MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 5th February 2026**
Time: **09:00 – 12:30**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** Register of Interest | Sherwood Forest Hospitals *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Staff Story – Leadership Development Offers** Gemma Gelsthorpe, Head of People Development, and Deborah Kearsley, Deputy Chief People Officer	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 4th December 2025** To be agreed as an accurate record	Agree	Enclosure 5
6.	09:25	**Action Tracker**	Update	Enclosure 6
7.	09:30	**Chair's Report**	Assurance	Enclosure 7
8.	09:35	**Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	09:45	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Perinatal Quality and Safety** Report of the Director of Midwifery • **Perinatal Safety Champions Update** Report of the Director of Midwifery	Assurance Assurance	Enclosure 9.1 Enclosure 9.2
10.	10:00	**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 (presented by the Associate Director of Nursing Workforce)	Assurance	Enclosure 10.1
	BREAK (10 mins)			

	Time	Item	Status	Paper
	Operational			
11.	10:30	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 11
	Governance			
12.	11:25	**Board Assurance Framework** Report of the Chief Executive	Approve	Enclosure 12
13.	11:30	**Well Led Action Plan Review** Report of the Director of Corporate Affairs	Assurance	Enclosure 13
14.	11:45	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • Audit and Assurance Committee Report of the Committee Chair (last meeting) • People Committee Report of the Committee Chair (last meeting) • Partnerships and Communities Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance Assurance Assurance Assurance	 Enclosure 14.1 Enclosure 14.2 Enclosure 14.3 Enclosure 14.4 Enclosure 14.5 Enclosure 14.6
15.	12:10	**NHS Oversight Framework (NOF) Summary – Quarter 2** Report of the Chief Executive	Assurance	Enclosure 15
16.	12:15	**Spotlight on – Maternity Triage Service**	Assurance	Presentation
17.	12:20	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
18.	12:25	**Any Other Business**		
19.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **2nd April 2026, Boardroom, King's Mill Hospital**		
20.		**Chair Declares the Meeting Closed**		
21.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

Board of Directors Information Library Documents

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

Enc 9	**Perinatal Safe Staffing Report**
Enc 9	**Nursing Monthly Safe Staffing**
Enc 9	**Regional Maternity Heatmap**
Enc 12	**Significant Risks Report**
Enc 14.1	**Finance Committee – previous minutes**
Enc 14.2	**Quality Committee – previous minutes**
Enc 14.3	**Audit and Assurance Committee – previous minutes**
Enc 14.4	**People Committee – previous minutes**
Enc 14.5	**Partnerships and Communities Committee – previous minutes**
Enc 14.6	**Charitable Funds Committee – previous minutes**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 4th December 2025, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Chair	GW
	Steve Banks	Vice Chair	SB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Lisa Maclean	Non-Executive Director	LM
	Richard Cotton	Non-Executive Director	RC
	Barbara Brady	Non-Executive Director	BB
	Jon Melbourne	Chief Executive	JM
	Richard Mills	Chief Financial Officer	RM
	Rob Simcox	Chief People Officer	RS
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Simon Roe	Chief Medical Officer	SR
	Phil Bolton	Chief Nurse	PB
In Attendance:	Chris Dann	Deputy Chief Operating Officer	CD
	Emma Crookes	Respiratory and Sleep Science Service Manager	EC
	James Thomas	Deputy Chief Medical Officer	JT
	Claire Hinchley	Director of Strategy and Partnerships	CH
	Paula Shore	Director of Midwifery	PS
	Helena Clements	Consultant	HC
	Mark Jackson	Director of Estates and Facilities	MJ
	Lauren Ward	Emergency Planning and Business Continuity Officer	LW
	Sue Bradshaw	Minutes	
	Jess Baxter	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Sreeda Krishnan	Nurse	
	Danielle Gavin	Liaison Group	
	Joseph Connolly	Nottinghamshire Live	
	Rich Brown	Head of Communications	
	Mark Bolton	Associate Director of Operational Performance	
	Chris Wilson	Operational Performance Manager	
	1 member of the public		
Apologies:	Manjeet Gill	Non-Executive Director	MG
	Jonathan Van Tam	Associate Non-Executive Director	JVT
	Simon Illingworth	Chief Operating Officer	SI

Item No.	Item	Action	Date
25/229	**WELCOME**		
1 min	The meeting being quorate, GW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. GW welcomed JM to his first Board of Directors meeting. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
25/230	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
25/231	**APOLOGIES FOR ABSENCE**		
1 min	Apologies for absence were received from Manjeet Gill, Non-Executive Director, Jonathan Van Tam, Associate Non-Executive Director, and Simon Illingworth, Chief Operating Officer. It was noted Chris Dann, Deputy Chief Operating Officer, was attending the meeting in place of Simon Illingworth.		
25/232	**PATIENT STORY – THE LAUNCH OF NEW SPIROMETRY TESTS AT MANSFIELD COMMUNITY HOSPITAL, AS PART OF THE COMMUNITY DIAGNOSTICS CENTRE PROJECT**		
12 mins	EC and JT joined the meeting. EC introduced the Patient Story, which highlighted the launch of new spirometry tests as part of the Community Diagnostics Centre (CDC) project. ARB commented the service is very patient focussed. NM noted 437 breathing tests have been delivered since February 2025 at Mansfield Community Hospital (MCH) and queried what this equates to in percentage terms across all sites. EC advised it is a small percentage, as the team is currently only operating at MCH for 1½ days per week due to space and staffing issues. However, once the CDC opens, the service will operate five days a week. NM queried if the CDC will take all patients from the acute site, or if there will still be a percentage who will attend the acute hospital. JT advised the CDC service would be in addition to, not a replacement for, the acute site. EC confirmed the intention is to reduce duplication, aiming for a 'one stop shop' model where patients receive all necessary investigations and see the consultant or specialist on the same day, leading to faster diagnostics and treatment. JM noted the move to the CDC is a big change for staff and patients and queried how colleagues are handling the change.		

	EC advised the team are very excited about the change and they already work cross-site. The team have proactively 'grown their own' trainees to meet future demand. No objections have been raised by the team regarding the move. EC and JT left the meeting.		
25/233	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 2nd October 2025, the Board of Directors APPROVED the minutes as a true and accurate record.		
25/234	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 25/202 and 25/206 were complete and could be removed from the action tracker.		
25/235	**CHAIR'S REPORT**		
6 mins	GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Chair's perspective, highlighting the work of the Trust's volunteers and charity, recent fundraising events, walkarounds in ED, opening of the Clinical Research Facility and the Celebrating Excellence Event. The Board of Directors were ASSURED by the report. **Council of Governors Highlight Report** GW presented the report, advising it was a positive meeting, with robust discussion on performance and patient experience feedback. The Board of Directors were ASSURED by the report.		
25/236	**CHIEF EXECUTIVE'S REPORT**		
5 mins	JM presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Chief Executive's perspective, highlighting three areas of focus for his first 100 days in post, the recent deaths of three colleagues, Clinical Research Facility, JAG accreditation for endoscopy service and CDC progress. The Board of Directors were ASSURED by the report.		
25/237	**MAKING TOMORROW BETTER – STRATEGY DELIVERY UPDATE**		
19 mins	CH joined the meeting. CH presented the report, advising the update is shaped by significant national and local changes, including the release of the NHS 10-Year Plan, a new medium-term planning framework and the expansion of the Integrated Care Board (ICB) into a cluster arrangement, which has impacted on some of the working arrangements.		

	These developments prompted a review of supporting strategies and delivery plans to ensure alignment with new targets and timeframes. Despite ongoing change, the Trust has delivered significant work across the organisation and CH highlighted several examples of progress made. The next steps will involve refining delivery timescales and engaging across the organisation to define priorities for the second half of the strategy, focusing on care closer to home, prevention and digital transformation. NM queried what the biggest challenge to delivery of the strategy is and what is required to overcome that challenge. CH advised the biggest challenge is a cultural one. The asks of the 10-Year Plan requires the Trust to think differently as an acute provider. There is a need for organisational development to support staff in considering prevention and partnership working, and to avoid duplication. The Trust is collectively resourced to meet this challenge, with support from other teams being brought on board. SB noted the ambition for the Trust to be rated as Outstanding by the Care Quality Commission (CQC) and queried how progress towards this can be measured. PB advised there is a peer review process in place, based on the CQC methodology, which provides an indication of performance in certain domains. This is reviewed by the Quality Committee. In addition, there are other audits and actions, but triangulating this information remains a challenge. The Trust is working on developing leading indicators and a balanced scorecard to improve measurement of progress towards outstanding status. NM felt there is a need to consider how to develop strategic opportunities into leading indicators to allow the Board of Directors to see the rate of improvement. GW felt the table of measures at the end of the report may need to include wider metrics. ARB queried if there was any further support required from the Board of Directors to help adapt to evolving plans and guidance. CH expressed appreciation for the Board of Directors' support and engagement in development sessions, which helps the team understand new directions. The focus should be on engagement to identify priorities for the next three years, after which further support or asks of the Board of Directors may be identified. JM noted the Trust has a very strong strategy, acknowledging the next challenge is to deliver the second half of the strategy and bring it to life for colleagues and the public. BB noted the resource supporting the health inequalities work is temporary and the Board of Directors need to be aware of this risk. In addition, consideration needs to be given to how the strategy, and its progress, is communicated more widely. The Board of Directors were ASSURED by the report. CH left the meeting.		

25/238	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
15 mins	PS joined the meeting. **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting visibility of the Safety Champions Team, listening forums, progress in relation to NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7, National CQC Maternity Survey, Home Births Service and the opening of the triage unit. BB queried how the learning from maternity, for example the work in relation to health inequalities, communication formats, etc. can be shared across other areas of the Trust. PS advised the learning can be shared through the Nursing, Midwifery and Allied Health Professionals (AHP) Committee. SB queried how Speaking Up 'feels' in the Maternity Team currently. PS advised she meets with the Freedom to Speak Up (FTSU) Guardian and there are forums within the division where staff can raise concerns, rather than go via the FTSU route. However, there are FTSU Champions within the division. The new perinatal leadership structure has joint forums for maternity and neonatal colleagues. Engagement has increased and concerns are being resolved at the appropriate level, rather than escalating unnecessarily. NM felt there is a need to consider how the approach to Speaking Up within Maternity can be shared across the organisation, noting issues are being resolved at the right level. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance Model*** PB presented the report, highlighting leadership recruitment into teams across the perinatal pathway, third and fourth degree tears and massive obstetric haemorrhage. It was noted there was one divert of service in October 2025. BB sought clarification if the standard for third and fourth degree tears is the national standard. PS confirmed the figure in the report reflected the new national standard, noting the Trust is slightly into the red. Unless a trigger is reached, standard reviews will continue through local governance arrangements. Work continues with the Pelvic Perinatal Health Service. The Board of Directors were ASSURED by the report. PS left the meeting.		

25/239	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
14 mins	HC and MJ joined the meeting. **Green Plan Refresh** RM introduced the updated Green Plan for 2025–2028, highlighting its alignment with NHS England (NHSE) guidance and the Trust's strategic objective for sustainability. The importance of partners was acknowledged, noting involvement in the Sustainable Development Strategy Group. MJ highlighted the Plan's ten focus areas, the creation of subgroups for delivery and the importance of collective ownership across the Trust. HC emphasised the need for everyone to contribute to sustainability, noting progress had sometimes been slow, but recent collective ownership was promising. The plan's integration with the wider ICB Green Plan was noted. LM reflected on a recent 15 Steps visit to the Path Lab and queried what steps are being taken to monitor levels of formaldehyde to ensure staff safety. SR advised levels are monitored on a weekly basis and the levels are low, reflecting the nature of the work carried out by the Trust, noting invasive post-mortems are no longer carried out by the organisation. NM requested a small set of key performance indicators (KPIs) be developed to enable the Finance Committee to track progress. MJ advised KPIs will be developed and monitored to keep everyone updated on progress. HC advised some things are easy to measure, for example electricity and gas usage, but clinical progress and cultural change are harder to quantify. The Board of Directors APPROVED the Green Plan for 2025-2028. HC and MJ left the meeting.		
25/240	**INTEGRATED PERFORMANCE REPORT (IPR)**		
57 mins	**QUALITY CARE** PB highlighted Clostridioides difficile (C.diff), increases in respiratory illness, flu vaccinations, hospital acquired pressure ulcers and still births. SR highlighted VTE (Venous Thromboembolism) GW noted the increase in C.diff and queried if it is known what is driving this increase. PB advised the pattern has been seen nationally, with a potential driver being linked to antibiotic usage. SR advised antimicrobial stewardship actions are under way, including recent policy changes to reduce broad-spectrum use and an emphasis on 24 to 48-hour clinical reviews to confirm diagnosis and de-escalate or stop antibiotics once investigation results are available. It was noted microbiology use digital lists to identify patients on prolonged courses and to conduct targeted ward reviews.		

