans were **removed from our plan** due to the need **to reduce spend against the winter reserve**. Many of these actions were deployed over winter in a reactive manner during periods of escalation (including during the critical incident). Using the winter reserve to deliver mitigations in a planned manner could have been more cost-effective and resulted in better staff and patient care and experience ▪ The expanded CDU that was introduced following the closure of the Transitional Care Unit has been very successful. Further work to be undertaken to **ensure that ambulatory and admission avoidance pathways are maximised** in readiness for Winter 2026/27 ▪ **Refine our approach to Frailty** in line with GIRFT recommendations.

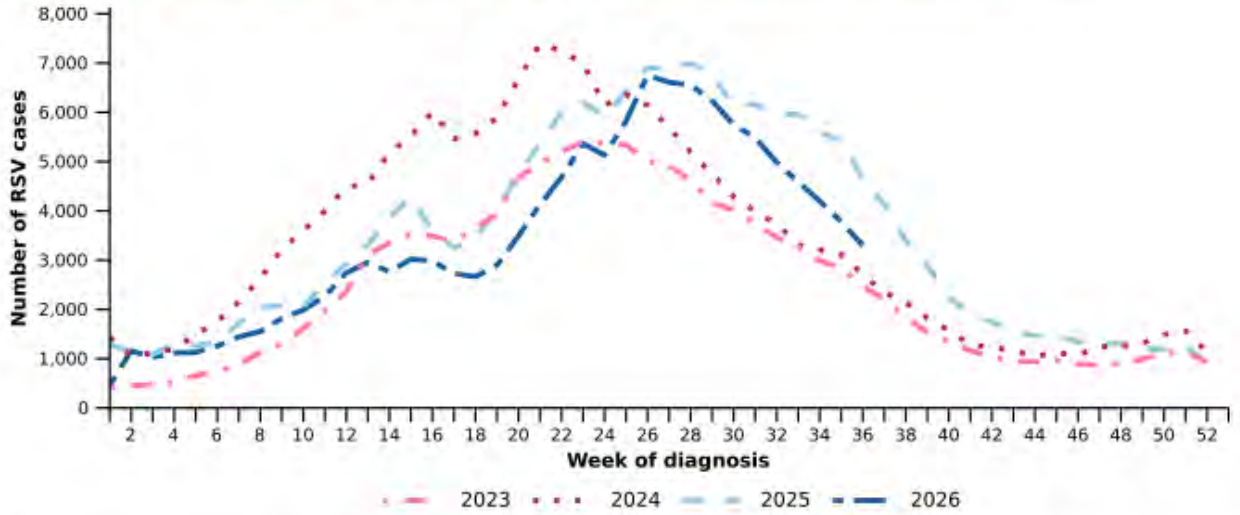
Australia Influenza Season

Figure 7: Notified influenza cases and five-year average* by year and week of diagnosis, Australia, 2023 to 6 September 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2019 and 2022 to 2025.

Figure 11: Notified RSV cases by year and week of diagnosis, Australia, 2023 to 6 September 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)

- In Australia they have seen:
  - Influenza tracking lower in 2026 in the ‘off-peak’ period than previous years. The main peak does not appear to have occurred yet, which means that it will be later than previous years. Areas of Australia has recently seen a rapid increase in cases (circa 10 weeks later than normal)
  - RSV tracking at similar levels to 2025 rising approximately 2-weeks later than last year (and 2023)
- Modelling assumes equivalent levels and timing to winter 2025/26.

Source: Australian Respiratory Surveillance Report

Bed Model: 2026/27 Approach

- Separate models in place for adult, paediatric, maternity, critical care and day case demand/bed bases
- Bed requirement in our adult model is based on:
  - 75th percentile of hourly demand
  - Goal to achieve 96% bed occupancy.
- **Capacity:** Operational view of core capacity based on beds that are in the establishment. Beds that flex up and down in line with demand are considered as escalation beds and not part of core bed stock. Note: following the move of Stroke rehab to MCH in Jan-26, there is now provision in our baseline for a decant ward to facilitate deep cleaning programme during the summer months.
- **Demand Assumptions:** 2025/26 outturn adjusted as follows for the initial version of the adult bed model ('nominal' state):
  - Growth aligned to operational plan (3.8% more electives, 1.9% growth in non-elective overnight stays and 0.9% growth in day case)
  - No change in Length of Stay (LOS)
  - Medically Safe for Transfer (MSFT) in Apr-26 and May-26 is held constant at the Mar-26 level
  - Accident and Emergency (A&E) bed waiters capped at 30-minutes from decision to admit. Balance of bed waits added to Urgent and Emergency Care demand
  - Where day case length of stay exceeds 16 hours, demand is included in our inpatient bed model
  - Specialty wards exclude day case demand, where LOS is less than 16 hours
- Further detail relating to the bed model is available as a separate pack on request.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Adult Bed Model: 2026/27 Forecast Demand

Overnight bed requirements

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Baseline	647	649	649	641	659	644	661	656	665	697	699	689
A&E waiters	8	7	8	10	16	14	24	20	25	26	17	15
Growth	34	34	34	34	35	34	35	35	35	37	37	36
Adjusted MSFT	8	11										
Forecast Unmitigated Demand	697	701	691	685	710	692	720	711	725	760	753	740

The table above describes how the forecast unmitigated demand line has been calculated for our nominal (expected) state

The position starts with 2025/26 outturn as the baseline and factors in:

(1) The elimination of A&E bed waits

(2) Planned growth (in line with our operational plan)

(3) MSFT adjustments to account for 2025/26 levels being lower in Apr-25 and May-25 than the position entering 2026/27.

Outstanding Care, Compassionate People, Healthier Communities

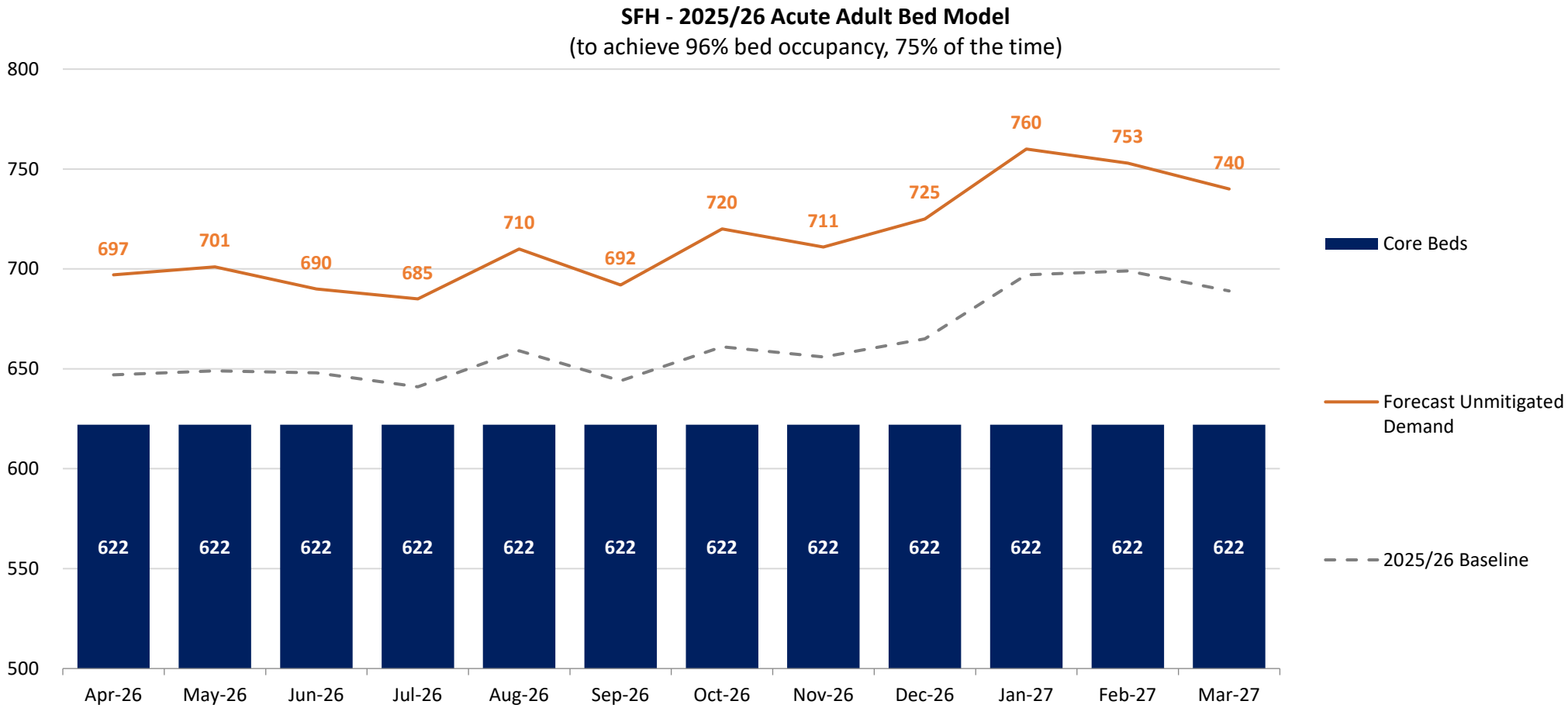
Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Adult Bed Model: 2026/27 Pre-Mitigated Chart

Significant year-round bed gaps exist to meet forecast unmitigated demand at 96% bed occupancy based on a do-nothing scenario (without any mitigations).
Peak demand month is Jan-26, which includes continued elective operating.



Do Nothing Bed Gaps @ 96% occupancy	-75	-79	-68	-63	-88	-70	-98	-89	-103	-138	-131	-118

Bed Model: Paediatric and Critical Care

- Occupied beds in paediatrics, NICU and our Critical Care Unit is projected on the basis that **2026/27 is a repeat of 2025/26**

- Based on year-to-date experience, the modelling assumptions appear fine.

		2026									2027		
Month		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paeds (Ward 25)	Forecast (25/26 repeat)	20	22	23	19	18							
	26/27 Actual	19	20	21	22	18							
	Difference	-1	-2	-2	+3	0							
NICU	Forecast (25/26 repeat)	9	12	12	11	12							
	26/27 Actual	11	9	9	11	12							
	Difference	+2	-3	-3	0	0							
Critical Care Unit	Forecast (25/26 repeat)	15	14	15	14	14							
	26/27 Actual	14	15	12	11	12							
	Difference	-1	+1	-3	-3	-2							

Bed Model: Day case

- This table shows the capacity requirements in each of the day case wards. It is based on the 75th percentile of demand at midday
- Only patients with a length of stay of 0-16 hours are included within the analysis
- The projections are broadly in line with actuals and demonstrate a level of variance that can be managed operationally.

		2026									2027		
Month		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Day Case Unit	Forecast	26	25	24	22	24							
	26/27 Actual	26	24	27	23	22							
	Difference	0	-1	+3	+1	-2							
Medical Day Case Unit	Forecast	5	5	6	4	4							
	26/27 Actual	8	6	5	6	6							
	Difference	+3	+1	-1	+2	+2							
Minster	Forecast	10	11	8	11	10							
	26/27 Actual	10	9	10	9	10							
	Difference	0	-1	+2	-2	0							

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Risks

IF

- Physical space is insufficient to meet demand
- Unable to provide sufficient medical, nursing or support services staff to meet demand
- Unable to maintain a resilient workforce
- Insufficient equipment to meet demand
- Insufficient system capacity to maintain system flow and the timely transfer of medically safe patients (including impact of any decommissioning discussions)
- Experience an influenza pandemic or significant norovirus or CRE outbreak (or any other infectious disease)
- Experience any significant issues with the fabric of our buildings or other infrastructure e.g. ICT

THEN

May not deliver resilient services over winter

RESULTING IN

- Adverse impact on patient safety
- Inability to deliver appropriate services to our patients (particularly on elective pathways)
- Adversely impact on our reputation causing undesirable media coverage and a loss in confidence from the population we serve
- Reduced staff morale, resilience and retention
- Lack of compliance with national performance standards or local planning commitments causing undesirable regulatory action

Existing dashboards, systems and process exist to identify when the risk items are triggering a live issue. Issues will be managed operationally through five-times daily Capacity and Flow meetings. Quality Impact Assessments (QIAs) will be complete for all approved winter schemes and supplement existing QIAs that exist around capacity and flow.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Prevent and Manage Infection

SFH has in place a series of guidance and policies that are followed throughout the year to avoid, manage and contain infections including any cases of Diarrhoea and Vomiting (D&V), Influenza and Norovirus

Influenza vaccination plan

- Staff vaccination led by Occupational Health, based on previous seasons with trained teams of peer vaccinators
- Focused approach to Health Inequalities to improve uptake amongst related groups within our workforce
- Strong communication strategy which will be responsive to the progress with uptake
- Drop-in ‘grab a jab’ pop-up flu clinics in high traffic staff areas alongside bookable appointments
- Flu vaccines will be offered to patients with a length of stay greater than 21 days and to patients being discharged to care homes

Covid-19 vaccination

- Covid-19 vaccines will not be offered by SFH to staff or patients. Eligible cohorts can receive Covid-19 vaccines in the community via the NHS National Booking Service which opened on 17 August for flu and Covid-19 bookings

RSV vaccination plan

- We will vaccinate all high-risk neonatal babies and any babies presenting can be vaccinated. Patients receiving shared care e.g. with NUH can be vaccinated at SFH if easier for families

Respiratory mask fit testing

- Focus on improving compliance in high-risk areas for appropriate mask fit testing to be complete on one mask and recorded on the Electronic Staff Record (ESR). Further work underway following a recent national ask
- Levels of Personal Protective Equipment (PPE) are presently managed at ward level. A Trust-level review is underway to ensure that the stock deemed to be sufficient for the anticipated winter pressures is in place.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Communications

SFH will work with system partners to deploy consistent messaging over winter

The focus will be on the Influenza vaccination campaign and supporting people to get the help they need at the right time, in the right place. Educating the public about which services are most appropriate for their needs will empower the public to keep well this Winter, and support a reduction in pressure on services

SFH communications will:

- Draw on national and system-produced material wherever possible
- Mobilise our system and place partners to support our activity
- Be bold and proactive in how we communicate pressures – encourage and support understanding of operational pressures among all audiences
- Support Team SFH colleagues' wellbeing and show we CARE (our values).