	PB advised cleaning schedules have been changed, noting although there is no full decant ward, a modular deep-clean approach is in place. **PEOPLE AND CULTURE** RS highlighted staff turnover, appraisals, sickness absence, flu vaccinations, agency usage, mandatory training, medical job plans and Staff Survey. RC noted approximately half of the workforce have not yet had their flu vaccination and queried if the reason for this is known. RS advised anecdotal feedback references the adverse impact of the vaccine (i.e. feeling unwell for a short time afterwards and the unintended consequence of a short absence from work) and vaccine fatigue. RS described revised approaches to improve access to the vaccine, including roving teams at evenings and weekends. PB advised myth-busting communications have been issued, together with offering colleagues the opportunity to speak to a clinician or Occupational Health Lead to discuss any concerns. SB reflected on the persistent sickness absence level and suggested the People Committee continue to interrogate underlying drivers beyond process compliance, noting positive assurance from 360 Assurance but seeking further levers. RS advised there is a need to balance supportive policy language with attendance expectations, so teams are treated fairly and pressure is not unduly shifted onto colleagues. NM emphasised contractual attendance and the impact of absence on service quality. LM sought assurance in relation to the Trust's preparations for the forthcoming period of industrial action by resident doctors. SR confirmed planning meetings had commenced, with a focus on maintaining urgent and emergency care and recognising the added personal pressures for colleagues due to the proximity to Christmas. ARB noted the dip in performance related to appraisals and queried the reasons for this. RS referenced the pressure in Urgent and Emergency Care (UEC) and Women and Children's Divisions. Meaningful conversations are encouraged, even where paperwork lags. An improvement in the next quarter is anticipated. **TIMELY CARE** In terms of the emergency pathway, CD highlighted ambulance handover times, 12-hour waits, 4-hour waits, type 3 ED activity and performance, the number of patients medically fit for transfer, bed occupancy rate and the opening of a new transitional care unit to improve patient flow. In terms of elective care, CD highlighted Referral to Treatment (RTT), 52-week waits and diagnostics. In terms of the cancer pathway, CD highlighted a reduction in the backlog, noting 31-day performance requires further improvement.		

	JM sought assurance that elective activity will be protected over winter. CD advised the biggest risk is industrial action and staff sickness. Inpatient orthopaedic surgery will be prioritised at Newark Hospital, which is less affected by winter pressures. NM queried how many ED attendances could have been managed in primary care. NM noted ambulance crews prefer to convey to King's Mill Hospital due to faster turnaround times, but this impacts on the Trust's 4-hour wait metrics. CD advised data shows some areas served by the Trust have poor same-day GP access, leading to higher ED use. Patient surveys sometimes indicate GP referral, but records do not always confirm this. PC-24 is intended to help, but performance and activity levels vary. There is a need to refine pathways. **BEST VALUE CARE** RM outlined the Trust's financial position at the end of Month 7, highlighting deficit support funding, forecasts, efficiency target, income position, impact of industrial action, bank and agency spend, corporate optimisation, productivity and cash position. JM queried what is the biggest opportunity to improve the financial position by year-end. RM advised the main opportunity is in delivering elective activity and realising efficiency schemes, especially those identified through benchmarking. SB noted targets for agency and bank usage are likely to reduce further for 2026/2027. However, this is likely to be a diminishing return. Therefore, SB queried what other indicators should be an area of focus. RM acknowledged agency and bank limits will continue to decrease over the next three years and there will be diminishing returns in relation to efficiency savings from these measures. The focus will need to move to workforce productivity, efficiency and transformation. The Board of Directors CONSIDERED the report.		
25/241	**EMERGENCY PREPAREDNESS (EPRR) ANNUAL REPORT**		
5 mins	LW joined the meeting. LW presented the report, advising the Trust achieved a 'substantial' compliance rating, improving from 90% to 97% against the national core standards. Of the 62 standards, 60 were fully compliant, with detailed action plans in place for the remaining two. Training compliance was reported at 100% for strategic commanders and 96% for tactical commanders, the shortfall being due to one person on long-term sick leave. LW advised the Trust's Incident Response Plan has undergone a full review and is now digital. The Business Continuity Management System was also reviewed and provided significant assurance that the Trust could respond to incidents.		

	NM queried how emergency preparedness links to cyber risk and NHS cyber incidents. LW advised cyber is a risk on both the Trust and National Risk Registers. The Trust has run a business continuity tabletop exercise for cyber security. CD advised the Resilience and Assurance Committee meets on a monthly basis with IT colleagues to discuss emerging risks. The Board of Directors were ASSURED by the report. LW left the meeting.		
25/242	**PROVIDER BOARD CAPABILITY SELF-ASSESSMENT**		
3 mins	SBS presented the report, confirming the Provider Board Capability Self-Assessment had been submitted. The assessment rated four domains as 'confirmed' and two domains as 'partially confirmed'. Formal feedback from NHSE is awaited. RC queried the frequency of future self-assessments. SBS advised this will be an annual, with the next submission expected in April 2026. The Board of Directors were ASSURED by the report.		
25/243	**REVIEW OF PUBLIC BOARD WORKPLAN**		
7 mins	SBS presented the report, advising the annual Provider Board Capability Self-Assessment has been added to the workplan, together with an additional national requirement for reporting in relation to antimicrobial resistance (AMR). SB noted the level of assurance the Board of Directors receives in relation to maternity services and suggested consideration be given to how the same level of assurance could be provided for other services. PB advised there is a national requirement for reporting in relation to maternity services to be presented to the Board of Directors. The Quality Committee will consider other areas and escalate as necessary. GW noted there are no review reporting dates noted for the sub-strategies and this needs to be considered. **Action** • **Reporting dates for review of sub-strategies to be considered and added to the Board of Directors workplan as necessary.** The Board of Directors APPROVED the Public Board workplan for 2026.	**SBS**	**05/02/26**
25/244	**ASSURANCE FROM SUB COMMITTEES**		
17 mins	**Finance Committee** RC presented the report, highlighting approval of a hybrid procurement model, planning, financial recovery plan and decarbonisation projects.		

	The Board of Directors were ASSURED by the report. **Quality Committee** LM presented the report, highlighting two recent inquests, introduction of a Patient Story to Quality Committee, Value Circle Theatre Culture Review and review of Board Assurance Framework (BAF) Principal Risk 1 (PR1), significant deterioration in standards of safety and care, PR2, demand that overwhelms capacity, and PR5, inability to initiate and implement evidence-based Improvement and innovation. The Board of Directors were ASSURED by the report. **People Committee** SB presented the report, highlighting trajectory towards Whole Time Equivalent (WTE) target, 10-point plan to improve Resident Doctors lives, provision of hot food out of hours and NHSE Annual Board Report (Medical Workforce). The Board of Directors were ASSURED by the report. **Partnerships and Communities Committee** BB presented the report, highlighting an ongoing concern regarding Quality Impact Assessment (QIAs) undertaken by partners within the system where a direct or indirect impact on SFHT might occur. The Board of Directors were ASSURED by the report. **Charitable Funds Committee** ARB presented the report, highlighting review of Investment strategy, annual accounts for the charity, purchase of two transoesophageal echocardiography probes and the recent abseil event. ARB paid tribute to Ken Godber, Head of Charity Development and Corporate Partnerships, who died suddenly in November, expressing condolences to his family, friends and colleagues. The Board of Directors were ASSURED by the report.		
25/245 6 mins	**SPOTLIGHT ON – HEALTHY WELCOME: THE FRUIT AND VEG STALL AT KING'S MILL HOSPITAL** A short video was played highlighting the fruit and veg stall at King's Mill Hospital.		
25/246 2 mins	**COMMUNICATIONS TO WIDER ORGANISATION** The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Flu vaccination campaign • Impact of industrial action • Winter pressures		

	• Financial position • CDC developments • Green Plan • Strategy update		
25/247	**ANY OTHER BUSINESS**		
1 min	No other business was raised.		
25/248	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 5th February 2026 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:10.		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Chair** **Date**		

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

25/249	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	GW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
25/250	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

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

Outstanding Care,
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NHS
Sherwood Forest Hospitals
NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
25/133	05/06/2025	Consideration of a 'making data count' approach to the IPR to be a topic for a future Board of Directors workshop	Public Board of Directors	None	TBC	S Roe		**Update 02/10/2025** On list for a future Board Workshop. Date note yet allocated.	Grey
25/198	02/10/2025	Trust's response to the 10-point plan to improve the working lives of resident doctors to be included in the next Guardian of Safe Working report to Board	Public Board of Directors	None	02/04/2026	S Roe			Grey
25/200.1	02/10/2025	People Committee to consider how early triggers of the impact of staff reductions on quality and performance can be identified.	Public Board of Directors	People Committee	05/02/2026	R Simcox		**Update 14/10/2025** To be discussed at Januaury meeting of the People Committee. **Update 30/12/2025** Item added to agenda for People Committee meeting on 3rd February 2026. **Complete**	Green
25/200.2	02/10/2025	Consider how a report can be developed triangulating information from FTSU, exit interviews, Staff Survey, etc.	Public Board of Directors	People Committee	05/02/2026	R Simcox		**Update 14/10/2025** To be discussed at Januaury meeting of the People Committee. **Update 30/12/2025** Item added to agenda for People Committee meeting on 3rd February 2026. **Complete**	Green
25/243	04/12/2025	Reporting dates for review of sub-strategies to be considered and added to the Board of Directors workplan as necessary.	Public Board of Directors	None	05/02/2025	S Brook Shanahan		**Update 27/01/2026** Sub strategies are included on the planner to maintain visibility. Review dates will be added as and when necessary. **Complete**	Green

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:**	5th February 2026
Prepared By:	Rich Brown, Head of Communications and Graham Ward, Trust Chair		
Approved By:	Graham Ward, Trust Chair		
Presented By:	Graham Ward, Trust Chair		

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

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

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

Committees/groups where this item has been presented before

None

Acronyms

ATTFE = Academy Transformation Trust Further Education
DEXA = Dual-Energy X-ray Absorptiometry
KTC = King's Treatment Centre
MRI = Magnetic Resonance Imaging
NICU = Neonatal Intensive Care Unit
NHS = National Health Service
SFH = Sherwood Forest Hospitals

Executive Summary

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

Preparing for this year's Council of Governor elections

Preparations have begun to hold this year's Trust Council of Governor elections, which are due to take place before July 2026. The election will consider eight positions on the Trust's Council of Governors, as a number of serving governors reach the end of their three-year term.

I look forward to updating you with more detailed timelines of the election as they are confirmed over the coming months.

Recognising the difference made by our Trust Charity, volunteers and fundraising partners

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

In December and January alone, 375 Trust volunteers generously gave over 9,000 hours of their time to help make great patient care happen across the 28 services they have supported during the month.

Notable developments from our brilliant Community Involvement team and our team of volunteers during the month include:

Making Christmas in hospital a brighter experience for our patients

A large quantity of Christmas gifts, chocolates and toys were received for our children's and health care of the elderly wards over the Christmas period. We are extremely grateful to the many individuals, community groups, fundraisers and local businesses who have supported so generously.

Lee Ogden from Skanska is thanked for creating a Christmas garden at Newark Hospital

Many donors chose items from one of our five Amazon Wish Lists, which were setup to support generous donors to purchase useful items that can be used by the Paediatrics, Care of the Elderly, Maternity and NICU, Learning Disabilities and End of Life Care Teams.

Around 600 schoolchildren attended for our Schools Carols Programme to entertain and lift the spirits of patients, visitors and staff in the main entrances of our hospitals. A fantastic £1,285 was raised from collection buckets for the charity.

Our fundraising partners, the Friends of Newark Hospital and League of Friends (Mansfield & Sutton) once again provided funding to provide a gift for all inpatients to open on Christmas Day.
The Christmas food bank appeal was generously supported by Trust colleagues and volunteers. Local foodbanks, who collected from each of our Trust sites, expressed their gratitude for the volume and quality of the items donated.

Christmas raffles were also well-supported, with the King's Mill volunteer raffle raising £1,300 and the Friends of Newark Hospital raffle £3,530.

Grateful thanks to ATTFE College who brightened up outdoor space in the KTC courtyard with Christmas decorations. These were kindly put up by Selcon Construction Consultants as part of their community volunteering offer.

Meanwhile, Skanska engineer Lee Ogden (pictured above) has created a festive garden at Newark Hospital for 20 years with funding from the Friends of Newark Hospital. He was thanked by Newark Hospital staff and presented with a small gift as a show of their appreciation.

Celebrating the long service and dedication of our Trust volunteers

Over recent months, we have celebrated the long service and dedication of a number of our Trust volunteers, including:

- Dot Hallam, who has celebrated 20 years at Newark Hospital. She's had roles in various departments over the years, including the coffee shop, helpdesk and MRI.
- Jacqui Cox, who volunteered initially in Pre-operative Assessment and in recent years on Main Reception at Newark Hospital, received her 15-year award.
- Angela Laverack, who volunteers at Newark Hospital first as a Chaplaincy volunteer and more recently in Podiatry, was presented with her 10-year award.
- Royston Worstencroft, a volunteer at Millside Radio, is received his 15-year award from Peter Wilson-Neasom, Station Manager.
- King's Mill Hospital café volunteers Heather Marriott, Christine Sutton and Janice Malbon have received their five-year awards.
- Mary Hopewell, pictured with Chief Finance Officer Richard Mills and the Christmas elves, has celebrated 10 years in the Daffodil Café.
- Val Caunt volunteers in the pre-operative department, Val has been a volunteer for 20 years at King’s Mill Hospital.
- Dyfrig Rees currently volunteers in our Same Day Emergency Department. He has been a volunteer for 10 years.
- Jean Shorthouse has been a volunteer for the main reception at Newark Hospital. Jean was presented with her long-service award from Jo Thornley, Community Involvement Manager.
- Christine Keeton received her 15-year award from Radiology Clerical Officer Julie Dobbins. Christine supports the Newark Radiology Team with escorting patients to the mobile scanner and also volunteers on main reception.

Thank you to everyone for the contribution you make to patients, their families and colleagues across our hospitals. You really do make a difference day in and day out, and it is greatly appreciated

Two lucky supporters each win £1,000 in Sherwood Forest Hospitals Charity Lottery

The lottery, which was launched in July 2025, gives people the chance to support the charity on an ongoing basis for the small amount of £5 per month, whilst also being in with the chance to win weekly cash prizes of up to £25,000.

71-year-old Carol Livesly lives in Derbyshire but receives treatment at King's Mill Hospital. She joined the lottery in the summer and returned from a trip to London to find a letter telling her she'd won £1,000, which she says she will be putting towards a trip away for her husband's 70th birthday later this year.

Another lucky winner is Sharon from Kirkby-in-Ashfield. She signed up to the lottery after attending an appointment at the hospital with her dad, saying that she thought it was a nice way to give back to the hospital.

Since it launched in July 2025, the lottery has brought-in nearly £48,000 to the Charity.

Donating to the Sherwood Forest Hospitals Charity is a brilliant way to give something back and helps to fund equipment to provide an even better experience for our patients.

With the current financial situation at the NHS, making every penny count is more important than ever and the Trust charity is a huge part of this. Thank you to everyone who has taken the time to sign up to the lottery – your support really is appreciated.

Amazon Breast Cancer Support Group continues incredible support for Trust

The Amazon Breast Cancer Support Group marked 30 years of supporting breast cancer patients at King's Mill Hospital, raising approximately £250,000 for cancer services at King's Mill Hospital since they began.

The Paxman Cold Cap system is presented to Welcome Treatment Centre colleagues

In a special presentation at the hospital, the group celebrated their commitment to fund two significant projects.

- The Welcome Treatment Centre were gifted a Paxman cold cap system at a cost of £40,000. This is an innovative piece of equipment which is designed to help reduce hair loss during chemotherapy. The cap will help patients to preserve their sense of normalcy and control during treatment, improve their self-esteem, and reduce the need for wigs or head coverings.

- The group have also committed to provide £43,000 of funding for breast services at King's Mill Hospital to purchase a small metallic seed called Magseed, for use in tumour surgery. Magseed can be implanted and accurately placed in a tumour before a surgery takes place. It means less delays compared to the traditional hook and wire technique and will ease stress for patients on the day of surgery. It will also reduce the need for re-operation and enable more surgeries to take place due to the quicker operation time.

Other gratefully-received donations to the Trust

- The League of Friends (Mansfield & Sutton) have kindly funded a Sit Assist pro-positioning device which supports patients with mobility issues to access the DEXA scanner at Mansfield Community Hospital.

  The device allows a more dignified transfer for the patient and reduces the risk of staff developing manual handling injuries.

- The Sherwood Forest Hospitals Charity has provided funding for BlazePod to be purchased to support the Physiotherapy team.

  The charity utilised donations that were specifically made to the therapy fund in recognition of great care. BlazePods are portable, interactive training lights used to improve motor skills, coordination, balance and cognitive engagement and are increasingly being used in a clinical setting to support a variety of patients undergoing physical rehabilitation.

Other notable engagements

- My latest regular catch-up with the Trust's Lead Governor, Liz Barrett OBE DL, also acted as an introduction session for the Trust's new Chief Executive, Jon Melbourne. The meeting also gave us the opportunity to discuss all aspects of the Trust.

- We held the latest Committee in Common meeting with colleagues from Nottingham University Hospitals.

- I undertook a '15 Steps' visit to Ward 22.

- I attended the latest NHS Confederation Chairs' Group Meeting.

- I joined our monthly catch-up meetings with the Regional Director of NHS England (Midlands), Dale Bywater, which have now been extended to include all chief executives, as well as chairs.

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

- We have continued discussions on the partnering front, attending meetings with Newark & Sherwood District Council, Doncaster & Bassetlaw Hospitals, and Healthwatch.

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:**	5th February 2026
Prepared By:	Rich Brown, Head of Communications and Jon Melbourne, Chief Executive Officer		
Approved By:	Jon Melbourne, Chief Executive Officer		
Presented By:	Jon Melbourne, Chief Executive Officer		

Purpose

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

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	
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
CEO = Chief Executive Officer
DM01 = Diagnostic Waiting Times and Activity (NHS Diagnostic Test Standard)
ED = Emergency Department
EU = European Union
NHS = National Health Service
NOF = National Oversight Framework
PIFU = Patient Initiated Follow-Up
PTL = Patient Tracking List
RTT = Referral to Treatment
TBC = To Be Confirmed
UEC = Urgent and Emergency Care

Executive Summary

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

Chief Executive's update

This is my second public meeting of the Trust's Board of Directors since I joined Sherwood Forest Hospitals and I remain so grateful to our colleagues and partners for the warm welcome they have offered me.

I shared my priorities for my first 100 days in post in my first report to the Board in December, which were to:

- **Listen**
- **Deliver our plan for 2025/2026; and**
- **Plan for the future**

Since I joined Sherwood Forest Hospitals, it has been my pleasure to have visited many teams and speak to many colleagues and patients across the Trust to learn more about their work, to hear about their successes, to understand our challenges and opportunities – and discuss how we can improve together.

Beyond the walls of our hospitals, I have met partners across Nottingham and Nottinghamshire and the Midlands region to build-on our commitment to working in partnership.

Through this report and this month's meeting of the Trust's Board of Directors, you will see the progress we are making to deliver our plans for the current financial year, as well as the work we are doing to plan for the future.

As I wrote in December, the challenges facing the NHS are significant. We must own our challenges and opportunities, and approach them with view them with realism, drive and ambition.

A key part of this ambition is presented in the Trust's *Improving Lives* strategy. Approaching its midpoint is an important milestone in our planning for the future and we are taking this opportunity to refresh our strategic plan with input from colleagues and partners, recognising the fast-changing world we live in and the continued rollout of the Government's *10 Year Health Plan for England* that was announced last year.

Our strategy as a Trust – and the plan to deliver that strategy – must ensure that we address the challenges and opportunities we have today, as well as those in the future. We must also build upon what makes Sherwood Forest Hospitals special s– including our culture.

That review is ongoing, as we have begun reaching-out to our colleagues, our patients and our partners to reflect on the progress we have made to date – and understand what it will take to go further, together.

During my time in-post to date, I have seen so much achieved to manage the pressures we are facing right now, as well as the work that is ongoing to outline what it will take to improve and transform the care we provide our patients in future, including through digital developments, transformation, the hospital to community shift and more.

I look forward to sharing more of those achievements and ambitions with you over the coming months. Summarised below are other key updates from across the Trust:

Operational updates

Overview of operational performance

Winter has been exceptionally challenging time across the NHS and we have seen those pressures present in our hospitals. I would like to thank colleagues for their tireless work to care for patients and to look after one another. Colleagues should be proud of what they have done and are doing in challenging conditions.

I acknowledge there have been delays to care on our urgent and emergency pathways due to the increasing demand we have seen and I am sorry for anyone impacted by these delays.

Improvement in our urgent and emergency care access is a key priority for us and our improvement plans cross access to our services, flow through our hospitals and discharge home or to an onward place of care.

The challenges we have seen this winter saw us take the decision to declare a critical incident on Tuesday 13th January 2026 to help us to overcome those challenges in high Emergency Department demand and the challenges we experienced in discharging patients from our hospitals in a timely way. While those pressures remain, we were able to stand-down that incident three days later, on Friday 16th January 2026, thanks to the hard work of our Trust colleagues and partners.

We will hear more about our operational performance in the Integrated Performance Report later on today's agenda, but some headlines include:

- Despite those obvious challenges throughout winter, four-hour performance – whilst not where we want it to be - was at a higher level in December 2025 than the equivalent period in the last three years.

- Our 52-week wait backlog was at 0.96% of the total Patient Tracking List (PTL) in December 2025, below the 1% operational planning guidance target to be achieved by the end of 2025/26.

- Our PTL size also decreased in December, however 18-week Referral to Treatment (RTT) performance deteriorated to 59.3% during the month.

- We continue with strong performance providing Patient Initiated Follow Up (PIFU), delivering performance consistently better than the standard.

- Our diagnostic DM01 performance continues to improve, closing at 92% in December 2025. This is reflected in our benchmarking position which is consistently above the national average.

- Our cancer performance for the 28-day faster diagnosis standard and the 62-day treatment standard remains favourable to plan, with 62-day cancer performance levels especially strong in November 2025.

Thank you again to all Trust colleagues who have been working hard to provide the best and most timely care possible over recent months – and thank you to patients and our communities for your support.

Reflecting on the impact of recent industrial action

The pressures we have seen across our services have been compounded by the continuation of national industrial action, which has impacted us here at Sherwood as resident doctors chose to take industrial action as part of their ongoing dispute with the government over pay and conditions.

The latest industrial action took place between 7am on Wednesday 17th December 2025 to 6.59am on Monday 22nd December 2025.

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

We recognise the vital role our resident doctors play in delivering excellent patient care here at Sherwood, which is why their absence was so deeply felt.

Our Trust's industrial action management team met regularly throughout the industrial action to ensure swift escalation of issues and to highlight any patient safety concerns. Work has continued during the past two months to ensure that activity postponed due to industrial action could be rescheduled at the earliest opportunity.

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

Trust's National Oversight Framework (NOF) position updated

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

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

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

For us here at Sherwood, the league tables see us ranked 56th place in the country, placing us in the third of the four segments, recognising that any trust working in financial deficit cannot climb any higher than segment three.

Partnership updates

Medical Education Team joins University of Nottingham showcase event

In late November, the Trust's Medical Education Team joined colleagues at the University of Nottingham for an event to share good practice across NHS trusts in the region.

The Team heard good practice examples on undergraduate medical education developments and will be exploring how they can learn more to achieve continuous improvement in Sherwood Forest Hospitals.

As a Trust, we also shared good practice of our own, as the Trust's Undergraduate Manager, Sam Edwards, presented on the use of 'Eolas' as an app for students (and soon resident doctors in the Trust) to access information at any time, but particularly at the point of learning. Sam also talked about the team's continued commitment to move their work forward digitally.

Other Trust updates

Patient experience continues through popular 'Coffee and Connect' sessions

Our Trust 'Coffee and Connect' patient engagement sessions continue to be a popular addition to the Trust's patient experience efforts, with the next session due to have taken place on Tuesday 3rd February 2026. The session was due to focus on climate health and what we can do about it.

Coffee and Connect sessions take place on the first Tuesday of each month via Microsoft Teams, giving patients the chance to join the discussion on how to improve services at the Trust across a selection of different topics each month.

February's session was due to explore how a changing climate impacts our health and wellbeing and explore what we can do to make a difference, in discussion with special guest Helena Clements, the Trust's Clinical Lead for Climate Action.

Sherwood enters the top five of the country's most accessible NHS websites

In January 2026, the Trust was proud to learn that the public-facing website that it relaunched in May 2025 has now entered the top five of the most accessible NHS websites anywhere in the country.

To achieve this, the website has reached its highest-ever level of compliance with EU web accessibility standards that the Trust legally has to meet as an organisation.

The improvements made to the Trust's website over the past two years ensure that all our patients – including those with disabilities and impairments – can access and understand the information we provide to patients online.

This forms a vital part of our efforts to reduce health inequalities and improve health literacy within the communities we serve.

Trust risk ratings reviewed

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

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

The full and updated Board Assurance Framework (BAF) is now due to be presented to the Trust's Board of Directors every four months, with the full BAF next due to be presented later on February's meeting.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Perinatal Quality and Safety	**Date:**	5 February 2026
Prepared By:	Sarah Ayre, Head of Midwifery and Sarah Sarjant, Lead Midwife for Quality and Safety		
Approved By:	Philip Bolton, Executive Chief Nurse, Neil McDonald NED and Paula Shore Director of Midwifery/ DDN for W&C		
Presented By:	Paula Shore, Director of Midwifery / DDN for W&C		

Purpose

The purpose of this paper is to provide a bi **monthly, integrated update** on maternity and neonatal (perinatal) safety and assurance activity. It brings together **PMRT reporting, the Legal Scorecard, and all relevant perinatal assurance information into a single, aligned reporting format**, in line with national and regional recommendations.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	**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

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

Acronyms

- Perinatal Assurance Committee (PAC)
- Local Maternity and Neonatal System (LMNS)
- Neonatal Intensive Care Unit (NICU)
- Head of Midwifery (HoM)
- Saving Babies' Lives Version Three: A care bundle for reducing perinatal mortality (SBLCBV3)
- Transitional Care (TC)
- Maternity Outcomes Signal System (MOSS)
- Perinatal Mortality Review Tool (PMRT)
- Maternity and Neonatal Safety Improvement Programme (MNSI)
- Operational Delivery Network (ODN)
- Obstetric Anal Sphincter Injury (OASI)
- Statistical Process Control (SPC)
- Baby Born before Arrival (BBA)

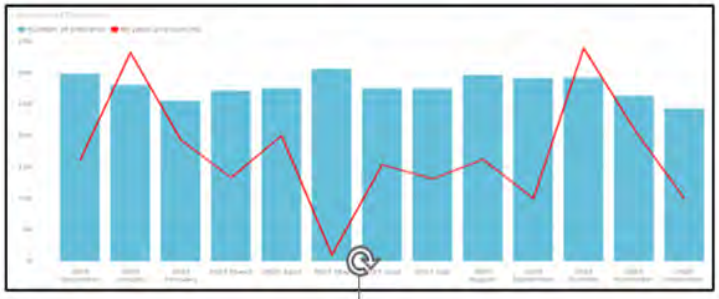
Executive Summary

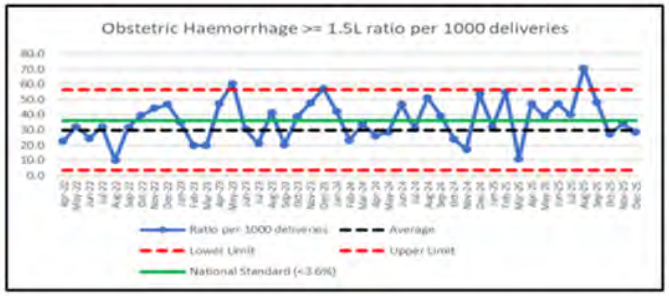
This bi-monthly Perinatal Quality Oversight (PQOM) report provides an integrated view of maternity and neonatal safety, quality, and assurance across the Trust, in line with the NHSE Perinatal Quality Oversight Model (August 2025).