Outstanding Care,
Compassionate People,
Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Winter Reserve

- The Winter reserve for 2026/27 is £700k
- Based on our learning and reflections on 2025/26, we identified a desire to repeat/enhance the following schemes in 2026/27:
  - Doubling of respiratory Physicians at weekends is now business as usual
  - Children's Assessment Unit has extended opening hours Monday to Friday as business as usual
  - Weekend trauma theatre operating lists - this is a proposed mitigation in 2026/27
  - Bedded schemes that are financially affordable - use of a decant ward is proposed for as long as funding allows
- Circa £1.8m was spent on winter mitigations in 2025/26. Our proposal is the best offer within the current financial envelope. Additional ED staffing to support crowding and continued use of EAU escalation spaces are already factored into divisional financial forecasts and have not been provisioned against the winter reserve.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Elective Activity over Winter

- Our ambition is that any adverse impact/compromise on elective care/activity and associated patient experience, income and performance is minimised and assessed on a patient-risk basis
- It is recognised that in 2023/24 and 2024/25 it was necessary to reconfigure the surgical bed base and transfer elective orthopaedic beds to Medicine in the peak of winter (from Christmas to end of January). This was enacted in a planned manner
- In 2025/26 elective operating continued in January except for two days during the critical incident
- Our intention in 2026/27 remains to provide sufficient mitigation against anticipated demand pressures to enable elective operating to continue year-round. To do this, we need to provide sufficient mitigation of the ‘nominal’ state in the bed model and the ‘nominal’ state forecast assumptions to be correct e.g. level of patient demand on our services.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Additional Beds

- Our 2026/27 plan for our adult bed base includes:
  - Using additional bed spaces in our base-ward bays that were created last year following the installation of additional curtain rails. The 25th bed on each ward will need to be used routinely; the 26th bed during the peak demand months; and the 27th bed will be reserved for day-time use and only in times of extreme pressure
  - Using escalation beds, including our decant ward, at times of peak pressure
  - Investing in schemes to reduce length of stay (demand avoidance) – please see the next slide
- There is sufficient flexibility within our paediatric bed base to flex the number of beds to match anticipated demand with a small commitment from our winter reserve to enable four additional paediatric beds to be open over a three-month period.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Flow Schemes

The following schemes are proposed to support patient flow and reduce length of stay over the winter period:

1. Continued use of Ashmere for medically fit patients
2. Reducing length of stay across specialties that show opportunity following national benchmarking analysis
3. Bridging capacity for pathway one delayed discharges awaiting packages of care
4. Implementing Frailty Same Day Emergency Care (SDEC) and pharmacy provision
   (mobilisation dependent on releasing medics from Mansfield Community Hospital)
5. General Internal Medicine ward discharge clinics
6. Additional trauma theatre operating lists
7. System interventions including enhanced GP provision, urgent community response services and unscheduled care co-ordination hub

Further schemes will be considered should additional funds become available i.e. from regional or national monies

A summary of bed and flow schemes together with the timeframe, impact and cost is on the next page.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Bed & flow scheme summary

Scheme	Impact						Cost
	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	
Pre-mitigated adult bed position @ 96% occupancy	**-98**	**-89**	**-103**	**-138**	**-131**	**-118**	
Bed schemes (increasing capacity)							
Additional bed spaces in existing wards (25th and 26th)	17	17	17	34	34	34	N/A
Emergency Assessment Unit (EAU) escalation beds	12	12	12	12	12	12	In forecast
Decant ward			12	24	24	12	£420k
Ward 25 (paeds) winter beds		4 (peads)	4 (peads)	4 (peads)			£32k
Flow schemes (reducing demand)							
Ashmere (commissioned from Jan-26)	15	15	15				Budgeted
Bridging capacity for pathway one delayed discharges	15	15	15	15	15	15	£156k
Length of Stay (LOS) reductions	2	4	4	6	6	6	N/A
Frailty Same Day Emergency Care (SDEC) and enhanced pharmacy	5	5	5	5	5	5	£37K
General Internal Medicine Ward discharge clinics	5	5	5	5	5	5	£1k (admin)
Additional trauma theatre operating lists				2	2		£54k
System interventions (provisional mitigation whilst details become clear)	10	10	10	10	10	10	N/A
Post-mitigated adult bed position @ 96% occupancy	**-17**	**-6**	**-8**	**-25**	**-18**	**-19**	
						Total cost	**£700k**

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area

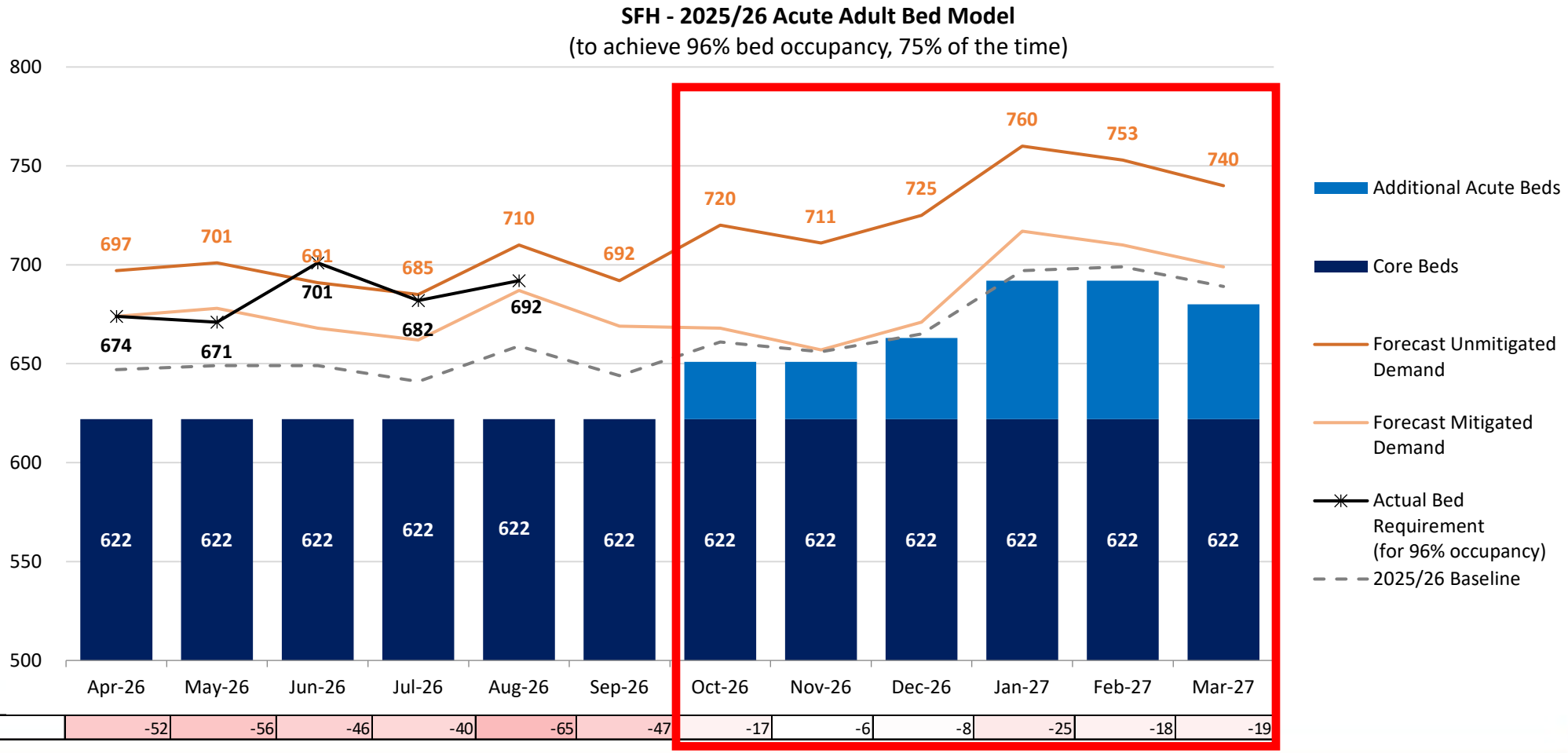
Anticipate & Assess | Prevent | **Prepare** | Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Adult Bed Model: 2026/27 Mitigated Chart

Focusing on the winter period (Oct-26 to Mar-27), the proposed schemes against our nominal state model leave us with a peak forecast bed gap over winter of 25 beds (Jan-26).

FCP actions could provide a bridged position if bed occupancy was also raised beyond 96%.



	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Bed Gaps @96% occupancy	-52	-56	-46	-40	-65	-47	-17	-6	-8	-25	-18	-19

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Workforce Implications

- The table to the right expresses a summary of the workforce needed, by staff group, to support the proposed winter schemes
- To support the growth, we plan to engage with staff primarily on bank contracts. This will add risk to national bank usage targets
- We have detail by scheme to support the engagement of staff.

Staff Group	WTE
Administration	0.1
Unregistered Nurse / Support	21.4
Registered Nurse	27.6
Medical	4.8
Physiotherapy	1.8
Pharmacy	0.5
Radiology	1.8
Scientific, Therapeutic and Technical	1.7
Total	**59.7**

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Winter Mitigations: Areas of Delivery Risk

Key areas of delivery risk that we will continue work to mitigate include:

- Capacity mitigations needing to be mobilised earlier than planned in response to year-round pressures
- Inability to realise length of stay reductions through the implementation of Getting It Right First Time (GIRFT) recommendations. We have risk adjusted the opportunity from benchmarking based on an initial assessment around deliverability across relevant specialties
- Difficulty engaging staff to mobilise schemes and associated impact on temporary staffing targets as we secure the workforce to mobilise our plans
- Outflow from package of care bridging service being insufficient to allow new patients to be brought into the bridging service in a timely manner
- System mitigations do not result in the required level of reduced demand to secondary care either through admission avoidance (via reduced attendance demand) or from a reduction in delayed discharges.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Key Areas of System Focus

- The Derbyshire, Lincolnshire and Nottinghamshire (DLN) Integrated Care Board cluster are overseeing the system Winter plan
- Key features of system plans that could support SFH are:
  - Population vaccination plans with accelerated delivery of early uptake in children and young people
  - Additional GP appointments
  - Unscheduled Care Co-ordination Hub (UCCH) and clinical navigation
  - Urgent Community Response (UCR)
  - NEMS focus on frailty with pilot underway including a single point of access for care homes
  - Increase use of SFH ‘call before convey’ advice line learning from best practice in Derbyshire
  - Further opportunities to harmonise best practice and offers across the DLN cluster are being explored

System support has been requested in four primary areas: (1) reducing discharge delays; (2) improving type three performance at PC24; (3) reducing attendance and conveyance demand; and (4) reducing mental health-related delays in our hospitals.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Existing Interventions that Support Maintaining Quality of Care

- Enhanced Emergency Department staffing to support increased attendance
- Daily review of staffing across clinical areas to maintain resilience and safe staffing levels, balancing risk as needed
- Same Day Emergency Care offering across medical and surgical pathways to support admission avoidance
- Hospital Out Of Hours team
- Discharge Coordinators
- Discharge Lounge
- Ambitious ward-level daily discharge targets in place (reviewed in Aug-26). Supported discharge targets known by the Integrated Discharge Advisory Team (IDAT) and Transfer of Care hub. Progress versus target reviewed at daily Flow and Capacity meetings
- Getting the Basics Right improvement programme with a continued focus on board rounds
- Step-down virtual ward offer in place across selected medical pathways. Surgical virtual ward under development for trial in autumn 2026
- Derbyshire Community Voluntary Services (CVS) support SFH with a home from hospital scheme.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Staff Wellbeing Campaign

Supporting colleagues through winter and beyond

Five connected ways to help colleagues feel safe, recharge, manage pressure, stay protected and recover well

01 **CONNECT SAFELY**
Meaningful supportive conversations to develop strong working relationships, ensuring individuals access wellbeing conversations, training and encouraging an empathetic approach

02 **RECHARGE**
Encourage individuals to take breaks to rest, refuel and rehydrate, ensure awareness of wellbeing training and winter rest areas

03 **MANAGE PRESSURE**
Targeted stress and burnout support across the Trust, promoting financial wellbeing resources and awareness of VIVUP offer to all staff

04 **STAY PROTECTED**
Encouraging and promoting flu vaccination

05 **RECOVER WELL**
Promoting Occupational Health, dedicated physiotherapy and MSK support, early intervention, sickness absence support and workplace adjustments.

Outstanding Care, Compassionate People, Healthier Communities

Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Escalation Plans and Contingencies

- **Full Capacity Protocol** (FCP) and **Operational Pressures Escalation Levels (OPEL) 4 action cards** in place that include:
    - Identified areas of surge capacity (options dependent on level/type of pressure/risk)
    - Actions for clinical teams to undertake to regain patient flow
    - Review of the balance between urgent and emergency care and planned care pathway activity
- **SFH command centre** multiple times daily email status updates shared seven days a week and viewable live 24/7 by SFH colleagues. The command centre provides real-time monitoring and reporting of pressures and key operational metrics
- **System control centre** in place; OPEL escalation status of system partners visible
- **On call structure** in place 24/7 to provide senior oversight and support to 24/7 Duty Nurse Management team
- The SFH named **Executive accountable for the winter period** is Simon Illingworth, Chief Operating Officer
- **Industrial action** planning takes place to deal with any notified instances of action throughout the year; this will sit alongside our winter plan for any instances over the winter period.

Concluding Remarks

- This document summarises the key components to our 2026/27 winter plan and is the cumulation of work undertaken by Divisional and Corporate colleagues over the Spring and Summer period
- Winter mitigations have been presented that will fit within the winter reserve. This should be regarded as our ‘best offer’
- The proposed schemes, together with working to a bed occupancy of 96%, leave us with a peak bed gap of 25 beds in Jan-26. We have not yet achieved a route to bridging the whole gap over winter. The consequences of not bridging the bed gap include:
    1. Bed occupancy being higher than 96%
    2. Patients waiting for admission in ED with associated patient experience and safety concerns
    3. The need to enact Full Capacity Protocol actions that are not already part of our winter plan

  The proposal does assume elective operating continues over Winter as we did in 2025/26
- Specific Christmas and New Year plans will be developed in Nov-26 covering the bank holiday periods
- Trust Board is requested to approve our winter plan and our board assurance statement
- An update to the Council of Governors will take place on 10 November.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board Assurance Statement

- The NHS England mandated board assurance statement has been completed and is embedded below
- For PDF versions of this document, the board assurance statement will be appended
- Trust Board is requested to approve the board assurance statement to meet the revised NHS England submission deadline of 7 October 2026.

Board Assurance Statement

Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **7 October 2026.**

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	Sherwood Forest Hospitals Foundation Trust
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	mark.bolton9@nhs.net, 07765 229876
Date:	23/09/2026

Please complete these sections

Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	Draft plan reviewed by the Board on 03/09/2026. Final plan scheduled for formal sign off in the Board meeting in public on 01/10/2026.	N/A
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Quality Impact Assessments (QIAs) are in place for each winter scheme and are available for review on request. These supplement existing QIAs which are under Board oversight as appropriate via Trust Board sub-committees.	N/A
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	The Trust is an active participant in all system-level Winter Planning groups. The Trust has sought support from system partners in delivering against key success criteria.	There remains concerns around the ability for social and community care to put in place sufficient packages of care to support timely hospital discharge. System support has been requested in four primary areas: (1) reducing discharge delays; (2) improving type three performance at PC24; (3) reducing attendance and conveyance demand; and (4) reducing mental
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	We attended a local stress-test exercise in Aug-26 and the regional winter event in Sep-26.	N/A
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	The Accountable Executive is Simon Illingworth, Chief Operating Officer.	N/A
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Daily system calls in place year-round which are supplemented by fortnightly system-level winter delivery group meetings. Within SFH five-times daily flow and capacity meetings take place attended by operational colleagues to oversee, resolve and escalate issues.	Discussions are ongoing about future system Urgent and Emergency Care governance following our feedback around the current system governance structure.

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Please complete these sections

		Section B: 26/27 Winter Plan checklist	Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	No	Plans are in place to offer the flu vaccine to the identified patient cohort but not the Covid-19 vaccine.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Discharge profiles are well understood with targets in place for P0 and P1-3 discharges. Within the acute, we have daily ward-level discharge targets in place. Daily	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes		
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Specific Christmas and New Year plans will be developed in November 2026.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Surgical SDEC pathways are being strengthened. We are working to implement a frailty SDEC pathway.	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Alternative approach to managing frailty in winter 2026/27 than in 2025/26 learning lessons from our previous frailty unit. Enhanced focus on ambulatory and early i	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	There is likely to be increased use of temporary staffing solutions over the winter period to support the mobilisation of our mitigations.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Rotas are set 6-weeks in advance and are periodically reviewed to maximise decision-making capacity within the context of availability/financial constraints. Risk re	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	We have and continue to focus on planned care activity levels to maximise the number of patients seen in the approach, and during, the winter period. Delivery plar	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Several of the stated trajectories are off-track as we enter the Winter period. Recovery action plans (that are separate to our winter plan) are in place. Extreme winter pressures could place additional pressure on key UEC and RTT metrics that will require increased, additional oversight.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	SFH has an integrated model and runs the community bed base for mid-Nottinghamshire. As such, we have control over the movement of patients between our acu	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	We make effort to minimise the risk to patients and reconise that corridor care is not acceptable. Measures being taken include adopting GIRFT recommendations,	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Timely handover is linked to ED occupancy and the volume of conveyances.	Support in ensuring that patients are conveyed to their local hospital; and only when cli
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Daily system-level calls in place year-round.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	All appropriate actions are included within our Emergency Care Improvement Programme overseen by our Emergency Care Steering Group.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Senior nursing colleagues have been actively involved in the development of our winter plan, with regular updates provided to our IPC team. Our IPC team have re	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Our clinical divisions are continuing to ensure that all relevant staff in high-risk areas have fit testing for at least one mask.	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Reviewed by our Infection, Prevention and Control committee and understood by our site management team.	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	In place 365 days a year.	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	Business as usual item reporting in an automated manner at Trust and system-level.	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Business as usual item.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:	Sherwood Forest Hospitals Foundation Trust
Provider CEO name:	Jon Melbourne
Date reviewed:	23/09/2026
Provider Chair name:	Rukshana Kapasi
Date reviewed:	23/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Simon Illingworth, Chief Operating Officer. Email: simon.illingworth2@nhs.net; Tel: 07725 268 727

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Confirmed.