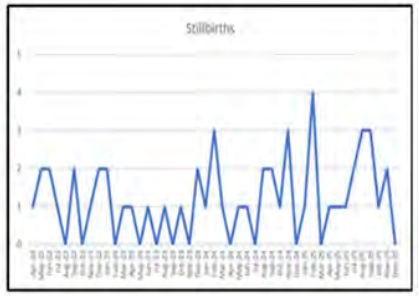
It brings together perinatal mortality intelligence, patient safety investigations, claims and legal insight, training assurance, national safety programme compliance and key performance metrics within a single, aligned framework. The report is designed to strengthen ward-to-board visibility, enabling early identification of emerging risks, clear triangulation of safety signals, and timely escalation where required. Overall, this report provides assurance that perinatal risks are being actively monitored, learning is systematically translated into improvement, and clear mitigation actions are in place.

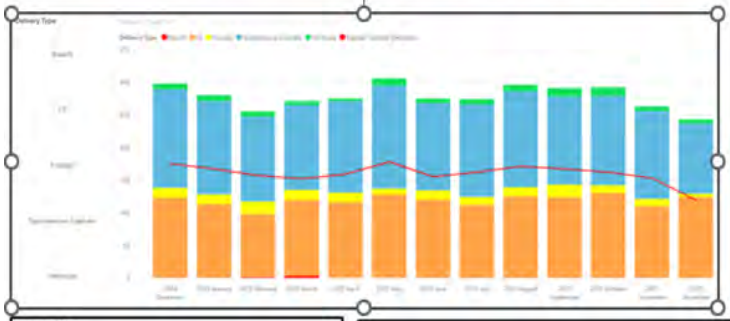
Areas of exception, emerging concern and required escalation are explicitly highlighted to support effective Quality Committee discussion and onward Trust Board assurance, reinforcing the Trust's commitment to safe, high-quality, and equitable maternity and neonatal care.

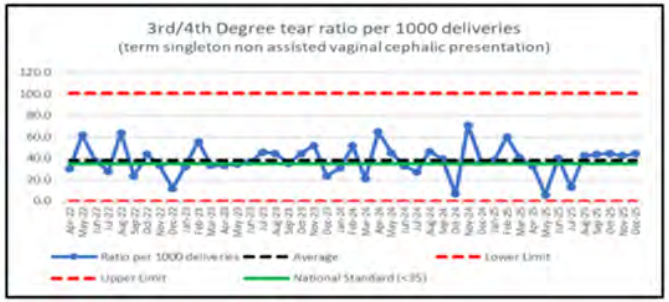
PERINATAL QUALITY SURVELLIANCE DATA – SPC

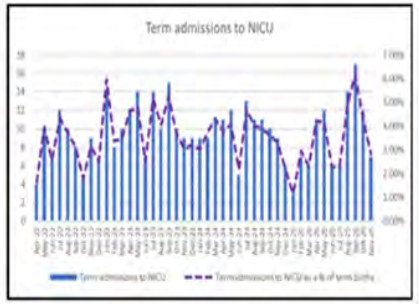


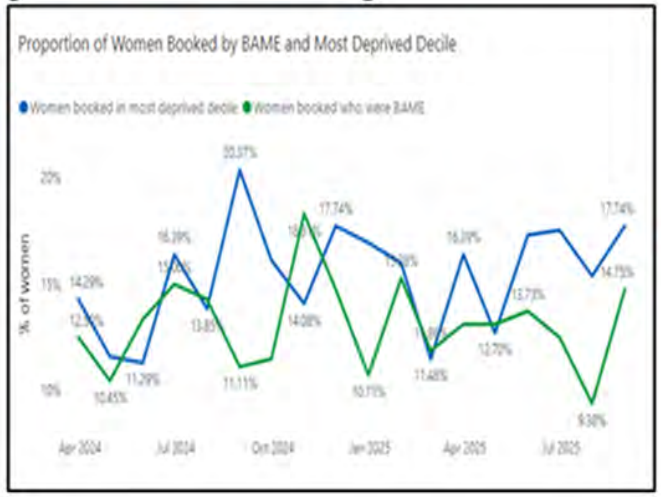


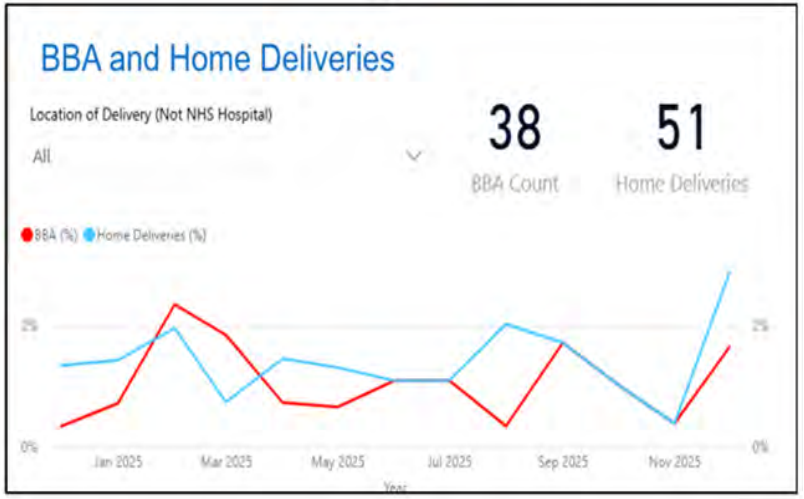












Report Overview

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE Perinatal Quality Oversight Model (August 2025). The purpose of the report is to inform the ICB Board and Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team.

1.0 SPC Data Overview

This Perinatal Quality Oversight (PQOM) report uses Statistical Process Control (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.
Across all SPC measures, performance demonstrates predominantly common cause variation with no evidence of sustained deterioration or unrecognised harm. The SPC methodology provides assurance that the service remains stable while enabling early identification of emerging risks should statistically significant change occur.

1.1 Delivery Numbers And Mode Of Birth

Overall birth activity remains stable month to month, with predictable seasonal variation. The proportion of women aged over 40 fluctuates but shows no sustained upward trend, remaining within expected limits and not demonstrating special cause variation. The distribution of birth modes (spontaneous vaginal, assisted vaginal and caesarean section) remains stable over time. Minor fluctuations are observed but there is no SPC evidence of a structural shift in clinical practice or outcomes.

1.2 Obstetric Haemorrhage

The SPC chart shows variation around the mean with occasional spikes; however, there is no sustained breach of upper control limits or evidence of a shift in the process. This indicates common cause variation rather than deterioration, with rates broadly aligned to historical performance.

1.3 Still Births

Monthly stillbirth numbers remain low and sporadic, with no evidence of clustering or sustained increase. SPC demonstrates random variation consistent with expected patterns for low-frequency events, providing assurance of stability.

1.4 BBA and Homebirths

BBA rates remain low overall, with occasional month-to-month variation. SPC does not indicate a sustained increase, suggesting no systemic access or pathway failure, though continued surveillance is warranted.

1.5 Health Inequalities

The proportion of women from the most deprived decile and those identifying as BAME fluctuates across months but without sustained trend or shift. Variation reflects population flow rather than inequity signal, supporting ongoing monitoring rather than escalation.

1.6 3rd and 4th Degree Tear

Rates fluctuate around the centre line and remain within control limits, with no sustained upward trend or special cause signal. Performance remains broadly consistent with national expectations, providing assurance of stable perineal outcomes.

2.0 Perinatal Mortality Rate

2.1 Perinatal Mortality Summary

Cases of Stillbirths and Late fetal loses			
Ref No.	**Incident Category**	**Outcome**	**Immediate actions**
November 2025			
101117	IUFD	Referred by CMW 24+4 weeks when unable to auscultate FHR at scheduled CMW appointment. No FHR detected on admission to triage, confirmed by consultant on-call and FM Consultant. Known under fetal medicine, paediatric alert for ventriculomegaly.	No immediate actions identified at present No immediate actions identified at present
101382	IUFD	Attended an ANC appointment at 36+4 weeks and no FH could be found on auscultation. Attended SBU where an IUFD was confirmed.	No immediate actions identified at present No immediate actions identified at present
December 2025			
No reportable cases			

Cases of Neonatal and Postnatal death			
Ref No.	**Incident Category**	**Outcome**	**Immediate actions**
November 2025			
No reportable cases			
December 2025			
No reportable cases			

2.2 Learning from PMRT reviews

Issue		**Action**	**By Who**	**By When**
2025-26 – completed actions				
Q1	Learning regarding waiting for sonographer to attend when Registrar and consultant present.	Learning in Maternity Services (LIMS) to be arranged and distributed	Specialist Midwife – Bereavement	July 2025
Q2	Learning regarding referral for consultant led care due to eating disorder.	Learning in Maternity Services (LIMS) to be arranged and distributed	Specialist Midwife – Clinical Governance	December 2025

Q2	Sonographer attended to confirm IUFD as opposed to consultant which resulted in delay in confirmation.	Learning in Maternity Services (LIMS) to be arranged and distributed and Doctor training.	Specialist Midwife – Clinical Governance	December 2025
Q2	Missed opportunity to repeat bloods when prescribed antibiotics	Learning in Maternity Services (LIMS) to be arranged and distributed	Specialist Midwife – Clinical Governance	December 2025
Q2	Learning to be shared regarding awareness of patients attending the birthing unit so as not to add to distress of explaining reason for attendance.	Learning to be added to the Team of the shift (TOTS) so that all staff are aware of any patients attendance.	Specialist Midwife – Clinical Governance	December 2025
Q3	No actions identified at present			

3.0 The Maternity and Newborn Safety Investigation Programme (MNSI) and Maternity Patient Safety Incident Investigations (PSIIs)

3.1 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
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	Not Received to date	
31/08/2025	MI-046096	05/09/2025	ENS-25-001	Not accepted	05/09/2025	Not received to date	
30/09/2025	MI-047287	02/10/2025	N/A	N/A	02/10/2025	21/01/2026	

3.2 Learning from MNSI reviews

Theme	Actions	Responsible role	By when
Fetal monitoring	Review of guidance and fetal monitoring tool.	Fetal monitoring lead	Dec 2025
MDT Handover	Review of local guidance	Service Director Maternity and Gynaecology and Director of Midwifery & Divisional Director of Nursing for W&C	Nov 2025
Neurological assessment	Ensure that the local neurological assessment (SARNAT) form is available and completed	Advanced Neonatal Nurse Practitioner	Sep 2025
CFM training	Cerebral function monitoring(CFM) training for senior nurses and the medical team	Neonatal Practice Development Matron and Advanced Neonatal Nurse Practitioner	Oct 2025
Escalation	Review and update the observation and escalation policy for neonates	Neonatal Practice Development Matron	Oct 2025
Escalation	Review of guidance and roles and responsibilities of on call consultant	Neonatal and Paediatric Governance Lead Nurse	Nov 2025
Guidance variation	Review of guidance on use of Aspirin in pregnancy	Governance team	Dec 2025
Induction of labour pathway	Review of Induction of labour pathway	Planned care Lead Midwife	Jan 2026
Process of reviewing and actioning results	Review of investigation results process	Antenatal Lead Midwife	Dec 2025
Communication	Ensure communication process is clear when changes to infrastructure	Senior leadership team	Dec 2025
Triage	Review of telephone triage process for early labour advice	Matron for Maternity Triage	Feb 2026
Triage	Review of telephone triage process for altered fetal movement advice	Matron for Maternity Triage	Feb 2026

3.3 Maternity Patient Safety Incident Investigation (PSII)

Ref No.	Incident category	Summary/ Update
DW222256	HIE	Investigation underway, external input requested from GP services and EMAS to support completion.

3.4 Incident tracker for ongoing investigations

	STEIS	PSII	MNSI	Thematic review	Local response	Rapid review	AAR	SHOT	TOTAL
Maternity	7	1	6	0	2	9	1	1	27

MNSI
3 final reports received from MNSI.
3 ongoing MNSI investigations

PSII
Awaiting service to service feedback to support completion of the report. Family updated on progress of the report
Local response
DW218288 - Awaiting Anaesthetist review
DW234233 - Await updated RR paper. Moderate harm, DoC performed

SHOT report
Delay in Anti D. SHOT report complete, for presentation at next rapid review meeting.

AAR
IUFD MNSI case rejected due to no family consent. AAR planned for Jan 2026.
Further support required in regard to detail needed for assurance within this meeting.

4.0 Coroners' report

4.1 Outstanding reports due

	Date Listed	Summary
Nothing to report		

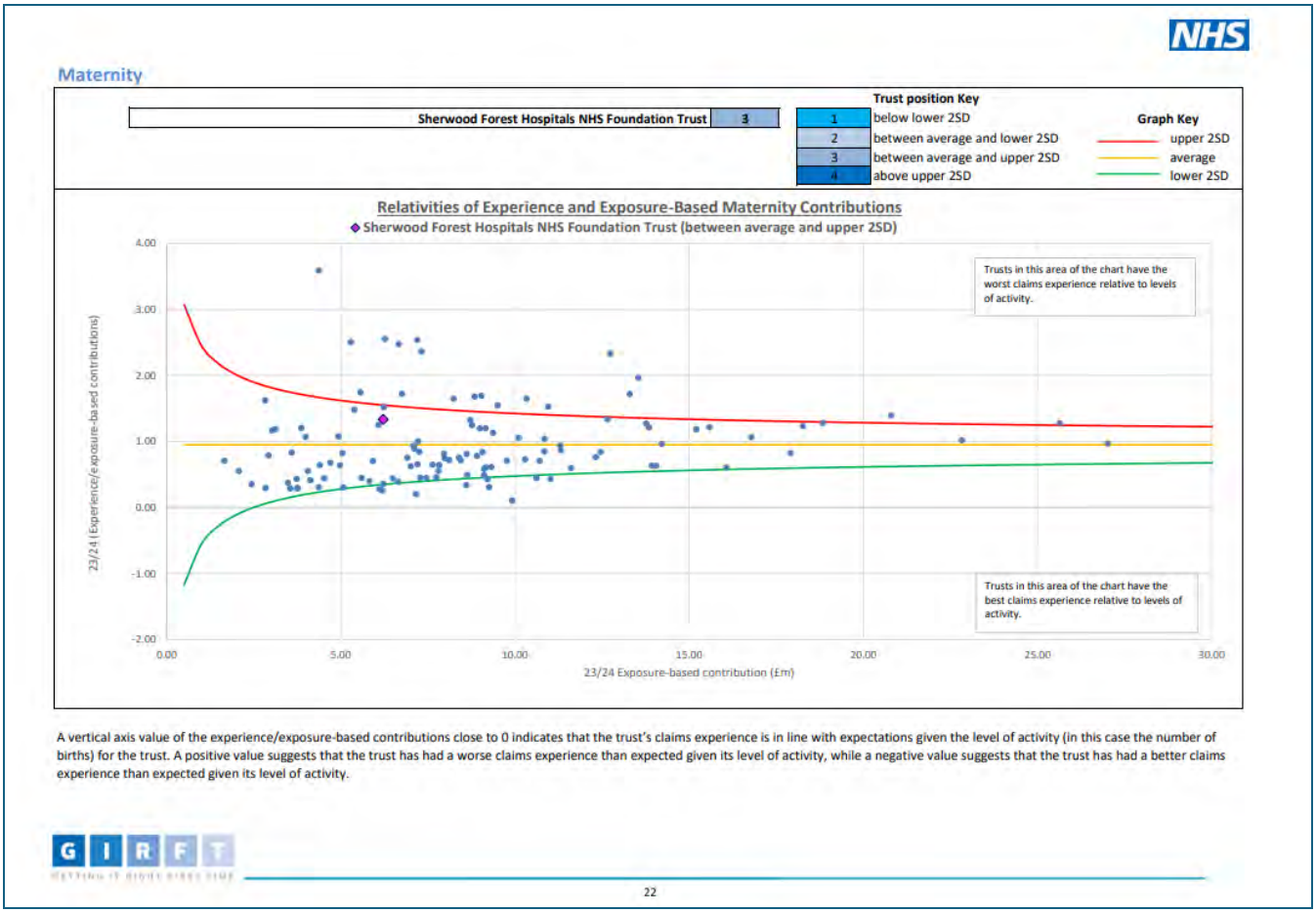
4.2 Regulation 28 report issued

Identifier	Action required	Progress	Responsible role	By when
Nothing to report				

5.0 Review of NHS Resolution Scorecard

Themes identified from Claims Scorecard (CNST claims received with an incident date between 01/04/2015 and 31/03/2025)
Failure to monitor second stage of labour Failure to monitor first stage of labour Failure to respond to an abnormal fetal hear rate Failure to monitor the dose/ rate of syntocinon

Please see below the GIRFT 2025 Maternity funnel plot which compares claims experiences of Trusts within England and Wales, which is represented over 5 years. SFH is represented within the chart by the purple diamond and shows within the expected area on the funnel plot.



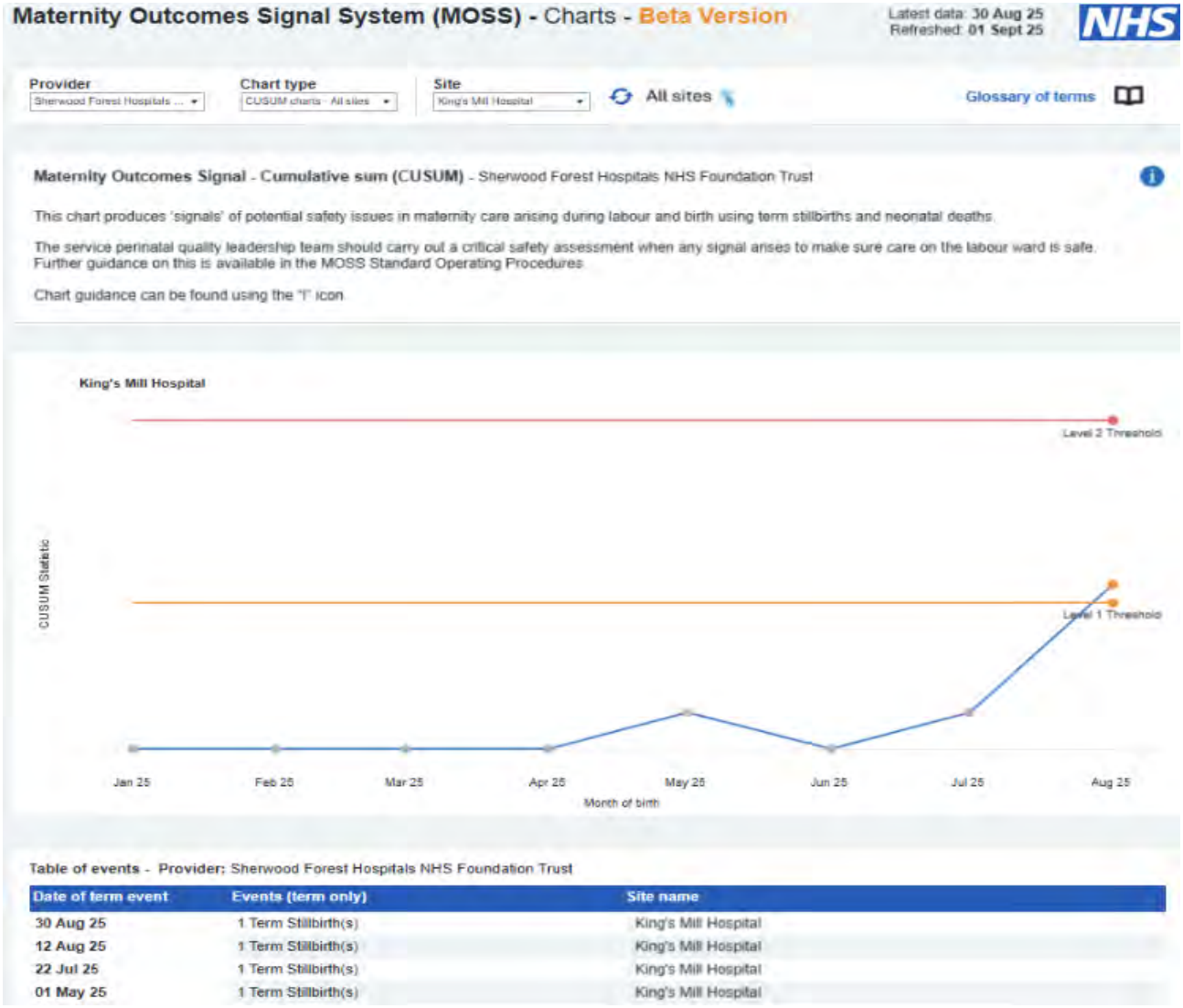
6.0 Maternity Outcomes Safety Signals System (MOSS)

The Maternity Outcomes Signal System (MOSS) was developed by NHS England in response to the East Kent Reading the signals report. MOSS operates at trust site level. It is a near-real time safety signal system that supports early detection and rapid responses to potential safety issues in Intrapartum care service delivery. MOSS operates within the perinatal quality oversight model (PQOM), ensuring consistent monitoring, support, and escalation across trusts, ICBs, regions, and nationally.

MOSS presents trend data on term stillbirths and neonatal deaths in maternity units in a new way. Signals of potential safety issues are flagged in units when there has been a recent doubling in the rate of these events compared to what would normally be expected, given the total numbers of births at a given site.

MOSS signal received by Trust 2025/2026		
Q2	Signal received; data reviewed with national MOSS team.	Follow up safety check completed by DoM and Q&S Lead Midwife. Plan for external review of cases – completed.

NB.There have been no Intrapartum stillbirths in November or December.



7.0 Performance Metrics

7.1 Service Diverts

Detailed report to PAC 6 monthly: Jan 2026 and July 2026.
See PAC agenda 23.01.26 for detailed report.

Themes from January 2026 analysis: 21 diverts from April – November 2025, no harm identified, and all service users were written to by DHoM to apologise and follow up.

7.2 Delays to induction >24hrs

	Nov 2025	Dec 2025
Delays to induction >24hrs	0.00%	4.92%
Reasons	Unexpected sickness/absence of midwife. Unable to fill vacant shifts.	
Mitigations	Staff redeployed from other areas. Specialist midwives supporting.	

8.0 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Anaesthetists	Neonatal medics (split by consultant/ other Dr)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle	97%	93%	93%			
Fetal monitoring and surveillance	97%	94%				
Maternity Emergencies and multi professional training	99%	100%	98%	95%		
Equality/ equity and personalised care (3-Year programme)	97%	93%	93%			
Care during labour and immediate post-natal period (3 Year programme)	99%	100%	98%	95%		
Neonatal Life Support training	93.33%				94%	97%
Mandatory & Stat training	75%	40%	83%	Figures unavailable at time of report	Figures unavailable at time of report	62%
Qualified in specialty						70%

9.0 Saving Babies' Lives V3.2

	Compliance/ progress/ action	Responsible role	Compliance required	Current compliance
Element 1	REF 1.3 Smoking status at 36/40 REF 1.4 Opt out referral into an inhouse tobacco dependence treatment service REF 1.6 Percentage of smokers who are referred into an inhouse tobacco dependence treatment service who set a quit date	LF	80% 90% 40%	64% 85% 25%
Element 2	REF 2.7 Women who are designated as high risk for FGR should undergo a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation	NA/SS	80%	60.5%
Element 3	Fully compliant	YJ	100%	100%
Element 4	Fully compliant	NP	100%	100%
Element 5	Fully compliant	BL	100%	100%
Element 6	Fully compliant	RW	100%	100%

Element 1 overall compliance – 70%
Element 2 overall compliance – 95%
Overall compliance across all elements – 94%

10.0 NHS Resolution Maternity Incentive Scheme update

Safety Action No.	Brief description	Responsible	Presented to PAC
1	PMRT	Sarah Sarjant	14.01.26
2	MSDS	Lisa Butler	21.11.25
3	Transitional Care	Rachael Giles	19.12.25
4	Clinical Workforce	Samantha Barlow	21.11.25
5	Midwifery Workforce	Lisa Butler	19.12.25
6	Saving Babies Lives	Sarah Sarjant	14.01.26
7	Listening to service users	Sarah Ayre	19.12.25
8	Training	Lisa Butler	19.12.25
9	Board Assurance	Sarah Ayre	19.12.25
10	MNSI	Sarah Sarjant	14.01.26

11.0 Transitional Care (MIS YR 7, SA3)

Compliant: Detailed paper on PAC agenda 23.01.26 includes highlight report on current work underway within Transitional Care and NICU following the December 2025 merge to a perinatal service model.

12.0 Risk Register Highlights

Risk 1683 - Staffing levels - medical – Maternity.

Risk increased from a score of 6 to 15. Discussed and escalated through perinatal governance and SA to action through SMT.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet and report

Subject:	Perinatal Safety Champions Update	**Date:**	5 February 2026
Prepared By:	Sarah Ayre, Head of Midwifery		
Approved By:	Philip Bolton, Executive Chief Nurse, Neil McDonald Non Executive Director and Paula Shore, Director of Midwifery/Divisional Director of Nursing.		
Presented By:	Paula Shore, Head of Midwifery		

Purpose

The purpose of this paper is to provide clear bi-monthly assurance to the Perinatal Assurance Committee on the safety, quality and delivery of maternity and neonatal services, in line with the Perinatal Quality Oversight Model (PQOM).	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	**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

SLT
PQSG

Acronyms

- Perinatal Assurance Committee (PAC)
- Perinatal Quality Oversight Model (PQOM)
- Maternity and Neonatal Safety Champions (MNSC)
- Perinatal Service Oversight Group (PSOG)
- Maternity Care Bundle (MCB)
- Neonatal Transisitional Care (NTC)
- Perinatal Quality Surveillance Group (PQSG)
- Multi-disciplinary team (MDT)
- Integrated Care Board (ICB)
- Local Maternity and Neonatal System (LMNS)
- General Medical Council (GMC)
- Provider Workforce Returns (PWR)
- Maternity and Neonatal Voices Partnership (MNVP)

Executive Summary

This bi-monthly report provides a **structured and triangulated overview of perinatal intelligence**, drawing together:

- Delivery progress against the **Three-Year Delivery Plan**
- Frontline insight from **Maternity and Neonatal Safety Champions**
- Staff and service-user feedback through the **Perinatal Services Forum**
- Assurance on implementation of the **Maternity Care Bundle**
- Perinatal Services QUAD Culture Project

The report presents a **coherent ward-to-board narrative**, linking frontline experience and system intelligence to key safety, quality, workforce and operational risks, alongside agreed mitigations and improvement actions. It highlights **key themes, areas of progress and emerging concerns**, assuring that learning is embedded and actions are tracked through routine governance, including **PQSG, PSOG and PAC**, in line with PQOM expectations. Overall, the report demonstrates a **robust, transparent, and improvement-focused approach to perinatal oversight, supporting timely escalation, informed decision-making, and the sustained delivery of safe, high-quality care for women, birthing individuals and their babies** and families.

1.0 Three-Year Delivery Plan

The Three-Year Delivery Plan for Maternity and Neonatal Services sets out NHS England's national framework for making care safer, more personalised and more equitable for women, babies and families over a defined three-year period. It brings together learning from national reviews, service-user feedback and workforce intelligence into a single, coherent plan with clear responsibilities for trusts, integrated care systems and national oversight.

The plan is structured around four core themes:

1. listening to and working with women and families with compassion;
2. growing, retaining and supporting the workforce;
3. developing and sustaining a culture of safety, learning and support; and
4. strengthening the standards, data and digital structures that underpin safe care.

Delivery is monitored through defined success measures and aligned to system oversight arrangements, providing a clear framework for local implementation, assurance and continuous improvement across maternity and neonatal services.