Please confirm date reviewed
30/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance

		Rating
Section B	Prevention	4 - Substantial assurance
	Flow, occupancy and discharge	**5 - Full assurance**
	Capacity and community	**5 - Full assurance**
	UEC Flow	**5 - Full assurance**
	Infection Prevention and Control (IPC)	**5 - Full assurance**
	Leadership and operational grip	**5 - Full assurance**
	Specific actions for Mental Health Trusts	Awaiting assessment

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors in Public - Cover Sheet

Subject:	Self-Assessment: Minimum Standards of Patient Experience for Elective Care	**Date:**	1st October 2026
Prepared By:	Charlotte Ainger – Associate Director of Operations for Planned Care		
Approved By:	Chris Dann – Deputy Chief Operating Officer		
Presented By:	Charlotte Ainger – Associate Director of Operations for Planned Care		

Purpose		
Update on the trusts self-assessment against the minimum standards of patient experience for Elective Care.	**Approval**	
	Assurance	
	Update	**X**
	Consider	

Recommendation

- Note the NHS England minimum standards for patient experience within elective care.
- Approve the Trust self-assessment against the standards.
- Endorse the proposed improvement actions which will be monitored in Planned Care Steering Group and reported to Trust Management Team meeting

Strategic Objectives

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

Indicate which strategic objective(s) the report support

Identify which Principal Risk this report relates to:

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

Committees/groups where this item has been presented before

Will be discussed at Planned Care Steering Group in Oct-26

Acronyms

FDP - Federated Data Platform
PKB - Patients Know Best
RTT - Referral to Treatment
SPoA - Single Point of Access

Executive Summary

NHS England has introduced eight minimum standards of patient experience for elective care

pathways in July 2026 and has requested that Trust Boards assess current performance against each standard, identify gaps and set out improvement actions where compliance is not yet fully achieved. Trust Boards are also expected to publish a statement during 2026/27 outlining their approach to compliance and progress.

This paper provides Sherwood Forest Hospitals NHS Foundation Trust's initial self-assessment against the standards and outlines proposed actions to strengthen compliance and patient experience across planned care pathways. The initial assessment identifies three standards internally rated as "Green", four as "Amber", and one as "Red"; this relates to the standard outlining that patients whose appointments are cancelled receive a new date within 28 days. Improvement actions have been identified for all areas where full compliance cannot yet be fully demonstrated. The Board is asked to review the self-assessment and support the improvement actions.

The Board is asked to:

- Note the NHS England minimum standards for patient experience within elective care.
- Approve the Trust self-assessment against the standards.
- Endorse the proposed improvement actions, which will be monitored through the Planned Care Steering Group and reported to the Trust Management Team.

Self-Assessment Against NHS England Minimum Standards of Patient Experience for Elective Care

Sherwood Forest Hospitals NHS Foundation Trust

Executive Summary

NHS England has introduced eight minimum standards of patient experience for elective care pathways in July 2026 and has requested that Trust Boards assess current performance against each standard, identify gaps and set out improvement actions where compliance is not yet fully achieved. Trust Boards are also expected to publish a statement during 2026/27 outlining their approach to compliance and progress.

This paper provides Sherwood Forest Hospitals NHS Foundation Trust's initial self-assessment against the standards and outlines proposed actions to strengthen compliance and patient experience across planned care pathways. The initial assessment identifies three standards internally rated as "Green", four as "Amber", and one as "Red"; this relates to the standard outlining that patients whose appointments are cancelled receive a new date within 28 days. Improvement actions have been identified for all areas where full compliance cannot yet be fully demonstrated. The Board is asked to review the self-assessment and support the improvement actions.

1. Background

In July 2026, NHS England published PRN02340, Minimum standards of patient experience – electives, introducing minimum standards that all acute trusts are expected to deliver for patients on elective pathways. The standards cover referral management, communication while waiting, and appointment management. Trust Boards are expected to undertake a self-assessment and implement improvement plans where required. The eight standards are:

1. Referral outcome communicated within 28 days
2. Clear and accessible communication
3. Information provided to support patients while waiting
4. Waiting list updates at least every 12 weeks
5. Ability to identify additional needs and reasonable adjustments
6. Appointment information provided at least 21 days in advance
7. Rebooking arrangements communicated within 28 days following cancellation
8. Patients informed when care is complete and what happens next

2. Self-Assessment

Standard	NHS England requirement	Current SFH position	RAG	Action	Owner	By when
1	Referral outcome within 28 days	Specialty triage arrangements support referral acceptance. However, outcomes are not communicated for referrals that are not triaged. Assurance is partially provided through Referral to Treatment (RTT) validation and referral management processes.	Amber	Dr Doctor referral acknowledgement contact and health assessment to be launched	Patient Facing Digital Solutions	March 2027
2	Clear and accessible communication	Patients are contacted through Patients Know Best (PKB) and the NHS App. All CareFlow outpatient appointments are shared digitally, with more than 3 million appointment records sent to date. Hybrid delivery ensures outpatient and radiology letters are also posted to patients who are not registered. Standard correspondence, advocacy, translation and accessibility support are available, but further work is needed to standardise communication across specialties, address health inequalities and strengthen digital inclusion support.	Green	“All about me” information to be available on the Notts Care Record; early stages of development for this to also be available in the NHS App	Patient Facing Digital Solutions	March 2027
3	Information provided to support patients while waiting	Some specialties provide waiting-list information and self-management support, but this is not yet standardised. PKB already supports pathway information, questionnaires, secure messaging, care plans, symptom tracking and digital libraries, providing a platform	Amber	Develop the Trust-wide “While You Wait” information package.	Patient Facing Digital Solutions	January 2027

		for a consistent Trust-wide “While You Wait” offer.				
4	Waiting list updates at least every 12 weeks	A waiting-list communication programme is in place, but the frequency and consistency of updates vary by pathway. The variation is due to this still being a manual process, developments in FDP are underway to enable data flows from Dr Doctor to the RTT FDP tool	Amber	Implement central reporting and assurance of 12-week patient contact.	Associate Director of Operations for Planned Care	January 2027
5	Ability to identify additional needs and reasonable adjustments	CareFlow, outpatient booking and clinical teams capture additional needs and reasonable adjustments. The Central Outpatient Booking Team uses a Federated Data Platform (FDP) tool to identify patients at greatest risk of cancellation or non-attendance, while Single Point of Access (SPoA) can identify needs at referral. Further review is required to assess the consistency with which information is recorded and used.	Amber	Review the Trust’s capture of communication preferences and reasonable adjustments across booking systems.	Patient Facing Digital Solutions	February 2027
				Single Point of Access referral criteria to ensure preferences and reasonable adjustments are included.	Associate Director of Operations for Planned Care	December 2026
6	Appointment information provided at least 21 days in advance	This is achieved for most routine appointments, with exceptions where short-notice capacity is used. Outpatient and radiology appointment letters are all available through the NHS App.	Green			

7	Rebooking arrangements communicated within 28 days following cancellation	Further work is required to strengthen monitoring and reporting. Subject to approval, planned PKB functionality will allow patients to request cancellation or rebooking directly from their NHS App appointment, improving access while formal assurance against the 28-day requirement is developed.	Red	Introduce reporting of cancelled appointment rebooking performance against the 28-day requirement.	Associate Director of Operations for Planned Care	January 2027
8	Patients informed when care is complete and what happens next	Digital discharge letters have been available in PKB since July 2026 and can be accessed through the NHS App. The letter is sent to the patient and their GP, providing clear confirmation that care is complete and outlining next steps.	Green			

4. Recommendation

The Board is asked to:

- Note the NHS England minimum standards for patient experience within elective care.
- Approve the Trust self-assessment against the standards.
- Endorse the proposed improvement actions, which will be monitored through the Planned Care Steering Group and reported to the Trust Management Team.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Public - Cover Sheet

Subject:	Board Assurance Framework	**Date:**	1st October 2026
Prepared By:	Gemma Barker, Head of Risk		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Jon Melbournce, 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**	**X**
	Assurance	
	Update	
	Consider	

Recommendation

Board members are requested to:

- Review the principal risks, taking into account the amendments proposed and agreed by the respective lead committees.
- Consider the implications of any current risk ratings that remain above the agreed tolerable levels.
- Identify and agree any further amendments required.
- Approve the Board Assurance Framework, subject to the incorporation of any further amendments identified.

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

Lead Committees review individual principal risks at each formal meeting (Quality Committee; People Committee; Finance and Performance Committee; Partnerships & Communities Committee; Risk Committee). Risk Committee reviews the full BAF quarterly.

Acronyms

See table 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. Each committee provides a rating as to the level of assurance it can take that the risk treatment strategy will be effective in mitigating those risks.

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, have been tracked on the attached document.

Schedule of BAF reviews since last received by the Board of Directors on 5th February:
Quality Committee: PR1, and PR5 – July
People Committee: PR3 – August
Finance and Performance Committee: PR2, PR4 and PR8 – July
Partnerships and Communities: PR 6- August
Risk Committee: PR7 – July and September
PR1, PR2, PR3, PR4 and PR7 remain significant risks. All risks except PR5 and PR8 are above their tolerable risk ratings.

As this report was prepared before the 28th September Quality, 29th September People and 29th September Finance and Performance Committee meetings, there may be further changes agreed at those meetings that are not on the attached BAF report.

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

Acronym	Description
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
HSSIB	Healthcare Services Safety Investigation Body
HSJ	Health Service Journal
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IGAF	Information Governance Assurance Framework
IPC	Infection prevention and control
JAG	Joint Advisory Group
LGBT	Lesbian, gay, bisexual and trans
MEMD	Medical Equipment Management Department
MFFD	Medically fit for discharge
MHRA	Medicines & Healthcare products Regulatory Agency
MSFT	Medically safe for transfer
NEMS	NEMS Community Benefit Services (formerly Nottingham Emergency Medical Services)
OD	Organisational development
PC&IC	People, Culture and Improvement Committee
PCI	People, Culture and Improvement
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-Led Assessments of the Care Environment
PMO	Programme Management Office
PPE	Personal protective equipment
PSC	Patient Safety Committee
PSC	Patient Safety Culture
QC	Quality Committee
QIPP	Quality, Innovation, Productivity and Prevention
SDEC	Same Day Emergency Care
SFFT	Staff Friends and Family Test
SI	Serious incident
SLT	Senior Leadership Team
SOF	Single Oversight Framework
TIAN	The Internal Audit Network
TMT	Trust Management Team
TTO	To Take Out (medications)

Acronym	Description
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): August 2026

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.

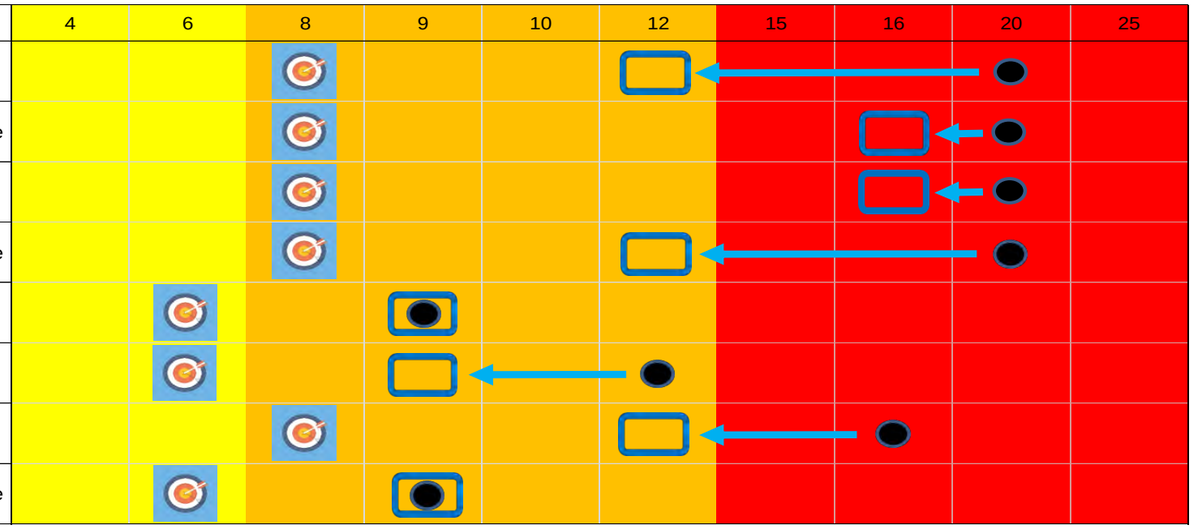
Likelihood score and descriptor

	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	Finance and Performance
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 and Performance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Chief Medical Officer	Quality
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	Partnerships and Communities
PR7	**Major disruptive incident**	Chief Executive Officer	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance and Performance



Board Assurance Framework (BAF): August 2026

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm	
Lead directors	Chief Medical Officer Chief Nurse	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal	
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	3. Possible	2. Unlikely			
Last reviewed	~~01/06/2026~~ 27/07/2026	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**			
Last changed	01/06/202627/07/2026							

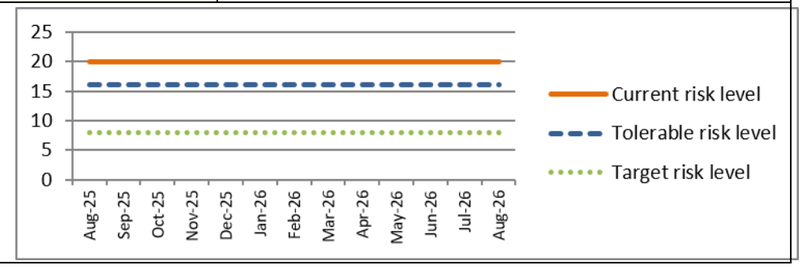
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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	Medical, nursing, AHP and maternity staff ~~gaps~~shortages when additional capacity is opened in key areas across the Trust, which may impact on the quality and standard of care ~~Lack of real time data collection, including information on overcrowding in ED~~ Insufficient capacity, particularly beds, to maintain safe standards of care ~~Lack of knowledge and application of skills and behaviour related to the treatment of children and young people~~ There is lack of appropriate CT staff overnight to cope with demand.	Continue to develop information systems to provide a unified position of flow across the organisation **Progress:** ~~Dependent on the rollout of Nervecentre, which has been delayed~~. In progress in federated data platform since Nervecentre went live in ED. **SLT Lead:** Chief Medical Officer / Chief Nurse / Chief Operating Officer **Timescale:** **September 2026**~~May 2026~~ ~~Roll out Nervecentre in ED~~ ~~**Progress:** Live in Newark UTC – rollout in King's Mill Hospital delayed~~ ~~**SLT Lead:** Chief Digital Information Officer~~ ~~**Timescale:** May 2026~~ Complete Roll out Nervecentre across all areas within the Trust. SLT Lead: Chief Digital Information Officer Timescale: December 2027 Radiology services are developing a plan to revise radiographer staffing overnight. SLT lead: Chief Medical Officer/Chief Nurse Timescale: December 2026	**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; Unannounced CQC visit in March 2026 – ~~outcomes awaited~~Overall good. Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening	Despite a significant number of actions being undertaken, there is still significant overcrowding in ED on a daily basis, although there has been an improvement in 4-hour ED performance Full capacity protocol does not fully address bed capacity requirements during winter, leading to overcrowding in the Emergency Department Financial restraints, including the need to reduce bank and agency spend, may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing The impact of financial restrictions on Corporate teams may result in reduced responsiveness to governance and regulatory requirements Potential impact of industrial action on quality operational performance and finances	Moderate Last changed January 2025