1.1 PQSG Update

A paper was shared at the last PQSG meeting offering assurance regarding the delivery of **Themes 2 and 3 of the Three-Year Delivery Plan**, responding directly to ICB and system queries regarding workforce capability, experience, supervision, retention and midwifery turnover. It demonstrates that workforce risks are well understood and actively managed through triangulated intelligence from LMNS dashboards, PWR submissions, staff survey feedback, GMC National Training Survey data and local governance forums.

While headline midwifery turnover remains above the national benchmark, the paper provides clear contextual explanation, confirming this largely reflects planned and temporary workforce movement (including maternity leave and long-term sickness absence), alongside a Trust-approved over-recruitment strategy to maintain safe staffing. Issues identified through trainee and staff feedback have been addressed through strengthened supervision, education and escalation arrangements, with evidence of improved experience.

Overall, the paper provides assurance of a clear grip, improving trajectory and robust governance through routine oversight via PQSG, with escalation to PAC as required, in line with PQOM expectations.

2.0 Safety Champions

Role/Name
Board Safety champion – Executive. Phil Bolton, Chief Nurse
Board Safety Champion - Non-Executive. Neil McDonald
Perinatal Obstetric Lead. Mrs Sharon Tao, Obsteric Lead
Perinatal Midwifery Lead.Paula Shore, Director of Midwifery/Divisional Director of Nursing
Perinatal Neonatal Lead. Aison Davies/Jess Cox, Neonatologists
Perinatal Management team. Steve Jenkins, Divisional General Manager
MNVP leads. Amanda Doughty/Clare Harris

2.1 Meeting log

(*new reporting format to commence from Jan 2026 per March's paper*)

2.2 Safety champion feedback:

Feedback raised by staff	**Action and progress**
Feedback raised by service users	**Action and progress**
Additional safety champions intelligence	**Action and progress**

3.0 Perinatal Services Forum Updates

3.1 13th November 2025 forum

Chaired by Chief Nurse Phil Bolton.

Matters arising	**Current Position / Key Highlights**	**Key Action / Next Steps**
Engagement & Wellbeing	•Staff survey participation is currently lower than in previous years; targeted divisional engagement activity underway.	Increase staff survey engagement through intranet FAQs, local leadership visibility and team-level encouragement.

Matters arising	Current Position / Key Highlights	Key Action / Next Steps
	• Flu vaccination uptake continues to increase, supported by a strong peer-vaccinator model, providing resilience ahead of winter pressures. • RSV vaccination ongoing for pregnant women and eligible neonates; neonatal inpatient offer under active review.	
Workforce & Education Pipeline	• Low vacancy rates across maternity and community services with successful integration of newly qualified and community midwives. • Services maintain cover across all four maternity sectors despite sickness and maternity leave pressures. • Positive student placement feedback; further work planned to increase survey participation. • Anticipated long-term workforce pipeline impact due to changes in local university programmes.	Strengthen forward workforce planning and optimise the use of development funding and graduate scheme opportunities.
Service Quality & Improvement	• Appointment of a Consultant Midwife and Ward Sister, strengthening clinical leadership and operational resilience. • External funding secured to support Family Integrated Care, including educator and expanded link nurse capacity. • Digital discharge transition underway, with early challenges managed through strong team engagement. • Standardised home birth kits introduced, improving safety, sustainability and cost effectiveness.	Embed digital discharge processes and monitor benefits realisation through governance and audit.
Home Birth Safety & Assurance	• Proactive benchmarking against national PFD recommendations following recent national case review. • Standardised equipment, enhanced training, joint emergency prompts and clear safety thresholds in place. • Formal assurance paper in development for governance review.	Complete benchmarking and assurance paper and progress equipment enhancements (e.g. home birth blood gas capability).
Transitional Care & Integration	• Flexible transitional care bed model embedded within the maternity ward. • Improved integration with neonatal services and enhanced family support. • Staff feedback actively informing next phase of service development.	Continue evaluation and co-design with staff and families to optimise the TC model.
Winter Pressures & IPC	• Anticipated increase in paediatric acuity and respiratory illness following half-term. • Ongoing IPC vigilance required, particularly in high-flow emergency areas.	Maintain escalation readiness and strengthened IPC oversight through the winter peak period.

3.2 12th December 2025 forum

Apologies were noted for the 12th December 2025 forum, namely from Chief Nurse PB and Director of Midwifery PS.

The meeting was attended by colleagues from the ICB/LMNS, who were present as part of their scheduled insight visit. Their attendance provided valuable system-level visibility and constructive engagement, supporting shared understanding of local priorities, assurance arrangements and ongoing improvement activity across maternity and neonatal services. Formal feedback from the Insight Visit, anticipated from Sarah Pemberton by the end of January 2026, verbal feedback on the day was encouraging and supportive, especially of the relocation of Triage and the ongoing work to improve NTC.

Minimal attendance from MDT was noted, but current operational pressures and ongoing staffing challenges were noted.

4.0 Maternity Care Bundle (MCB)

The Maternity Care Bundle (MCB) sets clear expectations for greater standardisation of practice, strengthened cross-speciality integration, enhanced monitoring of outcomes and inequalities, and more explicit Board-level assurance. Sherwood Forest Hospitals NHS Foundation Trust is well-positioned to deliver the MCB within national timescales, supported by clear leadership ownership, established governance arrangements and a credible, phased plan to further strengthen assurance and improve outcomes over the next two years.

A separate, detailed MCB assurance paper is presented to the Perinatal Assurance Committee (PAC) in January 2026, providing comprehensive oversight of the Trust's current position. Ongoing delivery, progress and assurance against the MCB will thereafter be monitored and reported through this bi-monthly report.

5.0 Perinatal Services QUAD Culture Project

The Perinatal Services QUAD Culture Project reflects the completion of a reconfigured perinatal leadership portfolio, designed to strengthen clear, end-to-end leadership oversight across the pathway experienced by women, babies and families. This has aligned accountability, acuity management and escalation arrangements across maternity, neonatal, NICU and Transitional Care, improving operational grip, decision-making and staff experience at times of pressure.

The model supports safer, more responsive care and is fully aligned with national expectations for integrated perinatal leadership, safety culture and workforce wellbeing.

As part of this programme, the QUAD will now focus on targeted multidisciplinary culture improvement support for NICU and Transitional Care teams, embedding compassionate leadership, psychological safety and inclusive working practices.

Progress, impact and learning from this work will be reported through this paper as a highlight report over the next 12 months, providing assurance on trajectory, emerging benefits and sustained cultural improvement across perinatal services.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Trust Board

Subject:	Nursing, Midwifery and Inpatient Allied Health Professional Annual Establishments Review 2026 - 2027 Report	**Date:**	February 2026
Prepared By:	Rebecca Herring Associate Director of Nursing (Workforce)		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Rebecca Herring, Associate Director of Nursing (Workforce)		

Purpose

The purpose of this paper is to provide the Trust Board with the outcome of the annual staffing reviews which utilised evidence-based workforce planning and triangulated with professional judgement. The report will provide assurance on the approved recommendations put forward for the nursing, midwifery, and inpatient allied health professional (AHP) establishments for the 2026-2027 financial year.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

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

Committees/groups where this item has been presented before

Trust Management Team, January 2026
Nursing, Midwifery and Allied Health Committee, January 2026
People Committee, February 2026

Acronyms

Executive Summary

1.0 <u>Introduction</u>

A multidisciplinary review of the establishments commenced throughout November & December 2025 and were led by the Deputy Chief Nurse, Associate Director of Nursing (Workforce), the Deputy Chief Financial Officer, Divisional Directors of Nursing, Divisional Matrons and Divisional Finance Managers.

Each review was aligned to the components below:

- Application of professional judgement,
- Consideration of skill mix and environmental factors,
- SNCT and Birthrate Plus modelling,

- Speciality and Royal College guidance,
- Benchmarking data from Model hospital (Peer ward level CHPPD and national mean CHPPD),
- A 12-month overview of nurse sensitive indicators for each area,
- Potential future service demand,
- Health Roster template confirm and challenge,
- Confirm and challenge of financial impacts upon budgets.

1.2 Outcome

The nursing, midwifery and AHP establishment recommendation is for an increase of **10.66** WTE to the collective workforce, with a total financial impact **of £516,144.24.** This was presented to and approved by the Trust Management Team in January followed by an assurance update to the People Committee in February.

The Trust Board is asked to endorse the recommendations approved by the Trust Management Team and presented to the People Committee.

The recommendation from the Chief Nurse and the Chief Medical Officer that there is good compliance with the Developing Workforce Safeguards, and they are satisfied that staffing is safe, effective, and sustainable.

Figure 1: Establishments Recommendations

Division	WTE Requested	NET WTE required after divisional efficiencies	Financial Investment Requested
Medicine	0.16	0.16	£0
Urgent and Emergency care	9.55	3.86	£152,200
Surgery	2.74	1.13	£ 0
Clinical Therapies, Services and Outpatients	0	0	£0
Women and Children	13.11	5.51	£363,644.24
		10.66	***£516,144.24***

The Trust Board is asked to receive this update report and note the compliance with the triangulated approach to deciding staff requirements described within the NQB guidance, and the Developing Workforce Safeguards published in 2018.

Report Title:	Annual Nursing, Midwifery and Allied Health Professional Establishment Budget Review 2026-2027 Report.
Date:	February 2026
Author:	Rebecca Herring: Associate Director of Nursing (Workforce)
Executive Sponsor:	Phil Bolton: Chief Nurse

Introduction

2.0 The purpose of this paper is to assure the Trust Board that the approved recommendations from the staffing establishment reviews are underpinned by evidence-based tools, professional judgement, and patient outcomes, which have informed the nursing, midwifery, and Allied Health Professional (AHP) establishments for the 2026/2027 financial year

Resetting Establishments for Inpatient Areas

3.0 The Safer Nursing Care Tool (SNCT) is the workforce planning tool utilised across inpatient areas within Sherwood Forest Hospitals NHS Foundation Trust (SFH). This objective, evidence-based tool provides intelligence on patient acuity and dependency, aligned with nurse-sensitive indicators and professional judgement, to inform the Trust's establishment setting process.

3.1 In accordance with the Imperial licensing agreement, two 30-day SNCT data collection cycles were undertaken in March and September 2025 to ensure representation of seasonal variation. The methodology underpinning SNCT is consistent with the National Institute for Health and Care Excellence (NICE) guidance for safe staffing in inpatient settings (2014) and the recommendations set out in the Developing Workforce Safeguards (2018) framework.

Maternity Services

3.2 Birthrate Plus® (BR+) is the recommended workforce planning tool adopted for maternity services utilised at SFH. The tool calculates the total midwifery time required to provide safe care, based on the principle of delivering one-to-one midwifery support throughout established labour. The BR+ methodology is aligned with NICE guidance on safe midwifery staffing in maternity settings (2015) and is endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

3.3 An external report was commissioned by the Executive Team to ensure that all recommendations were independent, unbiased, and directly aligned to the activity observed across Sherwood Forest SFH.

The Establishment Review Process

4.0 A multidisciplinary review of staffing establishments commenced in late November 2025. This review was led by the Deputy Chief Nurse, supported by the Associate Director of Nursing (Workforce), Deputy Chief Financial Officer, Divisional Directors of Nursing, Divisional Matrons and Divisional Finance Managers.

4.1 Each establishment review adhered to the following components:

- Application of professional judgement
- Consideration of skill mix and environmental factors
- SNCT and Birthrate Plus modelling
- Relevant specialty and Royal College guidance
- Benchmarking using Model Hospital data (peer ward-level CHPPD and national mean CHPPD)
- Review of 12-month nurse-sensitive indicator performance
- Assessment of potential future service demand
- Healthroster template confirm and challenge

- Financial impact confirm and challenge relating to budget.

4.2 Trust compliance with the Developing Workforce Safeguards (2018) can be found in Appendix One.

5.0 Recommended Nursing and Midwifery Establishments for 2026-2027

5.1 Staffing establishments recognise the need to enable nursing, midwifery, and clinical support workers (CSW) time to undertake professional development and supervision roles, therefore core principles in determining these establishments have remained aligned with previous reviews, namely:

- The ward/department leader role remaining supervisory, enabling them to apply their time to provide direct care, undertake front-line clinical leadership, and support unfilled shifts.
- The skill split upon ward areas should aim to have a recommended ratio of 65:35% split for registered nurses to CSW in acute wards, 60:40 for sub-acute wards and 50:50% for rehabilitation wards. However professional judgement is always taken into consideration noting environmental factors and multidisciplinary input across each service.
- 22% 'headroom' is allocated to establishments based on the minimum headroom supported within the SNCT and represents a built-in efficiency. However, ED, Newark Urgent Treatment Centre, SDEC, NICCU, ICU and Acute Maternity are allocated 25% headroom acknowledging the speciality guidance for additional training requirements for these specific areas.

5.2 The full breakdown of the establishment review and recommendations can be found in Appendix Two.

Medicine Division Review:

5.3 The Medicine Division is seeking an uplift of **0.16 WTE** with zero financial impact, this will enable the conversion of variable pay spend to reset skill mix of a band 4 to band 5 adjustment on Sconce.

5.4 The Divisional Director of Nursing highlighted the need to strengthen leadership visibility at Mansfield and Newark Community Hospital. Specifically, an increase to the Band 6 leadership presence on Oakham, Lindhurst and Castle ward was recommended to ensure more consistent and robust senior support. The Division confirmed that this requirement could be funded within the current financial envelope and would not require any additional investment.