Board Assurance Framework (BAF): August 2026

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
	▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight ▪ Digital Strategy Group ▪ Enhanced actions to full capacity protocol ▪ UEC Recovery Group meets weekly to discuss and agree additional actions ▪ Increase to bed capacity by 17 across the Trust as part of winter mitigations ▪ Additional 1/2 beds per ward to provide additional surge capacity to reduce ED overcrowding ▪ 24/7 Paediatric nurse cover in ED			- Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of: - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA) Patient Safety Incident Response Framework (PSIRF) internal audit Jun 25; Tissue viability – pressure ulcers internal audit Sep 25		
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 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 ▪ Dedicated ward (Chatsworth) for decant to maintain capacity		Decamp programme initiated with deep cleans of three wards completed. Temporarily paused due to bed capacity requirements. May 2026.	**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 quarterly; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee report to PSC quarterly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan; NHSE external review Sep 25 which will be used to support existing action plan	The impact of financial restrictions on Corporate teams may result in reduced availability of Corporate Nursing staff to support vaccinations	Moderate Last changed March 2025

Board Assurance Framework (BAF): August 2026

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					**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Finance and Performance	**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	~~30/06/2026~~28/07/2026	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	~~30/06/2026~~28/07/2026						

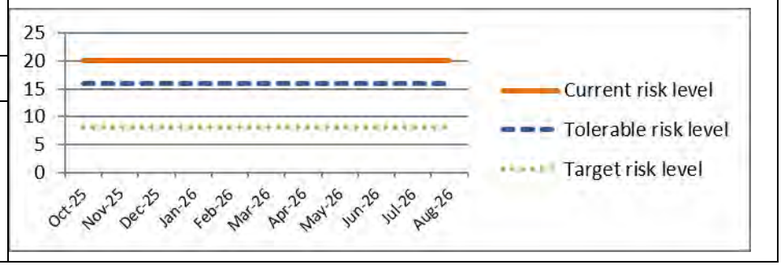


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 respiratory illness 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 and UEC Working Group – System leaders. ▪ Emergency admission avoidance schemes across the system under oversight of the Urgent and Emergency Care (UEC) Board and ~~the System Oversight Group~~ system meetings. ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place 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~~ and Business Continuity Incident actions as required.~~Full Capacity Protocol~~ ▪ Inter-professional standards across the Trust to ensure we complete today's work today, including a medically led relaunch ▪ 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, Cancer and Diagnostics Transformation Programmes with an overarching planned care plan with identified programme leads. ▪ Planned Care Steering Group with oversight of performance and improvement activities (including work of the Cancer Steering Group)	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our opel 4 and/ or Business Continuity Framework ~~full capacity protocol~~ e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Continue to work with local partners on collaborative working to address peak demand periods **SLT Lead:** Chief Operating Officer **Timescale:** Throughout 2026/27	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board bi-monthly; System Intelligence Report on Urgent & Emergency Care Demand, and Key Programmes of Work, presented to Board Development session Feb 25 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board bi-monthly **Independent assurance:** Operational Planning internal audit report Jul 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25	Some transformation schemes overseen by the System programme boards are not currently preventing increases in the number of patients presenting to SFH, although we are starting to see early indications of reduced numbers of non-elective admissions Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** throughout 2026/27	Moderate Last changed September 2024

Board Assurance Framework (BAF): August 2026

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
	▪ System support in place (mutual aid) with regular meetings via the System Elective Hub ▪ Increase capacity through use of Independent Sector for specific specialties					
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 ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Full Trust bed cascade plan, which improves capacity management			**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 bi-monthly, which is showing a deterioration in the latter stages of 2025/26 Q1 due to a lack of availability in packages of care	Challenges in the provision of the ICS-commissioned transport contract to deliver timely patient discharge Supplement the contract with commissioners with locally commissioned additional transport services managed via the ADO for UEC. **SLT Lead:** Chief Operating Officer **Timescale:** throughout 2025/26 Lack of packages of care to meet demand – System conducting a demand and capacity review to inform commissioning Unaffordability of the cost of increased bed usage	Moderate Last changed July 2025
Failure of Primary Care to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly System Oversight Group meetings across ICS ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan ▪ Nottingham Emergency Medical Services-run 24/7 primary care service within our Emergency Department			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand; ICS reports available on the System Analytical Intelligence Unit portal; System Intelligence Report on Urgent & Emergency Care Demand, and Key Programmes of Work, presented to Board Development session Feb 25	Shortages in GP provision in PC24 following the removal of additional capacity introduced in March 2025 Attempt to initiate a system-led review of PC24 provision **SLT Lead:** Chief Operating Officer **Timescale:** March 2026	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 ▪ Meeting established with senior partners across the DLN cluster to facilitate discussion around referral drift and mutual aid.	No agreement for the movement of long waiters to protect the receiving organisation from performance impact- request to manager via cluster system working.		**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 **Progress:** continued engagement with the ICB and the region as we move into a new framework relating to governance **SLT Lead:** Chief Operating Officer **Timescale:** June 2026	Moderate Last changed January 2025

Board Assurance Framework (BAF): August 2026

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	~~02/06/2026~~ 04/08/2026	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**			
Last changed	~~02/06/2026~~ 04/08/2026							

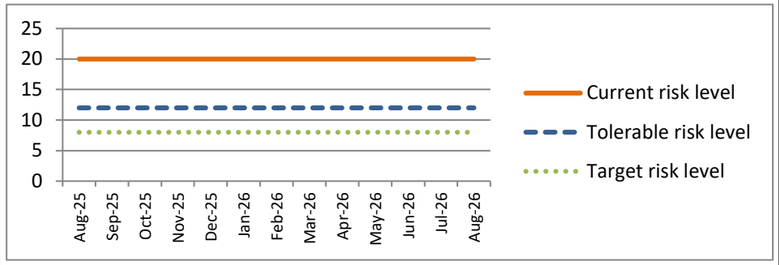
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 2025-2029 ▪ 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	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, and job review processes, creating competition and not maximising opportunities Fragile services, including workforce gaps, in some services/specialties	Deliver the 2025-29 People Strategy – Year 1 **SLT Lead:** Chief People Officer **Timescale:** Complete Deliver the 2025-29 People Strategy – Year 2 **SLT Lead:** Chief People Officer **Timescale:** March 2027 Develop a Clinical Services Strategy, including an associated workforce plan **Progress:** Review of Strategy under way, to be followed by divisions developing their associated workforce plans **SLT Lead:** Chief Medical Officer **Timescale:** ~~June~~ September 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; 10 Point Plan to Improve Resident Doctors Working Lives Sep 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; e-Rostering internal audit Sep 25	Potential impact of a decline in staff survey results, resulting in reduction of staff retention, recruitment and organisational reputation Develop divisional action plan to address the outputs of the staff survey, monitored through Divisional Performance Review meetings **SLT Lead:** Chief People Officer / Chief Operating Officer **Timescale:** September 2026 Potential impact of industrial unrest due to the job matching and profile review for Nursing and Midwifery staff In addition to this, there is now a Band 5 nursing profile review Timescales: National timescales not yet confirmed. Pay restructure reform negotiation in relation to agenda for change terms and conditions posing a financial, operational and industrial risk. Timescale: Paper to be presented at people committee 2nd June for oversight. Timescales not confirmed nationally. Engage with regional groups to ensure consistency of approach principles **Progress:** Awaiting the Programme Reform issue for Band 5 nursing review **SLT Lead:** Chief People Officer / Chief Nurse **Timescale:** September 2026	Moderate Last changed September 2024

Board Assurance Framework (BAF): August 2026

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
	▪ Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels					
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement	▪ People Strategy 2025-2029 ▪ 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 ▪ 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 ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occupational Health support including a revised Clinical Psychologist offer 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 Cultural concerns in theatres highlighted in the cultural review undertaken by Value Circle Inequalities in relation to availability of gender-neutral toilet facilities in line with the Lord Mann Review.	Implement the WRES and WDES action plans **SLT Lead:** Chief People Officer **Timescale:** Complete Implement the 2026 WRES and WDES action plans **SLT Lead:** Chief People Officer **Timescale:** March 2027 Implement the detailed action plan via the Theatres Assurance and Performance Group **SLT Lead:** Chief Medical Officer **Timescale:** March 2027 Detailed action plan in relation to the Lord Mann review to be progressed through people cabinet following TMT approval. SLT Lead: Chief People Officer Timescale: March 2027 Action plan in relation to the meaning of sex in the equality act review to be progressed through the Estates and Facilities Group following executive approval. SLT Lead: Director of Estates and Facilities Timescale: March 2027	**Management:** Staff Survey Action Plan to Board Apr25; Staff Survey Annual Report to Board Apr25; Equality and Diversity Annual Report Jul 24; WRES and WDES report to People Committee Jul 24; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, Committee Mar 24; People Plan updates to People Committee quarterly; Leadership Report to People Committee Jul 24; Diversity in the Trust – Senior Leadership Roles report to People Committee May 24; Violence and Aggression Improvement Plan update to People Committee Mar 25; Sickness deep dive to People Committee Mar 25 and Sep 25; Wellbeing Offer and Flu update Feb 26; Sexual Safety Charter Update Feb 26 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Jul 24; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to People Committee Mar 25; NHS Long Term Workforce Plan to People and Culture Committee Sep 23 and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar24; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22; Staff Wellbeing internal audit report Jan 24; Absence Management Audit Report Jan 26	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 Potential harm to staff due to work pressures, and the longevity and impact of the ongoing demands Continued concerns over sexual safety in the workplace ~~Ongoing industrial action, including strike action, of resident doctors.~~ Following the resident doctor deal there have been financial risk identified, these will be shared with the CFO for inclusion in PR4. From a workforce perspective the deal brings an opportunity to increase training places and competency assessments and therefore is not a threat to PR3. Consultants and SAS doctors have confirmed a ballot for industrial action including strike action. Ballot open from 11/05/2026 until 06/07/2026. Consultants have met the threshold in favour of strike action however a date for this has not yet been set.	Moderate Last changed March 2025

Board Assurance Framework (BAF): August 2026

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	~~30/06/2026~~ 28/07/2026	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**		
Last changed	~~30/06/2026~~ 28/07/2026						



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Regulatory action due to a failure to deliver NHS England financial targets	▪ ~~2025/26~~ 2026/2027Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return, monthly regional finance lead meetings, and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established ▪ ~~Financial Resources Oversight Group (FROG) meeting monthly~~ ▪ Executive level Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Financial Recovery Cabinet (monthly) meetings			**Management:** Monthly Finance Report to Finance Committee; Quarterly Integrated Performance Report to Board; NHSE updates to Finance Committee; Monthly efficiency programme reports to Financial Recovery Cabinet; divisional representation at Finance Committee on a cyclical basis; Financial Recovery Cabinet highlight reports to Finance Committee **Risk and compliance:** Review of NHSE 2025/26 Financial Management expectations tools, interventions and oversight guidance to Finance Committee Oct 25 **Independent assurance**: External Audit Year-end Report 2024/25 NHSE Performance Assessment Framework and Risk of Non-Delivery Assessment (RONDA); NHSE National Oversight Framework Quarterly ratings Internal Audit reports: - Key Financial Systems – Pay Expenditure (Jul 23) - Budget Setting, Reporting and Monitoring (Jun 24) - Operational Planning (Jun 24) - Financial Improvement Plan – Efficiency & Productivity (Jun 24) - System Financial Controls (Jun 24) - Key Financial Systems – Accounts Receivable and Asset Register (Mar-25) - Cash Management (Dec-25) - Financial Ledger and Reporting (Jan 26) - Absence Management (Jan-26) - Strengthening Financial Management (Jun-26)	Relevant Internal Audit Reports scheduled: • Financial Ledger & Reporting (2026/27) • Payroll (2026/27) • Contract Management (2026/27) • Vacancy Control Panels (2026/27) **SLT Lead:** Chief Financial Officer **Timescale:** March 2027	Moderate Last changed January 2025
Cash availability (limited access to national cash support) leads to delays in paying suppliers and workforce	▪ Daily cash flow forecasts prepared and forecast sensitivity modelled ▪ 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 Efficiency Programme in place to deliver cash-releasing efficiencies ▪ Budgetary control processes and Scheme of Delegation in place to prevent overspends	Limited national cash support and reliance on timely approval of cash applications may restrict the Trust's ability to manager supplier payment risk		**Management:** Monthly Finance Report to Finance Committee includes details on cash flow, debtors and creditors **Risk and compliance:** Review of requirements and cash forecast scenario and sensitivity analysis to Finance Committee Oct 25 **Independent assurance**: NHS England Financial Controls Assessment (Sep 23) Internal Audit reports: - Key Financial Systems – Accounts Receivable and Asset Register (Jan 25) - Financial Ledger and Reporting (Jan 26)		Significant Last changed November 2025

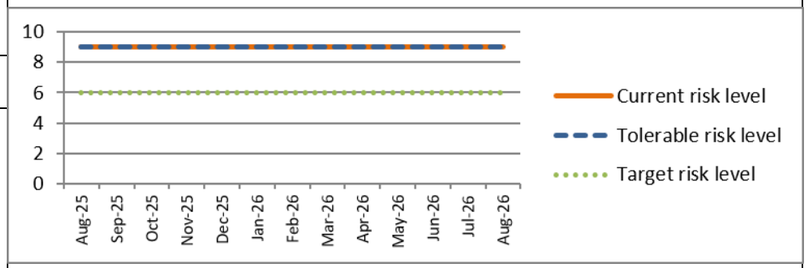
Board Assurance Framework (BAF): August 2026

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
	▪ 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			- Cash Management (Oct 25)		
ICB system financial performance challenge leads to disinvestment in SFH	▪ ~~2025/26~~ 2026/2027 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 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	~~Contracts for 2026/27 are yet to be formally agreed and signed~~ Pending confirmation of contract management arrangements from the ICB.	2026/27 Contract, including Indicative Activity Plan and Annual Value, to be agreed and signed **SLT Lead:** Chief Financial Officer **Timescale:** Q~~1~~2 2026/27 **Progress:** Heads of Terms signed; IAP still to be finalised.	**Management:** Income Oversight Programme established and reporting into Financial Recovery Cabinet **Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun 24)	Potential misalignment between ICB funding and expected contract income to the Trust	Moderate Last changed January 2025
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks ▪ Approved 2026/2027 Capital Expenditure Plan	2026/27 Capital Expenditure Plan to be approved by Board of Directors- Complete		**Management:** Board approved 2025/26 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team and Finance and Performance Committee; 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- All actions have since been completed.		Significant Last changed November 2025
Reliance on non-recurrent funding and efficiencies threatens long-term sustainability of services	▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Financial Efficiency Delivery & Sustainability team established to support the delivery of efficiency schemes ▪ Weekly Financial Efficiency programme governance structure in place to ensure SRO focus on efficiency and sustainability ▪ Financial Recovery Cabinet in place to support longer-term decision making ▪ Financial Strategy in place with longer-term priorities	~~Current operational plans only cover the period to March 2026~~		**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)		Significant New threat added July 2024

Board Assurance Framework (BAF): August 2026

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	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	~~01/06/2026~~ 27/07/2026	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	~~01/06/2026~~ 27/07/2026						

Strategic objective	Continuously learn and improve

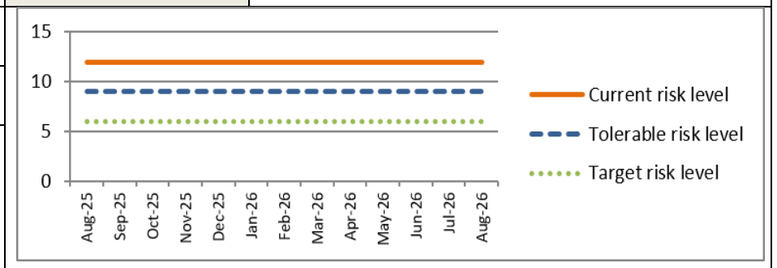


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 (including quality improvement) ▪ Leadership development programmes - opportunity for Trust leaders to gain improvement skills ▪ Talent management map ▪ Chief Medical Officer Cabinet – Executive Director oversight on all aspects of Improvement activity ▪ Ideas generator platform - easy-to-access mechanism to seek improvement support and advice ▪ Improvement Faculty - Single point of contact for all colleagues seeking improvement support ▪ Financial Recovery Cabinet - Provides Executive Director oversight on all aspects of financial improvement activity ▪ Trust Board 'Improvement Showcase' - Increased awareness of improvement activity and sharing of good practice ▪ Quality, Service Improvement and Redesign Networks and Service Level Quality Improvement Leads - informal forums to share knowledge, skills and experience ▪ ~~Getting is Right First Time (GIRFT) Oversight Group~~. Disbanded the GIRFT oversight group and implemented a GIRFT stewardship group supported by an MDT GIRFT taskforce ▪ Appointment of a Chief Improvement Officer	Continuous Quality Improvement Strategy not yet approved. Limited availability of capital resource to support digital and service transformation programmes represents a growing constraint on the Trust's ability to deliver improvement and innovation at scale. This is anticipated to become more significant over the next 2–3 years as infrastructure and technology requirements increase alongside a challenging capital landscape.	Develop a process for improving clinical input and for better engagement with patients and the public in improvement and transformation activities **Progress:** Process for improving patient and public engagement is under development with the support of key stakeholders (including the Council of Governors) In addition, three Clinical Transformation Leadership Roles have now been recruited to support the process for improving clinical engagement. The impact of these actions will be reviewed to ensure they encompass the pending recommendations in the Darzi report **SLT Lead:** Chief Medical Officer **Timescale:** ~~January 2026~~ Complete Develop and roll out a Continuous Improvement Strategy **Progress:** We will commence the development of a Continuous Quality Improvement Strategy; this has been purposefully delayed to encompass the outputs of the Advancing Quality Alliance (Aqua) review and the appointment to the Chief Improvement Officer role. Report due February 2026 (arrived March 2026 due to delays with Aqua) **SLT Lead:** Chief Medical Officer **Timescale:** September 2026 Develop a plan to implement the recommendations of the Aqua review **SLT Lead:** Chief Medical Officer **Timescale:** June 2026- Completed and presented to TMT and will progress via Quality Committee	**Management:** Bi-monthly Improvement report to Quality Committee, including update on NHS Impact Self-Assessment undertaken in 2026 **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:** Aqua review completed and findings received 2026. NHS Impact Self-Assessment reviewed by Quality Committee.	Availability and capacity of staff to undertake improvement activities due to financial challenges (corporate optimisation cost savings target), vacancy control processes, MARS and operational pressures	Moderate Last changed October 2022

Board Assurance Framework (BAF): August 2026

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	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	~~14/04/2026~~ 24/08/2026	**Risk rating**	**12. High**	**9. Medium**	**6. Low**		
Last changed	~~14/04/2026~~24/08/2026						

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 the Partnerships Oversight Group ▪ 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. Managed through newly established ICB programme boards. ~~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 DLN ICB executive board as a partner member representing hospital and urgent & emergency care services ▪ NUH/SFH Committee in Common oversees partnership working between the two trusts, supported by the Acute Services Oversight Group ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ ~~Mid~~North ~~-~~Nottinghamshire Place-Based Partnership (~~M~~NNPBP) annual place plan setting priorities and agreed actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including ~~Mid-~~ North Nottinghamshire PBP Executive providing oversight and leadership	~~Structure not yet in place to respond to the new format of commissioning intentions~~ Lack of agreed assurance and reporting routes for partnership arrangements, limiting effective oversight. ~~Partnership Strategy needs refreshing to align with the Trust Strategy refresh for 2026-29~~ Limited timely visibility and influence over ICB-led.	Agree a governance structure with partners ~~**Progress: C**~~Commissioning ~~intentions on hold while new Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster designs its governance structure~~ **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~July 2026~~Completed- ICB series of programme boards developed which are attended by SFH representatives. Define and agree formal assurance and reporting routes for key partnership arrangements, including responsibilities, reporting frequency and escalation routes. Timescale: September 2026 Review of partnership priorities to reflect the Trust's Strategy refresh for 2026-29	**Management:** Partnerships Oversight Group chair's report to PCC Provider collaborative effectiveness updates to PCC Partnership Delivery Plan updates to Partnerships Oversight group; supporting strategy reporting to relevant sub committees 6-monthly ~~M~~NNPBP highlight reports to Health Inequalities Steering Group quarterly Monthly HISG chair's report to Partnerships and Communities Committee **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): August 2026

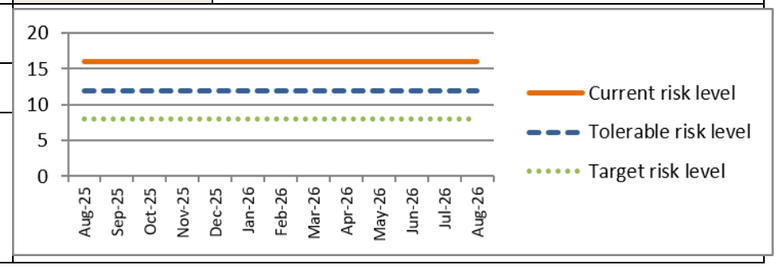
Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
	▪ ~~Membership of and c~~Engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources		**SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~July 2026~~Completed Establish a formal escalation and communication route with the ICB to ensure early notification of planned competitive tenders, timely progress updates and clear engagement at key decision points. **SLT Lead:** Director of Strategy and Partnerships **Timescale:** September 2026			
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. Managed through newly established ICB programme boards. ~~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 DLN ICB executive board as a partner member representing hospital and urgent & emergency care services ▪ NUH/SFH Committee in Common oversees partnership working between the two trusts, supported by the Acute Services Oversight Group ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ ~~Mid-~~ North Nottinghamshire Place-Based Partnership (~~M~~NNPBP) 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-~~ North Nottinghamshire PBP Executive providing oversight and leadership ▪ ~~Membership of and c~~Engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources	~~Partnership Strategy needs refreshing to align with the Trust Strategy refresh for 2026-29~~ Limited clarity on system providers' strategic intent, restricting the Trust's ability to anticipate changes, assess implications and inform strategic planning.	Agree a governance structure with partners ~~**Progress:** Commissioning intentions on hold while new Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster designs its governance structure~~ **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~July 2026~~ Completed – ICB series of programme boards developed which are attended by SFH representatives. Review of partnership priorities to reflect the Trust's Strategy refresh for 2026-29 **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~July 2026~~Completed	**Management:** Partnership Delivery Plan updates to Partnerships Oversight group ~~M~~NNPBP highlight reports to Health Inequalities Steering Group as appropriate HISG chair's report to Partnerships Oversight Group 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): August 2026

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
	▪ Formal partnership arrangements with Vision West Notts College, Nottingham Trent University and Universities of Nottingham		Establish regular strategic engagement with system providers to obtain timely insight into their intentions, planned changes and potential implications for the Trust. Timescale: Requires discussion and engagement from system providers.			
~~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~~ ▪ ~~Patient engagement stands, forums and digital opportunities used during strategy refresh and associated work~~			~~**Management:**~~ ~~Partnerships Oversight Group chair's report to PCC~~ ~~Partnership Delivery Plan updates to Partnerships Oversight Group;~~ ~~supporting strategy reporting to relevant sub committees~~ ~~MNPBP highlight reports to HISG as appropriate~~ ~~HISG chair's report to Partnerships and Communities Committee~~ ~~**Independent assurance**:~~ ~~None currently in place~~		~~Significant~~ ~~Threat updated August 2024~~

Board Assurance Framework (BAF): August 2026

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	~~14/07/2026~~ 08/09/2026	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	~~14/07/2026~~ 08/09/2026								



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) & ICS-wide Cyber Security Strategy ▪ Cyber Security Assurance Programme Board & Cyber Security Delivery Group and work plan ▪ Regular monitoring of Cyber Hygiene at Cyber Board ▪ National Cyber Security Centre (NCSC) updates to Cyber Programme Board; membership includes NCSC representation ▪ High Severity Alerts issued by Cyber Operations at NHS England responded to in a timely manner ▪ Network accounts checked after 30 days of inactivity – disabled after 60 days if not used ▪ Devices that have failed to take the most recent security patch checked after 21 days of inactivity – disabled after 28 days ▪ Major incident response plan in place ▪ Periodic phishing exercises carried out by the IG Team ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead ▪ Common approach to cyber security vulnerability across the ICS using software assessment screening tool. ▪ Cyber Security Operations Centre (CSOC) service in place with NHS England ~~3rd party provider (Maple)~~ ▪ Medical equipment cyber screening tool- Cynerio ▪ ControlUp solution implemented to provide additional Cyber alerting ▪ ~~No unsupported operating systems without extended support purchased~~ ▪ Microsoft Defender for Endpoint (MDE) fully implemented providing monitoring to the national Cyber team ▪ Quarterly review of passwords in use by employees within the organisation against weak passwords and those commonly used and the user is notified and provided with advise to change password. ▪ Dedicated team to monitor and implement available resilience tools ▪ NHIS Certification to ISO 27001 information security standard; alongside Cyber Essentials and Cyber Essentials Plus ▪ Connection of organisations across Nottinghamshire as Nottinghamshire Cyber Associates Network (NCAN) with a	Lack of full audit trail due to the use of Generic Accounts Limited assurance regarding 3rd party supplier compliance with cyber resilience. Vulnerability of supply chains to cyber threat. DPST Internal audit actions remain outstanding. The Clinisys system will continue to operate on an unsupported legacy operating system after extended support ends in October 2026	~~Cyber Security session to be delivered by Gartner to the Trust Board~~ ~~**SLT Lead:** Director of NHIS~~ ~~**Timescale:** March 2026~~- Completed Develop a plan for work in relation to shared accounts (Generic) to ensure they can be completely eradicated Progress: Work commenced and ongoing review of open shared **SLT Lead:** Chief Digital Information Officer **Timescale:** September 2026 Commenced a review looking to adopt the national job parameters and expectations for the Cyber function of NHIS aligned to work with colleges from Cyber Crowd, who have undertaken a comparison against industry best practice **SLT Lead:** Director of NHIS **Timescale:** December 2026 Review allocation of Information Asset Owners and reinforce their roles and responsibilities **SLT:** Chief Digital Information Officer **Timescale:** December 2026	**Management:** Data Security and Protection Toolkit submission to Board Jun 26; DSPT updates to Data Protection and Cyber Security Committee bi-monthly and Risk Committee 6-monthly; Hygiene Report to Cyber Security Assurance Programme 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; NHIS Cyber Strategy approved at DSG May 24; ICS Cyber Strategy to Board Nov 24 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar 2026; 360 Assurance Data Security and Protection Toolkit audit Jun 25 – high assurance; Cyber Essentials Plus accreditation (NHIS) Dec 25	NHS-targeted cyber-attacks continue to be increased and there are inherent risks which are almost impossible to fully mitigate Ensure the integration of the Cynerio system to provide cyber-security results and a work plan to be developed to address issues identified **SLT Lead:** Chief Digital Information Officer **Timescale:** September 2026	Limited Last changed January 2025

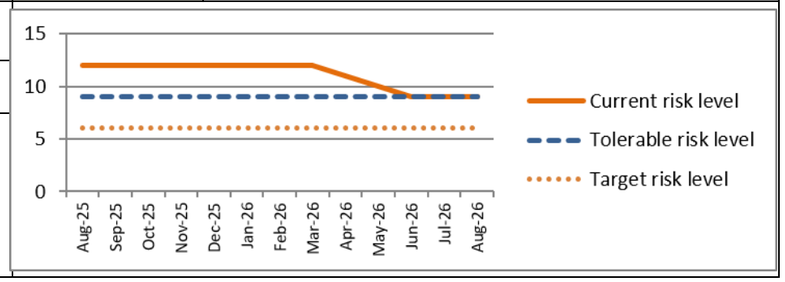
Board Assurance Framework (BAF): August 2026

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
	shared strategy and work plan, enforcing the 'defend as one' principles and information sharing ▪ NHIS have developed a taxonomy which provides up to date and standardised measure against legislation which is updated in real time, and provides an accurate reflection of current cyber compliance.					
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) ▪ Strategic (Gold), Tactical (Silver) and Operational (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 ▪ Undertaking of planned preventative maintenance schedules, review of the assets and condition			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report to Risk Committee; Fire Safety reports to Risk Committee quarterly; Maintenance and condition reports to Estates Governance Group bi-monthly **Risk and compliance:** Significant Risks Report to Risk Committee monthly; Statutory and Mandatory plans submitted to the relevant EFM Governance Group by Central Nottinghamshire Hospitals plc. Highlighting any issues (Water, MGPS, Electric etc.) **Independent assurance:** Centre of Best Practice Surveys (ARUP) and (WSP) reported to Risk Committee within the periodic Fire Safety Reports and Estates and Facilities Management Governance Report	Inconclusive evidence of buildings cladding and structures compliance with fire regulations and environmental conditions Determine the remedial work required to ensure that the cladding, fire stopping, fire doors and fire compartmentation are compliant with fire regulations **Progress:** Fire Alarm Cause and Effect works complete at KMH, BSA Wall Type 4 and 5 approved to be replaced in September 2027 and fire stopping to works at KMH PFI progressing. Details of remedial work received, programme of implementation remains outstanding and has been escalated with CNH. **SLT Lead**: Director of Estates & Facilities **Timescale:** September2026 Estates Strategy has expired Review and refresh Estates Strategy following the Trust's Clinical Strategy Review Progress: RISE project presented to Trust Board of Directors which will be included in the updated Estates Strategy under development. **SLT Lead**: Director of Estates & Facilities **Timescale:** ~~September 2026~~ March 2027	Moderate Last changed March 2024
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; adverse weather; evacuation; CBRN) ▪ Strategic (Gold), Tactical (Silver) and Operational (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 and engagement with ICB processes ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS)	Limited assurance regarding divisional evacuation business continuity plans. Limited assurance regarding the resilience of the CSSD service following recent unit failure and a related incident.	Ongoing review of divisional evacuation business continuity plans and updates to risk committee within RAC quadrant report. **SLT Lead:** Chief Operating Officer **Timescale:** December 2026 Mobile CSSD Unit due to be installed. **SLT Lead**: Director of Estates & Facilities **Timescale:** October 2026	**Management:** Monthly RAC Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating 2025 – Substantial Compliance; EPRR Business Continuity internal audit report Nov 24 – Significant assurance; CBRN Audit carried out in Feb 25 by EMAS		Significant New threat added May 2023

Board Assurance Framework (BAF): August 2026

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
	▪ 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 ▪ Post incident and exercise action tracker ▪ Senior management rota for Newark Hospital to ensure support is available to support with BCP's as required.					

Board Assurance Framework (BAF): August 2026

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 and Performance	**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**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	~~26/05/2026~~ 28/07/2026	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	~~26/05/2026~~ 28/07/2026								

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 funding, capacity and/or capability)	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2025-2028 ▪ 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 ▪ 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)	Estates strategy under review		**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board Dec 25; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Restricted financial resources, both within the Trust and from partners, to support the green agenda. Progress: Paper for funding to support the green plan approved by the investment and value group. To progress via TMT. Lead: Director of Estates and Facilities Timescale: September 2026	Significant Last changed May 2026

Finance & Performance Committee Chair's Highlight Report to Board of Directors

Subject:	Finance & Performance Committee (FPC) Meeting	**Date:**	25/08/2026
Prepared By:	Marie McAllister, Corporate PA		
Approved By:	Richard Cotton, Non-Executive Director and FPC Chair		
Presented By:	Richard Cotton, Non-Executive Director and FPC Chair		

Purpose:

To provide an overview of the key discussion items, risks, assurances, decisions and actions from the Finance & Performance Committee meeting held on 25 August 2026, for the Board of Directors and other relevant committees

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• Month 4 reported an in-month deficit of £2.57m, an adverse variance of £2.65m; the year-to-date deficit was £10.5m, rising to £13.6m excluding deficit support funding. • Efficiency delivery was £2.2m in Month 4 against a plan of £2.6m, and YTD is £7.0m against a plan of £10.0m. • Agency spend was £0.9m in Month 4 and YTD is £3.3m; at current rates this will exceed the annual limit of £5.4m. Bank spend was £2.0m in Month 4 and YTD is £8.1m; at current rates this will exceed the annual limit of £18.8m. • Approximately 90 medically fit patients remained in hospital, equivalent to three to four wards, creating significant flow and financial pressure. • The CT 24/7 service was clinically desirable but carried an additional unbudgeted operating cost of £149k; affordability, recruitment and alternative delivery models were challenged. • Critical risks remained around cash availability and the new NHS SBS ledger go-live.	• Quantify and separately report the costs attributable to delayed discharges; continue daily escalation to system partners and pursue recovery from responsible organisations. • Convene a system discussion on winter pressures and wider system actions and progress longer term discharge to assess and admission avoidance solutions. • Provide assurance next month that the new MRI facility will not adversely affect DM01 performance, and track income from additional elective schemes. • Reissue the full procurement forward view, including service level agreements and insourcing/outsourcing tabs, and strengthen forward planning for competition and direct awards. • Share the NHS SBS go-live criteria and convene a Committee subgroup to discuss the decision recommendation. • Convene a FPC meeting on 14 September to approve the October cash application before the 16 September deadline.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
• Four-hour performance improved in July; DM01 was broadly back on trajectory, and elective recovery schemes supporting delivery of 75% were being implemented. • Productivity grew by 4.7% in 2025/26, including a 1.1% real-terms expenditure reduction, although performance remained 7.7% below 2019/20 by NHSE calculations. • The procurement forward view had been strengthened and was now used as a central resource across divisions and the IVG. • The August cash application secured £3.4m of the £4.9m requested. • ECHO insourcing capacity was expected to increase to approximately 373 ECHO's per week against demand of 335, maintaining the six-week DM01 position while delivering a forecast financial improvement saving of £100k, with potential for further savings.	Approved the • EMRAD contract, noting a potential in year pressure of £346k and ongoing annual pressure of £536k for the next three years. • CT 24/7 with a net adverse run rate impact of £149k FYE. Case approved by majority. • IPR for onward submission to the Board. • Rhapsody contract for two years, noting cost pressures of £88k this year and a further £199k next year. • Phased exit and retrospective invoices from ECHO insourcing. Supported further development of the robotic surgery business case. Agreed closer Committee scrutiny of the imminent NHS SBS go/no-go decision.

Comments on effectiveness of the meeting

The meeting was open, detailed and appropriately challenging, with strong scrutiny of financial recovery, affordability, patient safety, procurement governance, cash and operational delivery. Discussion remained constructive and resulted in clear approvals, escalations and follow up actions.

Items recommended for consideration by other Committees

Audit and Assurance Committee: Note improvements to procurement governance, including oversight of direct awards without competition.
People Committee: Consider the digital business management capability and resourcing gap; consider corporate benchmarking WTE's / action plan.
Board of Directors: Receive an update on financial recovery, cash, the NHS SBS decision and approved recommendations. The draft Provider Capability assessment will be circulated to FPC members for comment before submission to the Board for approval.

Progress with Actions

Number of actions considered at the meeting – 7
Number of actions closed at the meeting – 6
Number of actions carried forward – 1
Any concerns with progress of actions – One action remains open to allow the Committee to consider the corporate analysis at its next meeting.

Note: Cover sheet not required; sufficient information included.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Extraordinary Finance & Performance Committee Chair's Highlight Report to Board of Directors

Subject:	Extraordinary Finance & Performance Committee (FPC) Meeting	**Date:**	14/09/2026
Prepared By:	Marie McAllister, Corporate PA		
Approved By:	Richard Mills, Chief Financial Officer & Andrew Rose-Britton, Non-Executive Director and FPC Chair		
Presented By:	Andrew Rose-Britton, Non-Executive Director and FPC Chair		

Purpose:

To provide an overview of the key discussion items, risks, assurances, decisions and actions from the Extraordinary Finance & Performance Committee meeting held on 14 September 2026, for the Board of Directors and other relevant committees

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• Quarter 3 cash support of £12.9m is required: £3.0m in October, £4.7m in November and £5.2m in December. • Key risks are the £9.6m risk-adjusted efficiency forecast shortfall, continued temporary staffing costs and BPPC non-compliance (causing supplier challenges). • No Quarter 3 deficit support funding has been assumed due to the adverse financial position.	• Finalise and submit the cash application and supporting letter within the NHS England timetable. • Reschedule the detailed financial recovery discussion.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• Cash risk is subject to Board, FPC and Risk Committee oversight and is reflected in BAF Principal Risk 4. • The financial recovery plan has been approved and submitted to NHS England. • Payment prioritisation continues under the approved cash management policy.	• The Committee approved submission of the £12.9m Quarter 3 revenue cash support application under delegated Board authority.

Comments on effectiveness of the meeting

The meeting was focused and provided sufficient scrutiny of the cash request, associated risks and required actions.

Items recommended for consideration by other Committees

• People Committee to continue oversight of workforce trajectories.
• Financial Recovery Cabinet and F&PC to review BPPC performance and benchmarking.
• Risk Committee to continue oversight of supplier, clinical and operational cash risks.

Progress with Actions

Actions will be discussed at the Finance and Performance Committee 29 September 2026.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	**Monday 24th August 2026**
Prepared By:	Esther Smith, PA to Chief Nurse Office		
Approved By:	Lisa Maclean, Non-Executive Director/Committee Chair		
Presented By:	Lisa Maclean, Non-Executive Director		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
System discharge pressures remained a significant risk, with 70–90 medically fit patients awaiting Pathway 1 care, a longest wait of 48 days and associated deterioration, deconditioning and capacity concerns. **Corridor care continued, peaking at 40 Emergency Department patients on 18 August, with additional beds also affecting ward staff and care.** **A Never Event involving a femoral nerve block to the wrong leg is under investigation; the planned procedure proceeded without complication.** **Repeat short-notice cancellations required further action, particularly in gastroenterology, urology and orthopaedics.** **Mental health demand, infection prevention trajectories, fragile paediatric radiology and trauma waits remained concerns requiring continued oversight.**	System escalation continues through senior meetings with Adult Social Care, the ICB and Nottinghamshire Healthcare to address Pathway 1 capacity. System-level escalation and three-times-weekly senior meetings continue with Adult Social Care, the ICB and Nottinghamshire Healthcare regarding Pathway 1 capacity and differing assessments of commissioned provision. A harms review is being developed for patients awaiting packages of care, including a case review of the 48-day wait. A system briefing will support discussions with partner chairs and leaders on discharge delays and corridor care. Cancellation governance and rebooking oversight will be strengthened, alongside a review of pre-operative assessment focused on urology and gastroenterology. Patient Safety Committee will review trauma waits and delay-related harm, while IPC and antimicrobial stewardship work continues. Quality Committee will review the quality BAF risk monthly.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
Strong assurance was received from the integrated respiratory pathway, which is improving community access, reducing secondary-care referrals and lowering acute attendances. **The mortuary report confirmed closure of five of six major HTA shortfalls, all 17 minor shortfalls and 17 David Fuller recommendations, with compliance across all five Board assurance categories.** **The Governance Support Unit demonstrated continued PSIRF maturity, stronger investigation capability and improved patient and family involvement.** **GIRFT oversight was strengthened through a multidisciplinary taskforce, tracker and executive-led stewardship group, with early specialty improvements.** **Further assurance was received on emergency and planned care improvement, diagnostic waits, maternity voice arrangements, radiology leadership and the promotion of CPR and basic life-support training.**	The Committee AGREED that the quality-related Board Assurance Framework risk would become a standing monthly agenda item. The current BAF position was considered accurate and no immediate change to the risk score was identified.

Comments on effectiveness of the meeting
LM thanked contributors for the quality and breadth of the papers and discussion. The operational update at the start of the meeting was particularly valued for setting the context for subsequent assurance and scrutiny. The meeting supported constructive challenge, clear attribution of actions and appropriate escalation of significant quality and safety risks, while recognising substantial progress in respiratory integration, mortuary services, governance, GIRFT and improvement capability.
Items recommended for consideration by other Committees
Progress with Actions
Number of actions considered at the meeting – 8 Number of actions closed at the meeting – 7 Number of actions carried forward - 1 Any concerns with progress of actions – No If Yes, please describe –

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Audit and Assurance Committee Chair's Highlight Report to the Board of Directors.

Subject:	Audit and Assurance Committee	**Date:**	17th September 2026
Prepared By:	Acting Chair: Andrew Rose-Britton		
Approved By:	Acting Chair: Andrew Rose-Britton		
Presented By:	Acting Chair: Andrew Rose-Britton		
Purpose:			
To provide an overview of the key discussion items, risks, assurances, and actions from the Audit and Assurance Committee held on 17th September 2026 to the Board and other relevant Committees.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
No immediate concerns to be escalated to the Board. A Board Workshop item to ensure alignment of the 2027/28 Internal Audit workplan to the key risks of the Trust is recommended by the Committee.	It was noted that the external audit contract was still to be finalised. Register of Interest work continuing to reduce non-compliant numbers to a minimum. Updating and review of non-clinical polices work ongoing. Further discussions as to risk to strategy and BAF to be held.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Assurances were received from Internal Audit as to progress on the outstanding audit actions. Assurance was also received with respect to the three high risk reviews that remain from 2025/26. Positive assurance was given to an additional review of Mortuary Services in 2026/27. It was noted that there were no Audit reports with limited assurance.	Confirmed assurance and supported approval of losses and special payments for the period July to August 2026. Confirmed assurance and supported approval of one direct award for the period July to August 2026. The Committee 's Annual Workplan was approved.

Assurance was received from the Finance and Performance Committee as to the implementation of SBS accounts package and to the approval of the Cash Application by NHSE. Register of interest: Significant progress made in reducing the number of non-compliant employees. Non-Clinical policies: Assurance received as to the progress being made.	

Comments on effectiveness of the meeting

Good all-round discussion. Reports received were of high quality.

Items recommended for consideration by other Committees

Concerns raised in Risk Committee report as to staff morale (violence and aggression) to be considered by the People Committee

Progress with Actions

Number of actions considered at the meeting - 2
Number of actions closed at the meeting – 3
Number of actions carried forward - 7
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.

Public Board - Cover Sheet

Subject:	Provider Board Capability Self-Assessment	**Date:**	01/10/26
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Jon Melbourne, Chief Executive		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To share with the Board the final draft narrative response to the 2026 Provider Capability Self-Assessment incorporating its feedback for final approval and onward submission to NHS England by the 2nd October 2026 deadline.	**Approval**	**X**
	Assurance	
	Update	
	Consider	

Recommendation

That the Board:

- approves the six domain ratings and their associated narrative responses to the capability statements,
- delegates authority to the Chair and Chief Executive to sign the final version, and
- notes that the completed Provider Capability Self-Assessment template 2026 will be submitted to NHSE to meet the submission deadline on 2nd October 2026.

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	**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

Executive and NED Update meeting on 3rd September 2026
Executive Committee, most recently on 23rd September 2026

Acronyms

NHSE – National Health Service England
NED – Non-Executive Director
Others defined on first use

Executive Summary

The Board approved the submission of the first Provider Board Capability Self-Assessment in October 2025 following which the Trust was notified by NHS England on 6th February 2026 that its overall rating was "Amber-Green".

The 2026 draft has been prepared collaboratively by Executives and their teams who have collated detailed responses under the six domains that are further divided as described above into 18 self-assessment criteria, two more than in the initial return. The only new requirement is No. 5

in section 1 about cyber security and digital technology. The other increase is due to what was a single statement in the Quality of Care domain in 2025 being divided into two for the 2026 return.

This paper presents the final draft of the Trust's Provider Capability Self-Assessment 2026 comprising the six domain ratings and their associated narrative responses to the eighteen capability statements.

The first draft was reviewed by the Board at the Executive and NED update meeting on 3rd September 2026 where feedback focussed on the need to adequately describe gaps, and improvement requirements or conditions for success. A specific point about whether the strategy and leadership narrative sufficiently tested the effectiveness of the Trust's strategies has also been addressed.

The Domain ratings proposed for the 2026 return are:

Domain	**Rating**
Strategy, leadership and planning	Green
Quality of care	Amber-Green
People and Culture	Amber-Green
Access and delivery of services	Amber-Green
Productivity and value for money	Amber-Green
Financial performance and oversight	Amber-Red

It is not possible to make direct comparisons with last year's Self-Assessment as the Board was required to assess using different descriptors, in the case of this Trust – "confirmed" or "partially confirmed".

This final section provides general background information about the Board Capability Self-Assessment process

As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts' capability – using its Provider Capability Self-Assessment alongside providers' NOF segments – to judge what actions or support are appropriate at each trust.

As a key element of this, Boards are asked to assess their organisation's capability against a range of expectations across 6 areas, referred to as "domains" derived from the Insightful Provider Board publication, namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

The purpose of the Self-Assessment is to focus Boards' attention on a set of key expectations related to their core functions and to encourage an open culture of 'no surprises' between Trusts and oversight teams.

NHS England regional teams will then use the self-assessment, along their own views of management and their track record and relevant third-party information, to derive a view of the organisation's capability based on various factors including what the guidance describes as 'grip' –

that is, the board's ability to understand problems, retain control, and deliver effective action.

Following a national moderation process and NHSE executive board ratification, the rating will be confirmed and utilised to drive the focus of the oversight relationship.

The guidance document, published on 28th July 2026 sets out the process and helps boards to make their self-assessment using a RAG-rating comprising four options: green, amber-green, amber-red and red - against each of the 6 domains of the Insightful Provider Board, in response to 18 supporting capability statements. Boards are required to consider:

- the extent to which their Trust meets each capability statement, based on the return template
- the evidence underpinning their view, logging this in the return to the region as well as the issues preventing a 'green' return and actions underway to address them
- what, given the above, the overall rating should be in each of the 6 domains

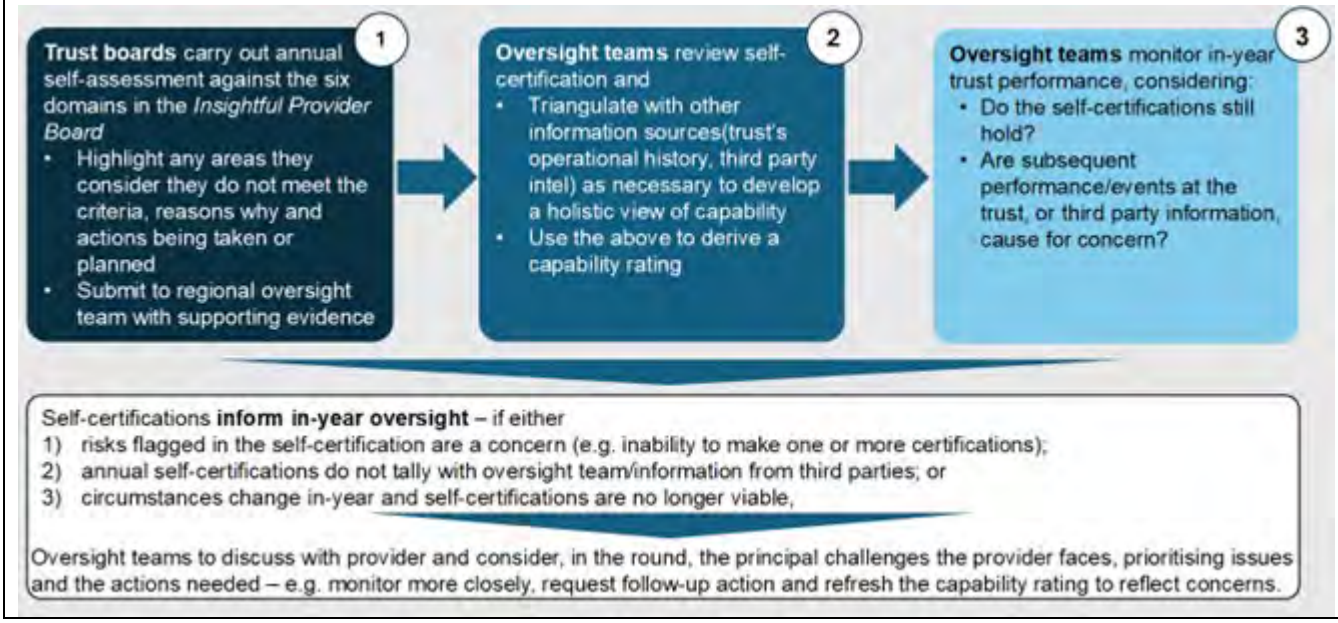
Annexed to the guidance are descriptors of the evidence that may be considered in making the self-assessment.

Regions may ask to see this evidence as part of the follow-up process to determine the Trust's rating based on their views and third-party intelligence. However, it is not required to be routinely submitted with the return unless requested by regional oversight team. A comprehensive list of evidence was prepared and submitted with the 2025 return and this will be updated in readiness should it be requested.

The guidance makes clear that NHSE will use the self-assessment RAG ratings, its own views, and those of third parties, to propose a capability rating for national moderation. NHSE also emphasises that the self-assessment process should not be seen as a 'tick box' exercise and instead its purpose should be recognised as being to promote Board self-awareness and transparency regarding organisational capabilities, strengths, weaknesses and an acknowledgement of the challenges faced.

Trusts have been given until 2nd October 2026 to carry out this self-assessment and return it to their regional oversight lead.

The following diagram summarises the capability assessment annual process from which the rating will be generated:



The following table summarises the indicative features of the four ratings that the Executive team has taken into account in its proposed domain ratings that feature alongside each Domain heading:

Rating – in either a specific domain or overall	**Indicative characteristics –** in either a specific domain or overall
Green High confidence in management	• Strong track-record across management team • No concerns with board's grip, • No reputational issues, system partner or other third-party concerns
Amber-green Some minor issues that should be addressed	• No material concerns, but some areas may require a watching brief and as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS, **or** • Trust in 'probation' – no concerns but trust capability recovering from previous concerns before final assurance.
Amber-red Material issue needs addressing or failure to address major issues over time	• Serious governance/capability issues in at least one domain or capability statement **and/or** • Trust recovering from red-rating below, with serious Issues still present but evidence of improvement and grip
Red Significant and persistent concerns	• Serious issues in multiple domains **and/or** • Serious ongoing issues in a single domain that management has been unable to address sufficiently over time • In breach of governance licence condition or likely to be.

Proposed ratings will be submitted for review with supporting evidence to the provider capability moderation panel comprising regional and national directors.

The panel will then recommend ratings for ratification by NHSE's executive board.

Following ratification, oversight teams will discuss the capability rating with the Trust and consider, in the round, the principal challenges the organisation faces, prioritising issues and the actions needed – for example, monitor something more closely, request follow-up action(s), or refresh the capability rating to reflect concerns if necessary.

Across the year the capability assessment will be used to inform oversight in situations, for example, where:

- risks flagged in the self-assessment are a concern (e.g. amber-red or red in one or more

domains)
or

- annual self-assessments do not tally with the oversight team's views or information from third parties
or
- subsequent performance/events at the Trust or third-party information are a cause for concern such that elements of the self-assessment are no longer valid and, in order to assess 'grip', teams may wish Trusts to review the basis on which they made the initial assessment
or
- improvements at the trust need to be reflected in the rating

Note regarding inability to make a positive self-assessment, the guidance states that "The board may not be able to make a positive self-assessment (i.e. the return is Amber-Red or Red) in a domain either because it considers the risks in a specific domain are too great or there are clear and evident issues in play. In these situations – and in line with the 'no surprises' ethos – in the self-assessment template boards should provide: • the reasons for concerns and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors) • how long these have persisted • a summary of any mitigating actions the trust has taken or is taking • if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress. Oversight teams will use this information to form their view of the overall capability of the trust and tailor their oversight relationship with it"

Provider capability self-assessment template 2026

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead at england.midlands.scot@nhs.net by **5pm Friday 2nd October 2026**.

I. Strategy, leadership and planning

Capability statements	**Proposed domain rating**
	Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Trust leverages its position as a leading provider in Mid-Nottinghamshire, serving a population of over 350,000, and aims to add value to local healthcare and economic development through its purchasing power and the development of local residents for future employment. Its five-year strategy, 'Improving Lives' (2024–2029), has been refreshed at its mid-point to align with the national 10-Year Health Plan (2025) and local commissioning and population health strategic plans (2026). The refresh retains a strong focus on delivering outstanding care while extending the Trust's role beyond the traditional acute hospital model through partnership working, prevention, reducing health inequalities and neighbourhood-based care. It identifies three key delivery areas: improving through change, driving best practice and being a great place to work, all enhanced through partnership working. The North Notts Place Based Partnership neighbourhood plan, led by the Trust, includes a target operating model to be delivered with health, care and third-sector partners. The Trust also has a mature anchor institution role as a major employer, educator, procurer and civic organisation. Its Anchor Plan aligns workforce development, procurement, environmental sustainability, neighbourhood working and social value activity with local economic and health priorities, using the Trust's workforce, procurement spend, estates and partnerships to improve population health, reduce inequalities and strengthen local prosperity. The strategic direction is coherent and provides a strong basis for delivery. There is an opportunity to strengthen the supporting evidence by demonstrating more consistently how these priorities translate into measurable outcomes across all domains. The Board already receives regular updates on the changing external landscape, prompting discussion of risks, mitigations and next steps. The translation of strategy into action with partners is evidenced by the recent news of North Nottinghamshire being selected as one of the national Trailblazer sites, led by Sherwood Forest. The output will

	be a robust, implementation-ready business case for neighbourhood health in North Nottinghamshire by March 2027. It is acknowledged that there is further work to develop the partnership approach to outcomes in areas such as urgent and emergency care, and this work is continuing. Integrated reporting across quality, workforce, activity, productivity, finance and inequalities would help the Board identify emerging variation and trade-offs and provide assurance on responsive action. Trade-off discussions have taken place at recent Board development workshops and will inform this integrated reporting. Clear baselines, milestones, accountable owners and periodic use of benchmarking and patient, staff and partner insight would further evidence delivery of the intended strategic impact.
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	The Trust is not in breach of its licence.
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	The Trust appointed a new Chief Executive in October 2025 and a new Chair in July 2026. A Chief Improvement Officer has been recruited and joins the Trust in November 2026 – with a portfolio including digital, improvement and strategy. We have no Non-Executive Director vacancies – with recruitment to our only vacancy concluding in September 2026. There are no acting or interim Board roles. The Board holds regular development sessions focused on strategic direction and emerging requirements, including Board-level leadership of health inequalities. The recent leadership transition and remaining vacancy provide a timely opportunity to continue building the evidence of collective Board capability and effectiveness. Board and committee effectiveness reviews continue to test how performance, quality, workforce and finance are triangulated, how agreed actions are followed through and how Board challenge supports delivery, particularly in the context of the access, productivity and financial performance assessments.

	A planned skills and capabilities assessment is in development for senior leaders, which will highlight gaps and training needs to meet the requirements of the 10-year plan. The Board has put itself forward for the National Board Development Programme and we are awaiting the formal outcome.
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	The Trust's approach to partnership working, including risks and benefits, is reviewed quarterly by the Partnerships and Communities Committee alongside the relevant Board Assurance Framework risk. The Trust is actively involved in, and leads, a number of local and regional collaboratives, including the East Midlands Acute Providers Network, Acute Services Oversight Group, Bilateral Committee in Common with Nottingham University Hospitals, East Midlands Radiology Network, East Midlands Pathology Network and the North Notts Place Based Partnership. These arrangements support service improvement and the sustainable management of resources. The Trust also works closely with universities and local colleges to support workforce development, broaden opportunities for local people and increase participation in research. Discussions with the emerging North Notts Primary Care Federation are helping to shape responses to new contractual models and the planned shift of care closer to home. The Trust is an active participant in ICB neighbourhood, urgent and emergency care, and planned care programme boards, where mutual aid and the sharing of resources are discussed and enacted. Through partnership working across North Nottinghamshire, the Trust has led applications to the National Neighbourhood Pilot, the ICB Transformation Fund and the Trailblazer social finance opportunity, reflecting its position as a trusted lead. The Trailblazer application has been successful, opening new ways of working with our partners. This demonstrates breadth of engagement and strong relationships. As these arrangements mature, the narrative could be strengthened through more consistent evidence of benefits realised, changes in outcomes, progress against shared milestones and the way inter-organisational barriers are addressed. In the context of the access,

	productivity and financial assessments, this would help show how collaborative working is improving pathways, reducing duplication and inequality, and supporting sustainable use of system resources. Periodic Board assurance on benefits, delivery risks and partner feedback would support timely action where joint plans require additional focus.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	The Trust has embedded digital and cyber security within its corporate governance, assurance and risk management arrangements. The Board receives assurance through established governance structures, including the Data Protection and Cyber Security Committee and Cyber Security Assurance Programme Board, ensuring that digital, cyber resilience and information governance are routinely considered as part of strategic planning, service delivery and organisational risk management. Cyber security is recognised as a significant organisational risk, with assurance provided through cyber hygiene reporting, vulnerability management, audit activity, DSPT compliance, cyber maturity assessments and formal risk reporting processes. The Trust's Digital Strategy 2026-2031 positions digital as a key enabler of quality, productivity, access, safety and workforce experience. Recent initiatives include the development of digitally connected care pathways, increased interoperability to support hospital-to-community care, reduction of paper-based processes, enhanced analytics and insight-led decision making, strengthened cyber resilience, and improved assurance reporting through the IT Health Dashboard. The strategy is aligned to Trust objectives, Integrated Care System priorities and national NHS policy, including the transition from analogue to digital services, supporting care closer to home and enabling prevention through better use of data and technology. Through collaborative working with NHIS and system partners, the Trust maintains a coordinated approach to digital transformation and cyber security, providing assurance that digital investment supports both organisational and wider system objectives.

II. Quality of care

Capability statements	Proposed domain rating Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	Recent CQC activity has provided positive assurance regarding the quality of care delivered by the Trust. However, the Board recognises ongoing challenges relating to healthcare-associated infections, operational pressures, patient flow and corridor care. The Trust's quality governance arrangements are focused on ensuring these risks are identified early, escalated appropriately and addressed through measurable improvement activity. The Trust systematically considers all relevant NHS England guidance when developing and reviewing quality, safety and governance processes. This includes explicit alignment with the Patient Safety Incident Response Framework (PSIRF), the Patient Experience Improvement Framework (PEIF), Improving Patient Experience Guidance, Friends & Family Test (FFT) Guidance, and Duty of Candour Guidance. The Trust also draws on GIRFT (Getting It Right First Time) findings to understand variation in clinical pathways and to ensure patient experience insight is considered alongside clinical outcomes and operational performance. Although the National Quality Strategy was only published in July 2026, the Trust is already incorporating its expectations into local quality planning, with a commitment to strengthening assurance around safety, effectiveness and experience as the Strategy becomes embedded. This is supported by triangulation of: - Care Quality Commission intelligence and inspection findings - Internal patient safety incident trends and learning, analysed through PSIRF-aligned learning responses, thematic reviews, and system-based approaches - Complaint themes and concerns raised by patients, families, and staff, ensuring compliance with Duty of - Candour and national compassionate-communication standards - Additional quality metrics selected to support local priorities, including real-time patient experience insight, FFT trends, and ward-level assurance data. Under PSIRF, the Trust ensures learning responses are proportionate, system-focused, and linked to strategic risk. Patients, families, and carers are involved in accordance

	with national expectations, and their insight is triangulated with complaints, concerns, and experience data. Patient experience guidance is embedded through structured use of real-time feedback mechanisms, strengthened involvement of patients and families, and transparent reporting of FFT and complaint's themes. This ensures national expectations around experience, equity, personalised care, and compassionate communication are reflected in local practice. Data is reviewed through divisional governance, Quality Committee, and Board reporting cycles. This ensures national guidance is interpreted appropriately, embedded into practice, and monitored for impact, with clear accountability and evidence of improvement across safety, effectiveness, experience, and equity. The Board recognises that compliance with national guidance alone is insufficient and continues to use external intelligence, quality metrics and patient feedback to identify areas where further improvement is required. Recent Board/ sub board committee discussions have focused on healthcare-associated infections, including Clostridioides difficile, MRSA bacteraemia and gram-negative bloodstream infections, together with the impact of sustained urgent and emergency care pressures and corridor care on patient safety, experience and dignity. These issues are monitored through established governance arrangements with improvement programmes, executive oversight and regular reporting to the Quality Committee and Board.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	The Trust has established arrangements to monitor and improve quality of care, supported by divisional governance structures, the Patient Safety Committee, Quality Committee and Board reporting. These arrangements have supported positive external assurance, including recent CQC activity. However, the Board recognises that significant quality challenges remain in

	areas such as infection prevention and control, urgent and emergency care pressures, patient flow and corridor care. The focus is increasingly on ensuring that governance processes translate into demonstrable and sustained improvements in patient outcomes, safety and experience. Clinical teams are already using real-time data, pathway-level insight and quality metrics to monitor performance, identify variation and take targeted action to improve outcomes. Work is underway to improve consistency, reduce unwarranted variation and enhance patient outcomes. The Trust has a well-embedded Quality Impact Assessment (QIA) process and is expanding quality improvement capability by supporting staff to use evidence-based tools, modern service frameworks and improvement methodologies to redesign pathways, test changes and measure impact, aligning with the National Quality Strategy's emphasis on continuous improvement and evidence-based practice. Patient experience improvements are being strengthened through using real-time feedback, patient stories and engagement insight to shape improvements in communication, personalised care, accessibility and responsiveness. As the National Quality Strategy becomes embedded across the NHS, the Trust will incorporate its expectations into local quality plans, improvement priorities and monitoring arrangements. This will ensure that existing strong foundations are aligned with national direction and that assurance continues to strengthen over time. While quality improvement capability continues to develop, the Trust recognises the need to strengthen the consistency with which learning from incidents, complaints, mortality review, patient experience and operational

	performance is triangulated to demonstrate measurable impact. This remains an area of focus for the Board and Quality Committee.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	The Trust has established systems to monitor patient experience in real time and to ensure that any safety concerns identified through patient feedback are escalated promptly to the senior leadership team and Board. Patient experience insight is gathered via multiple routes, including the Friends and Family Test, complaints and concerns, compliments, patient stories, ward-level feedback, engagement activity and national survey findings. Services use this information to understand what care feels like for patients, families and carers and to identify areas requiring improvement. Patient experience data is routinely reviewed at service and divisional level, with themes analysed to identify emerging issues, deteriorating trends or concerns that may indicate a potential impact on safety or quality. Where patient feedback highlights a safety concern, clear escalation pathways ensure this is raised through operational and clinical leadership and, where appropriate, through the Patient Experience Committee, Patient Safety Committee or Quality Committee for oversight. In addition to formal patient experience measures, the Board receives information regarding operational pressures and their impact on patient experience, including emergency department crowding, delays in care and corridor care. Patient stories, complaints, FFT feedback and engagement activity are used alongside safety and operational indicators to provide a more complete understanding of care quality and to inform improvement priorities. Significant concerns, risks or themes identified through patient experience monitoring are escalated to the Board

	through established reporting mechanisms, including the Integrated Performance Report and patient experience updates. This ensures the Board has visibility of issues that may affect safety, quality or experience and can provide appropriate challenge, oversight and direction. Patient experience insight is actively used to identify safety concerns and support timely escalation to the Board, strengthening assurance and supporting continual improvement in the quality of care provided.

III. People and culture

Capability statements	Proposed domain rating **Amber-Green**
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Board receives a comprehensive range of workforce information to understand the experience of working at the Trust and identify opportunities for improvement. Workforce metrics are routinely reported through the Integrated Performance Report (IPR), People Committee, People Cabinet and Trust Board, including NHS Staff Survey outcomes, NHS Staff Standards indicators, People Promise metrics, sickness absence, retention, turnover, equality and inclusion data, Freedom to Speak Up themes and workforce planning information. This enables the Board to triangulate information and maintain an evidence-based understanding of organisational culture and staff experience. The Board also receives information relating to medical and non-medical trainees, including feedback from the General Medical Council (GMC) National Training Survey, National Education and Training Survey and university placement evaluations, with action plans developed and monitored where improvements are identified. The People Committee receives annual reports relating to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and Equality, Diversity and Inclusion (EDI) performance, together with associated improvement plans. Workforce diversity data is routinely monitored to provide assurance that the organisation is making progress towards building a workforce that reflects the communities it serves. Progress against actions is monitored through established governance arrangements, with escalation to the Board where appropriate. The cultural heat map continues to support the triangulation of workforce intelligence and enables targeted interventions in areas requiring additional support. The Board actively engages with staff forums and staff networks to understand staff experience and identify opportunities to improve both the working environment and the quality of care provided to patients. Each Staff Network is sponsored by an Executive Director and regular engagement takes place through the People Cabinet, workforce listening events, Executive walkarounds and Board-led 15 Steps visits. Feedback from these forums has informed organisational priorities relating to wellbeing, inclusion, leadership visibility, violence and aggression reduction, flexible working and staff support. The Chair of the People Committee periodically attends the People Cabinet to gain direct

	assurance regarding workforce priorities, concerns and opportunities for improvement. National Staff Survey results and local staff feedback are considered routinely by the People Committee and Board. Action plans are developed at organisational, divisional and departmental levels, with progress monitored through Divisional Performance Reviews, People Cabinet and People Committee reporting. The Board is able to evidence actions taken in response to staff feedback and receives assurance that agreed actions are being implemented and delivering improvement. The Trust continues to maintain a strong reputation as an employer and remains committed to ensuring staff voices shape both workforce experience and the quality of care delivered to patients. While staff feedback mechanisms are well established and provide the Board with a comprehensive view of workforce experience, the Trust recognises there remain opportunities to strengthen consistency in translating feedback into measurable improvements across all services and departments. Although NHS Staff Survey results demonstrate areas of good practice, variation remains across some indicators and staff groups, particularly in relation to wellbeing, inclusion, violence and aggression, and perceptions of speaking up. The Trust continues to use workforce intelligence, staff network feedback, cultural heat mapping and divisional action planning to address these areas. Success will depend upon sustaining visible leadership, strengthening local accountability for action plan delivery, and demonstrating to staff through regular "You Said, We Did" reporting that feedback consistently leads to meaningful improvements in both staff experience and patient care. Additionally, the Trust launched a ‘Together, we will’ campaign following the last staff survey, focussing on actions we are taking in response to feedback.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	The Trust has well-established processes to ensure staff have the skills, knowledge and capability required to undertake their roles safely and effectively. Workforce planning, succession planning, talent management and organisational development arrangements provide assurance that skills are reviewed at all levels of the organisation. Appraisal compliance, workforce establishment reviews, professional workforce plans and education reports are routinely monitored through the People Committee and Board. Skills requirements also form an integral component of the workforce planning process, ensuring that future workforce requirements are identified and addressed.

	Staff development is supported through a comprehensive range of learning, leadership and professional development programmes. The Trust has continued to implement the NHS Leadership and Management Framework and maintains a strong focus on developing leadership capability at all levels. Professional education, apprenticeships, preceptorship programmes, clinical skills development, quality improvement training and leadership development opportunities are available across staff groups to support career progression and service improvement. The Board receives assurance regarding delivery of these programmes through routine workforce reporting and annual reports to the People Committee. Mandatory training compliance is monitored through established governance arrangements and routinely reported through the Integrated Performance Report. Compliance levels are reviewed by Divisional Leadership Teams, Divisional Performance Reviews, the People Committee and Board, enabling timely intervention where standards fall below expected levels. Compliance includes safeguarding, information governance, health and safety, patient safety and other role-specific statutory and mandatory requirements. The Trust maintains clear processes to ensure learning is completed and compliance is sustained. The Board receives assurance regarding incidents, patient safety events and workforce-related risks through the Integrated Performance Report, Quality Committee and People Committee reporting structures. Learning from incidents, investigations and avoidable staff-related events is reviewed and shared across the organisation to strengthen capability, support continuous improvement and minimise recurrence. The Board is satisfied that appropriate systems are in place to monitor workforce skills, training compliance and organisational learning, and that staff are supported to maintain the competence required to deliver safe, effective and high-quality care. The Trust recognises that maintaining workforce capability and capacity remains challenging within the context of national workforce shortages, increasing service demand and financial pressures across the NHS. Whilst workforce planning arrangements are established and training opportunities are extensive, there remain challenges in some professional groups and specialist roles where recruitment, retention and succession planning require ongoing focus. The Trust continues to prioritise workforce supply, leadership development, apprenticeship pathways and career progression opportunities to mitigate these

	risks. Success will depend upon maintaining safe staffing levels, improving retention, ensuring continued investment in learning and development, and supporting managers to develop the skills required to lead increasingly complex services and multidisciplinary teams.
11. Staff can express concerns in an open and constructive environment	The FTSU Report is presented quarterly in rotation to the Board and the People Committee. The report includes themes, progress, triangulation of concerns and ongoing developments. Quarterly meetings are also held with the Senior Independent Director for FTSU, the Executive Lead for FTSU (Director of Corporate Affairs) and the FTSUG to discuss FTSU themes and allow for escalation and challenge to the Board if required. The FTSUG and the Executive Lead for FTSU meet at least fortnightly to discuss FTSU information and ensure appropriate escalation and oversight. All patient safety and quality concerns are referred to the relevant senior / executive lead where action plans are put in place. All concerns are logged on the FTSU Database. All other concerns that are not in the patient safety category and may not have consent for escalation are triangulated regularly through sharing themes and areas of concern with the Wellbeing, Organisational Development (OD), Equality, Diversity & Inclusivity (EDI) and Occupational Health (OH) teams. This enables learning points to be extracted and taken forward, even where the reporter does not want open escalation. A new maternity specific FTSU arrangement has been agreed with executive oversight. An experienced, current FTSU Champion has agreed to undertake the required development and transition into a Maternity FTSU Guardian role, providing a dedicated route for colleagues working within maternity services. This arrangement is intended to strengthen speaking up access and psychological safety within Maternity, reflecting learning from national maternity reports and recommendations. The maternity specific Guardian will offer an alternative choice, alongside the current FTSUG, for the maternity workforce. In response to recommendations in the 2025 Grant Thornton LLP developmental Well-Led review, the actions from which are now implemented, two new guidance documents are available, one for staff and the other for managers, about the FTSU process. The “FTSU Process & Timescale Guidance” explains clearly the process, expectations and demonstrates a streamlined process for all. These have recently been updated, reflecting feedback from users. There is guidance for those who feel detriment for speaking up and the opportunity for escalation to the Senior Independent Director for review.

	A team of c.30 trained FTSU Champions is in place across the Trust with targeted recruitment to ensure they are accessible to all staff. These Champions support FTSU visibility and messaging. In addition, they receive feedback from the FTSUG including updates, learning, and actions in response to themes raised to share with colleagues to encourage them that speaking up leads to action and improvement and, importantly, that hearing staff voices matters. The Trust has implemented “They said, We did…” feedback, led by divisional teams, to showcase learning and safety in speaking up.

IV. Access and delivery of services

Capability statements	Proposed domain rating **Amber-Green**
12. Plans are in place to improve performance against the relevant access and waiting times standards	Performance and oversight is led by the Chief Operating Officer There are robust oversight forums in place to ensure performance is delivered, improved and sustained. The Trust operates a weekly TMT meeting where performance and operational delivery is discussed with managers and clinicians. Regionally performance is overseen through the Quarterly Trust / Region PRM, along with other escalation meetings as required. Examples of performance improvement groups in place include: - Divisional Performance Reviews, increased to monthly from Bi-Monthly. - Planned and Emergency Care Steering Groups. - GIRFT Stewardship Group with support from the Improvement Faculty. - Weekly local Cancer and Elective PTL meetings in place. Recovery action plans exist and have been jointly agreed with ICB colleagues to deliver improvements in performance and waiting time standards in line with submitted trajectories. The Trust Board has regular oversight of performance and access including of the National Oversight Framework results on a quarterly basis GIRFT remains the primary approach for service improvement, focussed on delivering better access and more efficient services. We continue to operate a 15-steps process to support all Executive Directors to visit clinical and non-clinical areas.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	The Board has strengthened oversight of health inequalities through the Partnerships and Communities Committee, Health Inequalities Steering Group, Board development sessions and the implementation of a Trust-wide Health Inequalities Vision and Action Plan. The Trust has developed a Health Inequalities Equity Index which brings together operational metrics including outpatient activity, diagnostics, elective waiting times, emergency care, maternity services, readmissions and cancer performance. Data are segmented by factors such as age, ethnicity and deprivation,

	enabling inequalities in access, experience and outcomes to be identified and monitored. The Equity Index is being applied to planned care pathways and transformation programmes, with DNA rates being used as an early indicator of inequity within waiting list management. Health inequalities measures are increasingly being incorporated into routine reporting and performance management processes. The Trust is moving beyond identification of variation towards targeted action. This includes work focused on Priority Plus populations, including people with learning disabilities and severe mental illness, supported by divisional Health Inequalities Leads and a range of service improvement initiatives including respiratory, diabetes, diagnostics and planned care programmes. Through its Health Inequalities Programme, neighbourhood partnerships and Anchor Programme, the Trust is increasingly using population health intelligence to identify communities at greatest risk of poor outcomes and barriers to care. This supports targeted interventions that address both healthcare access and the wider determinants of health. Overall, the Trust has moved beyond the identification of variation towards a systematic approach of intelligence, partnership working and targeted intervention, enabling population health insights to be translated into practical actions to reduce unwarranted variation in access, experience and outcomes. We do however recognise this as an area for further action and improvement – both internally and in partnership.
14. Appropriate population health targets have been agreed with the ICB	The Trust works closely with the Integrated Care Board, local authorities, Public Health teams and place-based partners to develop priorities, improve population health intelligence and align delivery with system objectives. The Trust's Health Inequalities Priorities and Action Plan have been developed through this collaborative approach. Population health management principles are increasingly being applied to service redesign, operational performance and improvement activity. This includes programmes such as

	respiratory transformation, Diabetes WAVE, the Community Diagnostic Centre and neighbourhood-based models of care, helping to target interventions towards populations with the greatest need. As a major employer and public sector organisation, the Trust has adopted an Anchor Institution approach, recognising its contribution to population health extends beyond healthcare delivery. Through partnerships with local authorities, education providers, the voluntary sector, the Integrated Care Board and the East Midlands Combined County Authority, the Trust is supporting employment, skills, community wellbeing, sustainability and wider determinants of health. The Trust's refreshed Anchor Plan for 2026-29 provides a prevention-focused framework centred on healthier and fairer communities, local prosperity, inclusive employment and environmental sustainability. Programmes such as Waiting Well, MSK Together and Connect to Work demonstrate how the Trust contributes to wider system priorities for prevention and reducing inequalities. The Trust has invested in building organisational capability through Board development, staff education, Making Every Contact Count training and strengthened Equality Impact Assessment processes. Anchor principles are increasingly being embedded within core Trust functions, helping staff recognise their contribution to wider population health outcomes. Whilst we have made progress, we do recognise that there is further to go in developing meaningful and measurable population health targets with the ICB. Overall, the Trust demonstrates a growing link between population health priorities, operational delivery and organisational culture. Through health inequalities, neighbourhood health and anchor programmes, the Trust is increasingly translating population health insight into practical action that supports prevention, reduces inequalities and improves outcomes for local communities.

V. Productivity and value for money

Capability statements	Proposed domain rating **Amber-Green**
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Financial Efficiencies and Productivity is a standing agenda item on the Finance and Performance Committee (Board sub-committee) and the Financial Recovery Cabinet (which reports into the Finance and Performance Committee). The monthly Productivity Report includes performance against all of the Headline Productivity and Efficiency metrics published on the Model Health System, including benchmarking against the peer and national averages. Relevant updates are escalated/highlighted to the Trust Board by the Finance Committee. The IPR that is presented to the Trust Board also includes relevant metrics and benchmarking information. The IPR includes a Rate of Productivity metric, which is based on the Implied Productivity values reported through the Model Hospital. We have strengthened our governance arrangements in relation to GIRFT, with the Chief Medical Officer providing executive level sponsorship and a GIRFT Oversight Group established. The GIRFT Operational Lead provides dedicated leadership and coordination to support the delivery of the Trust's GIRFT priorities, including quality improvement, operational performance, service transformation, productivity and financial efficiency. Our programme of work here will be further strengthened by our incoming Chief Improvement Officer, as we look to expand our culture of continuous improvement across the Trust. Other benchmarking information published by NHSE, for example Corporate Benchmarking information, is shared with Board and/or relevant sub-committees as and when necessary. Our business case template for service change includes section on productivity and requires narrative to explain how any new proposals deliver on the 10-year health plan for 2% productivity improvement. Plans to improve productivity and efficiency are incorporated into the Trust's CIP programme, with updates flowing through Financial Recovery Cabinet and Finance and Performance Committee.

VI. Financial performance and oversight

Capability statements	Proposed domain rating **Amber-Red**
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The annual Internal Audit (IA) plan is reviewed and approved by the Audit and Assurance Committee (AAC) on an annual basis. Any changes to the IA Plan in-year also require AAC approval. The annual plan includes reviews of financial systems and process, with all elements reviewed on a cyclical basis over a 3-year period. Significant assurance received from head of Internal audit opinion, along with an unqualified and 'clean' opinion from External Audit as evidenced in the ISA 260. There have been no formal contract disputes in the last 12 months and contractual review meetings are in place for our main contracts (with the Derbyshire, Lincolnshire & Nottinghamshire ICB Cluster). Workforce information is reported in the financial ledger, in terms of Whole Time Equivalent (WTE) budgeted, contracted and worked, to enable triangulation with financial information. Activity information is also reported alongside workforce and financial information in the Board IPR. Supplementary information is provided to the Board as and when necessary.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	We have a robust Quality Impact Assessment (QIA) process in place, which is used to consider the impact of efficiency plans and is aligned to the NHSE QIA toolkit. The QIA process includes staged approval requirements, with those scoring 8 and above requiring submission to a bi-weekly QIA panel for review by the Chief Nurse and the Chief Medical Officer. For those that are approved, a continued review process is in place. Our continued review process provides a safeguard to monitor the impact of efficiency schemes and are actioned, where required. As an example, Urgent and Emergency staff reductions had a significant impact on performance and consequently have been partially reversed. Any subsequent risks are added to the risk register and those above a certain threshold are reported to the Risk Committee (sub-committee of the Board) for further assurance on management and mitigation.

	The Finance and Performance Committee receives a monthly report on financial performance, which includes performance against plan and the underlying position, and includes understanding of the drivers and the actions taking place to improve.
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Trust executives are regular attendees at ICB meetings to discuss a wide range of topics, including those focused on financial performance and the use of resources. The Trust is an active participant in a monthly meeting of Chief Financial Officers and Deputy Chief Financial Officers is established across the Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster. This forum enables shared learning and generates ideas for improved use of resources. The Trust Chief Financial Officer also meets with peers from the East Midlands Acute Provider network on a monthly basis.

Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____