5.5 Consequently, Division is not seeking any additional financial investment and have capacity to fund the net requirement of **0.16 WTE** within their current financial means. The SNCT data was triangulated with nurse-sensitive indicators and professional judgement to inform the discussion. Based on this evidence, the proposal was supported by both the Divisional Director of Nursing and the Deputy Chief Nurse

Surgery Division Review:

5.6 The Surgical Division is seeking an additional uplift of **2.74 WTE** (CSWs) to support Ward 33, reflecting the volume of patients and the high number of non-registered transfers across the organisation. The Division presented an activity analysis comparing the number of patients per bed over a monthly period, based on the current 17 commissioned bed modelling versus the original 24 commissioned beds. This analysis demonstrated that patient volume has remained consistent despite the reduced number of beds, highlighting increased productivity. The additional staffing request has been informed by data collected over several months and triangulated with SNCT information, nurse-sensitive indicators, and staff wellbeing feedback. This request also came with no additional financial request as the budget was available within the current divisional budget. This recommendation was supported the Divisional Director of Nursing and the Deputy Chief Nurse.

5.7 The Division has requested to reduce the WTE of the Daycase Unit to align with the reduced opening times over a Friday and Saturday. This reduction would equate to 0.71 WTE. During the professional confirm and challenge discussion, the division discussed the case of need with Quality

Impact Assessment and highlighted the reduced occupancy over a Friday and Saturday, and no adverse impacts were noted in the QIA. This recommendation was supported by the Divisional Director of Nursing and Deputy Chief Nurse.

5.8 The Division has requested to reduce the WTE of the Minister Unit establishment to align with the reduced opening times over the weekend. This reduction would equate to 1.81 WTE. During the professional confirm and challenge discussion, the division discussed the case of need with Quality Impact Assessment and highlighted the reduced utilisation over the weekend hours. No adverse impacts were noted in the QIA.

5.9 Division presented a detailed and complex review of the perioperative pathway which was underpinned by The Association of Perioperative Practice (AfPP) guidelines. It is acknowledged that this review had been a huge undertaking but a much-needed insight into the workforce requirement across these services. The discussion focussed on the methodology and associated culture work running alongside this and it determined that the baseline establishment was safe and sustainable. Division requested to continue with the current funded establishment for 2026/2027.

5.10 The Division is not seeking any additional financial investment, due to efficiencies achieved across several ward budgets and through refining roster templates. These efficiencies have resulted in a divisional net requirement of **1.13 WTE** with **zero** financial impact. This recommendation was supported by the Divisional Director of Nursing and the Deputy Chief Nurse.

Women's and Children Division Review:

5.11 The Women's and Children's Division is seeking an additional staffing uplift of **6.66 WTE** (RMs) across the Maternity Team. This recommendation has been made by the external review undertaken by the national BirthRate Plus Team. The additional resource will support the ongoing complexities of care and the increasing number of women accessing the Maternity pathway at SFH. Recognising the additional 9 WTE investment approved by the Executive Team earlier in the year, this has been deducted from the overall recommendation made the external review resulting in overall ask of 3.67 WTE recommended for Acute Maternity services, 1.24 WTE recommended for Community Midwifery services and 1.75 WTE across the Specialist Midwife teams.

5.12 The Division is requesting an additional **4.21 WTE** Registered Nurses (RNs) for the NICCU team to enable the NIC role to be supervisory. Within the neonatal unit, the Nurse in Charge fulfils a critical coordination role which enables patient flow, leadership, and overall unit operations. These responsibilities significantly limit the NIC's capacity to provide direct patient care and contribute to workload pressures during each shift. However, the NIC is frequently required to carry a patient workload, often caring for the most clinically complex infant. This compromises the ability to fulfil the essential coordination function of the NIC role and aligns with the British Association of Perinatal Medicine (BAPM, 2022) standards. In addition, **0.16 WTE** is requested to enhance senior leadership capacity within the Transitional Care Lead role. These adjustments will be funded by division, and no financial ask is being made from the Executive team.

5.13 A request from Division presented headroom provisions for Ward 25 RNs increasing from 22% to 25%. This equated to a **0.13 WTE** uplift. This is line with the Royal College of Nursing guidelines and the British Association of Paediatric Nursing. These adjustments will be funded by division, and no financial ask is being made from the Executive team.

5.14 Additionally, there is an ask to increase the RN workforce across within Ward 14 of **1.24 WTE**, this will align the budget with the current roster. Clinic 11 is also requiring a **0.36 WTE** increase to align the budget with the roster template, and the Play team are also requiring a **0.35 WTE** roster ad budget alignment. These adjustments will be funded by division, and no financial ask is being made from the Executive team.

5.15 Due to **7.60 WTE** efficiencies achieved across the Specialist Paediatric Team, the Transitional CSW team and the MSW team, the overall recommendation from the Women's and Children's Division is seeking a net requirement uplift of **5.51 WTE** with a financial ask of **£363,644.24.**

5.16 To ensure compliance with BAPM standards in the forthcoming financial year, it is essential that should the recommendation be endorsed by the Trust Board, the recruitment process to uplift staffing commences as soon as possible to enable us to provide this level of assurance and meet safe nursing and BAPM standards.

Clinical Support Therapies and Outpatients (CTSO) Review:

5.17 The Division has made excellent progress in establishing a baseline for AHP therapy services. This has involved a complex and detailed transformation review of the current workforce model, aligning affiliated therapy services with the job-planning process and undertaking an individual service needs review. This work has created greater transparency across all services and strengthened understanding of workforce and service requirements. It has also enabled teams to feel heard, valued, and actively involved in the wider strategic planning process and overall cultural change. Work remains ongoing, but the scale of effort and consideration undertaken by the divisional team to achieve this level of oversight should not be underestimated.

5.18 The same methodology has also been applied to the nursing teams working across the outpatient clinic pathways. The team has introduced key performance indicators, grip-and-control frameworks for roster management and approval and established a baseline for essential service delivery. This approach has identified areas with potential for transformation as well as highlighted exceptions requiring attention.

5.19 Consequently, the CSTO Division has not requested any additional establishment changes to current services while this review continues, which is now being extended to Radiology as the next phase. This approach is fully supported by the Divisional Director of Nursing, the Chief AHP, and the Deputy Chief Nurse.

Urgent and Emergency Care Review:

5.20 The Urgent and Emergency Care Division is seeking additional investment to support the proposed uplift of **2.40 WTE** Registered Nurses (RNs) within the Emergency Assessment Unit (EAU). This increase will enable an improvement in the current headroom provision specifically; the study leave component from 22% to 25%. The proposal is consistent with the guidance issued by the Society of Acute Medicine and reflects the recognised need to strengthen study provisions and development opportunities.

5.21 The Division has submitted a request for an uplift of **4.97 WTE** within the Emergency Department Registered Nurse establishment to sustain the delivery of core essential services. However, this request does not reflect the current level of surge activity being experienced. Analysis presented by the Divisional Director of Nursing indicates that delays between decision to admit and transferring patients out to base wards generates approximately 9,000 additional unplanned care hours per month. This sustained demand is placing significant pressure on workforce capacity and presents a tangible risk to the consistent delivery of safe, and timely care, with evidence of missed care and increased patient harm. These findings are corroborated by staff feedback and adverse trends in nurse-sensitive clinical outcomes.

5.22 A request has been submitted for an additional **1.18 WTE** to strengthen leadership capacity within the Band 6 RN workforce in Same Day Emergency Care (SDEC). This uplift will ensure the presence of a senior nurse on duty seven days per week, while maintaining appropriate senior oversight within the direct SDEC service. This enhanced leadership model is intended to maintain patient safety, provide consistent operational oversight, and support robust clinical decision-making. In addition, a request has been made for an additional **1.0 WTE** within Short Stay Unit (SSU) to bring the roster into alignment with the current budget, as there is presently a **1.0 WTE** deficit.

5.23 Repurposing financial efficiencies achieved within the Division have resulted in an overall net requirement of **3.86 WTE**, representing a financial impact of **£152,200**. This recommendation has been supported by both the Divisional Director of Nursing and the Deputy Chief Nurse.

6.0 Recommendations

6.1 The Trust Board is asked to note the approved annual establishment recommendations which have been approved by the Trust Management Team in January. The collective establishment recommendation is for a NET increase of **10.66 WTE** within the nursing and midwifery workforce; with a total cost impact of **£516,144.24.**

6.2 The Trust Board is asked to endorse the recommendations approved by the Trust Management Team and further presented to the People Committee.

Figure 1: Establishments Recommendations

Division	**WTE Requested**	**NET WTE required after divisional efficiencies**	**Financial Investment Requested**
Medicine	0.16	0.16	£0
Urgent and Emergency care	9.55	3.86	£152,200
Surgery	2.74	1.13	£ 0
Clinical Therapies, Services and Outpatients	0	0	£0
Women and Children	13.11	5.51	£363,644.24
Total		***10.66***	***£516,144.24***

6.3 The Trust Board is asked to note the revised establishments will support a reduction in the use of higher-cost temporary staffing arrangements currently required to mitigate these service pressures, thereby enabling the conversion of temporary staffing hours into substantive, more financially sustainable posts.

6.4 Finally the Trust Board is asked to note compliance with the triangulated approach to determining staffing requirements, as set out in the NQB guidance and the Developing Workforce Safeguards (2018). The Chief Nurse and Chief Medical Officer confirm that there is good compliance with the Developing Workforce Safeguards and is satisfied that staffing arrangements are safe, effective, and sustainable.

7.0 Appendix One: Developing Workforce Safeguards Compliance Standards

Recommendation:	Compliance:
Recommendation 1: Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	**Compliant** ✓ SNCT has been embedded within adult in-patient areas, paediatric in-patient areas, and the Emergency Department. ✓ BirthRate Plus is embedded with Maternity services and a refresh of training has been undertaken. ✓ Monthly, biannual and annual reporting to Trust Board, Perinatal Committee and NMAHP Committee
Recommendation 2: Trust must ensure the three components are used in their safe staffing process.	**Fully 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, workforce information and benchmarking data 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.	**Fully Compliant** ✓ Confirmation is included in the annual governance statement that our staffing governance processes are safe and sustainable. ✓ Confirmation is also included within the biannual and annual workforce report.
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.	**Fully 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.	**Fully 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.	**Fully Compliant** ✓ Annual submission to NHS Improvement
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.	**Fully Compliant** ✓ Monthly Safe Staffing Reports for Nursing and Midwifery and staffing dashboard triangulates this information. This is circulated through the NMAHP Committee, Perinatal Committee and Trust Board Bimonthly
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	**Fully Compliant.** ✓ A bi-annual review for nursing using SNCT is completed across all services; establishments are reviewed on an annual basis. An annual and bi-annual staffing report is presented to

the 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.	the NMAHP Committee, Culture and Improvement Committee, and to the Trust Board.
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.	**Fully Compliant** ✓ SNCT and Birthrate Plus 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.	**Fully Compliant** ✓ Reviewed as part of the establishment setting process and any changes in service provision. These are owned by divisional leads.
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.	**Fully Compliant** ✓ Staffing resource is also discussed at the flow and capacity meetings throughout the day. ✓ Staffing escalation process via Matron and Bronze on call. ✓ Safe Staffing Standard Operating Procedure. ✓ Monthly Safe Staffing Report for Nursing and the Monthly Safe Staffing Report for Perinatal Services. ✓ Implementation of Safecare across all divisions to ensure real time oversight of acuity and dependency.

Developing Workforce Safeguards (NHSI, 2018)

8.0 Appendix One: Establishments Outcome Breakdown 2026/2027

	Ward/ Depart	WTE	Proposed WTE	WTE Variance	SNCT	Cost Impact	CHPPD Actual	CHPPD Peer Median	Skill Mix	RN Ratio	Comments:
	21/ RSU (24 beds) Respiratory	40.40	40.40	0	39.3	0	7.6	7.3	63/37	1:4.8	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
Medicine	**Ward 22 (24 beds) Gastroenterology**	37.9	37.9	0	30.4	0	6.8	8.0	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 23 (23 beds) Cardiology	35.16	35.16	0	33	0	7.0	8.0	71/29	1:4.6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 24 (24 beds) Haematology/ cardiology	37.9	37.90	0	32	0	6.8	8.0	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 32 (24 beds) General medical	37.95	37.95	0	33.6	0	7.0	7.6	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 34 (24 beds) Endocrinology	37.53	37.53	0	40.3	0	6.8	7.0	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 41 (24 beds) General medical	37.89	37.89	0	40.3	0	6.6	7.3	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 42 (24 beds) General medical	37.89	37.89	0	37.9	0	6.9	7.3	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 43 (24 beds) Respiratory	37.90	37.90	0	37.3	0	6.9	7.3	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 44 (24 beds) Respiratory	37.90	37.90	0	35.1	0	6.8	6.64	50/50	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse

	Ward 51 (24 beds) HCOP	40.71	40.71	0	37.5	0	6.7	7.8	44:36	1:6	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Ward 52 (24 beds) HCOP	42.01	42.01	0	39.3	0	7.6	7.8	50/50	1:4	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Stroke Unit (35 beds, 4 HASU and 31 acute stroke beds)	73.73	73.73	0	75	0	9.6	8.1	56/44	1:3	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Sconce (24 beds & 6 escalation beds) Sub-acute medicine	42.79	42.95	0.16	44.4	0	6.36	7.5	50/50	1:6	The SNCT principles and professional judgement have been applied and a 0.16 WTE uplift to the establishment has been recommended. By disestablishing the 2 vacant band 4 posts into band 5 posts to ensure a strengthened registered workforce. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Castle (18 beds) Rehabilitation	27.19	27.19	0	26.5	0	7.1	7.5	40/60	1:9	The SNCT principles and professional judgement have been applied with no changes to the overall establishment recommended. An increase in B6 utilising a band 5 post has been recommended to increase the leadership visibility. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Lindhurst (19 beds) Rehabilitation	27.19	27.19	0	28.5	0	7.4	7.8	40/60	1:9	The SNCT principles and professional judgement have been applied with no changes to the overall establishment recommended. An increase in B6 utilising a band 5 post has been recommended to increase the leadership visibility. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	Oakham MCH (24 beds) Rehabilitation	32.42	32.42	0	33.7	0	6.0	6.7	50/50	1:8	The SNCT principles and professional judgement have been applied with no changes to the overall establishment recommended. An increase in B6 utilising a band 5 post has been recommended to increase the leadership visibility. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse

	Ward/ Depart	WTE	Proposed WTE	WTE Variance	SNCT	Cost Impact	CHPPD Actual	CHPPD Peer Median	Skill Mix	RN Ratio	Comments:
SURGERY	**Ward 11 (24 beds) Trauma & orthopaedics**	37.90	37.89	-0.01	39.5	Repurposed	New Ward	New Ward	50:50	1:6	The SNCT principles and professional judgement has been applied an a 0.01 WTE reduction to the establishment has been recommended. Roster efficiencies have been undertaken to ensure roster templates align with budgets

											and this has realised 0.01 WTE improvement. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse, and the relevant QIA has been undertaken
	Ward 12 (24 beds) Trauma & orthopaedics	40.43	40.40	-0.03	39.2	Repurposed	6.4	7.6	50/50	1:6	The SNCT principles and professional judgement has been applied an a 0.03 WTE reduction to the establishment has been recommended. Roster efficiencies have been undertaken to ensure roster templates align with budgets and this has realised 0.03 WTE improvement. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse, and the relevant QIA has been undertaken
	Ward 14B (12 beds) Elective Orthopaedics	20.88	20.62	-0.26	18.2 (small ward)	Repurposed		NA	60/40	1:3.6	The SNCT principles and professional judgement has been applied an a 0.26 WTE reduction to the establishment has been recommended. Roster efficiencies have been undertaken to ensure roster templates align with budgets and this has realised 0.26 WTE improvement. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse, and the relevant QIA has been undertaken
	Ward 31 (24 beds) General Surgery	40.45	40.40	-0.05	33.5	Repurposed	7	8.1	63/37	1:4.8	The SNCT principles and professional judgement has been applied an a 0.05 WTE reduction to the establishment has been recommended. Roster efficiencies have been undertaken to ensure roster templates align with budgets and this has realised 0.05 WTE improvement. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse, and the relevant QIA has been undertaken
	Ward 33 SAU/SDEC (17 beds, 5 recliners and 4 trolleys) Surgical Admissions	36.65	39.39	2.74	39.8	Funded from repurposed	11.54	8.0	57/43	1:4.2	The SNCT principles and professional judgement have been applied, and it recommends a 2.74 uplift on the unregistered workforce. This additional resource will support the off-ward patient transfers and the high volume of patients accessing the 17 beds environment. Patient activity has not reduced despite reduced bed base. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse, and the relevant QIA have been undertaken.
	ITU Adult Intensive Care	94.73	93.73	-1.0	GPICS	Repurposed	26.17	26.17	GPICS	GPICS	The GPICS principles and professional judgement have been applied and with roster efficiencies suggested by the team this has resulted in a 1.0 WTE reduction. Additionally, it has been recommended B7 weekend cover is reviewed and supports leadership activity in the week. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse.
	DCU - King's Mill Daycase Surgery	39.09	38.38	-0.71	PJ	Repurposed	22.64	8.06	58/42	NA	Professional judgement has been applied an a 0.71 WTE reduction to the establishment has been recommended. This is to reflect the reduced weekend opening times. This is

							supported by the Divisional Director of Nursing and the Deputy Chief Nurse, and the relevant QIA has been undertaken
	Minister - NWK	22.64	20.83	-1.81	NA	Repurposed	NA	NA	64/36	NA	Professional judgement has been applied an a 1.81 WTE reduction to the establishment has been recommended. This is to reflect the reduced weekend opening times. is supported by the Divisional Director of Nursing and the Deputy Chief Nurse the relevant QIA has been undertaken.
	Theatres	252.5	252.5	0	AfPP	0	AfPP	AfPP	AfPP	AfPP	Professional judgement and the AfPP guidelines have been applied have been applied no changes to the establishment have been recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse.

	Ward/ Depart	WTE	Proposed WTE	WTE Variance	SNCT	Cost Impact	CHPPD Actual	CHPPD Peer Median	Skill Mix	RN Ratio	Comments:
UEC	**UCC RN - Newark**	15.7	14.07	-1.63	PJ	Repurposed	NA	NA	78/22	NA	Professional judgement has been applied with no changes to the rostered establishment, but a 1.63 efficiency to the overall financial budget has been realised and will ensure budget and roster align. There are no changes to the roster and skill mix. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse
	UCC - Newark	6.2	5.47	-0.73	PJ	Repurposed	NA	NA	22/78	NA	Professional judgement has been applied with no changes to the rostered establishment, but a 0.73 efficiency to the overall financial budget has been realised and will ensure budget and roster align. There are no changes to the roster and skill mix. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse
	SSU (48 beds) Short stay acute medicine	70.83	71.83	1	70.82	40,800	7.09	8.02	58/42	1:6	The SNCT principles and professional judgement has been applied with no changes to the rostered establishment, but a 1 WTE increase to the budget to ensure budget and roster align. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse
	EAU RN (46 beds) Medical admissions	53.79	56.19	2.40	91.8	106,100	9.9	9.6	58/42	1:4.1	The SNCT principles and professional judgement have been applied and a 2.40 WTE increase for the headroom for the RNs to be increased from 22% to 25% has been recommended. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	EAU CSW	41.98	41.90	-0.08	91.8	Repurposed	9.9	9.6	52/48	1:4.1	The SNCT principles and professional judgement has been applied and a 0.08 WTE efficiency to the overall financial budget has been realised and will ensure budget and roster align. There are no changes to the roster and skill mix This is

										supported by the Divisional Director of Nursing and the Deputy Chief Nurse
	Discharge Lounge	26.74	26.74	0	PJ	0	NA	NA	50/50	NA	Professional judgement has been applied, and professional judgement has been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	SDEC Same day emergency care	22.77	23.95	1.18	PJ	52,900	NA	NA	57/43	NA	Professional judgement has been applied and a 1.18 WTE across the registered workforce has been recommended the senior visibility. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	ED RN Emergency care	134.55	139.52	4.97	125.5	310,100	NA	NA	66/34	NA	The SNCT principles and professional judgement have been applied and a 4.97 WTE increase across the RNs workforce has been recommended. It has been acknowledged that this additional resource will support the core essential flow through the department and is not intended to address the current surge capacity. This is supported by the Divisional Director of Nursing and Deputy Chief Nurse
	ED HCA Emergency care	80.63	77.75	-2.88	31.4	Repurposed	NA	NA	34/66	NA	The SNCT principles and professional judgement has been applied and a 2.88 WTE efficiency to the overall financial budget has been realised and will ensure budget and roster align. There are no changes to the roster and skill mix. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse
	HOOH Hospital out of Ours	12.06	11.69	-0.37	PJ	Repurposed	NA	NA	NA	NA	Professional judgement has been applied and a 0.37 WTE efficiency to the overall financial budget has been realised and will ensure budget and roster align. There are no changes to the roster and skill mix. This is supported by the Divisional Director of Nursing and the Deputy Chief Nurse

	Ward/ Depart	**WTE**	**Proposed WTE**	**WTE Variance**	**SNCT**	**Cost Impact**	**CHPPD Actual**	**CHPPD Peer Median**	**Skill Mix**	**RN Ratio**	**Comments:**
	Ward 25 RN (26 beds) Children & Young People	36.74	36.87	0.13	53.2	Funded from repurposed	10.93	14.24	66/33	1:4	The SNCT principles and professional judgement have been applied with 0.13 increase to the establishment. This increase is to facilitate a 25% headroom uplift and aligns with speciality Royal Collage guidance. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Ward 25 CSW (26 beds) Children & Young People	15.71	15.71	0	53.2	0	10.93	14.24	33/66	NA	The SNCT principles and professional judgement have been applied with no changes to the rostered establishment. Budget and roster templates have been aligned to ensure transparency. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Ward 25 (HDU)	7.59	7.59	**0**	PJ		NA	NA	PICS	PICS	Professional judgement and guidance from PICS guidance

	High Dependency Care					0					have been applied with no changes to the establishment recommended. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Ward 14 (12 beds) Gynaecology	22.30	23.54	1.24	22.6 (small ward)	Funded from repurposed	14.22	8.9	60/40	1:6	The SNCT principles and professional judgement have been applied and a 1.24 WTE increase has been recommended to correct a budget anomaly. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	NICU RN Neonatal Care	29.76	33.96	4.21	BAPM	Funded from repurposed	13.5	18.35	BAPM	BAPM	The BPAM principles and professional judgement have been applied and a 4.21 WTE Increase has been recommended. This is based on the BAPM guidelines and network data regarding bed occupancy. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	NICCU HCA Neonatal Care	5.24	5.24	0	BAPM	0	13.5	18.35	BAPM	BAPM	The BPAM principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Neonatal RN Transitional Care	5.97	6.13	0.16	BAPM	Funded from repurposed	NA	NA	BAPM	BAPM	The BPAM principles and professional judgement have been applied and a 0.16 WTE Increase has been recommended. This is based on the BAPM guidelines and network data regarding bed occupancy. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Neonatal CSW Transitional Care	5.24	0	-5.24	BAPM	Repurposed	NA	NA	BAPM	BAPM	The BPAM principles and professional judgement have been applied, and it has been recommended that a workforce change is undertaken and 5.24 WTE reduction is recommended. A QIA has been submitted, and this recommendation is supported by the Deputy Divisional Director of Divisional Nursing and Divisional Director of Nursing and Deputy Chief Nurse.
	Clinic 11	15.17	15.53	0.36	PJ	Funded from repurposed	NA	NA	NA	NA	Professional judgement has been applied with 0.36 WTE changes to the establishment recommended. This will align current budget and roster. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	GYN OPA	10.08	10.08	0	PJ	0	NA	NA	NA	NA	Professional judgement has been applied with no changes to the establishment recommended. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Play staff	3.8	4.15	0.35	PJ	Funded from repurposed	NA	NA	NA	NA	Professional judgement has been applied with 0.35 WTE changes to the establishment recommended. This will align current budget and roster. This is supported by the Deputy

											Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Paeds SN	17.38	14.71	-2.07	PJ	Repurposed	NA	NA	NA	NA	Professional judgement has been applied and a 2.07 WTE reduction to the establishment recommended. This is supported by the Deputy Divisional Director of Divisional Nursing, Divisional Director of Nursing and the Deputy Chief Nurse.
	Midwifery RM	107.2	110.94	3.67	BR+	£205,766	NA	NA	BR+	BR+	Professional judgement and the Birthrate Plus principles have been applied and a 3.67 WTE increase has been recommended. to the establishment. This recommendation is based on the data provided to the external review from BR+ which acknowledged the increasing complex care needs of the individuals accessing the maternity pathway. This is supported by the Head of Midwifery, Divisional Director of Nursing and Deputy Chief Nurse
	Midwifery MSW	30.99	30.7	0.29	BR+	£9,762	NA	NA	BR+	BR+	Professional judgement and the Birthrate Plus principles have been applied and a 0.29 WTE reduction has been recommended to the establishment. This is ensuring transparency with the budget and roster alignment. This is supported by the Head of Midwifery, Divisional Director of Midwifery and the Deputy Chief Nurse.
	Community Midwives	45.44	46.68	1.24	BR+	£69,523	NA	NA	BR+	BR+	Professional judgement and the Birthrate Plus principles have been applied and a 1.24 WTE increase has been recommended.to the establishment. This recommendation is based on the data provided to the external review from BR+ which acknowledged the increasing complex care needs of the individuals accessing the maternity pathway. This is supported by the Head of Midwifery, Divisional Director of Nursing and Deputy Chief Nurse
	Specialist Midwives	21.12	22.87	1.75	BR+	£98,117	NA	2NA	BR+	BR+	Professional judgement and the Birthrate Plus principles have been applied and a 1.75 WTE increase has been recommended to the establishment. This recommendation is based on the data provided to the external review from BR+ which acknowledged the increasing complex care needs of the individuals accessing the maternity pathway. This is supported by the Head of Midwifery, Divisional Director of Nursing and Deputy Chief Nurse

Key: *PJ* = Professional Judgement, *BR+* = BirthRate Plus, *GPICS* = Guidelines for the Provision of Intensive Care Services, *BPAM* = British Association of Perinatal Medicine and, *AfPP* = Association for Perioperative Practice

- The nursing, midwifery and AHP establishment recommendation is an increase of 10.66 WTE to the collective workforce, with a total financial impact of £516,144.26

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – To December 2025	**Date:**	5th February 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	

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 28 January 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 in respect of the indicators allocated under the following domains: Quality of Care, People and Culture, Timely Care and Best Value Care. Key activity metrics are provided as context to support all domains.

This report covers performance to Dec-25. Performance indicators are marked as 'met' or 'not met' using a green tick and red cross respectively where a standard or plan value exists.

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

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

During Nov-25 and Dec-25 (latest reporting period), the sustained operational pressures, particularly across Urgent and Emergency Care (UEC), have persisted and, at times, intensified.

- **Quality of Care** saw three off-track metrics in Nov-25 and Dec-25, including elevated clostridioides difficile infections in Dec-25, Venous Thromboembolism (VTE) risk assessment compliance challenges in both Nov-25 and Dec-25 and an elevated still birth rate in Nov-25. Positive outcomes included zero MRSA bacteraemia, strong gram-negative performance, and zero never events.
- Eight of thirteen **People and Culture** metrics were on track in the latest period including our vacancy rate, turnover, bank usage and agency off framework and over-price cap. Challenging performance areas in this domain included sickness absence. Agency usage remained higher than our plan, however, on a reducing trend. Our appraisal rate has been stable for the past three months, slightly below plan; however, benchmarks favourably.
- Within the **Timely Care** domain, the UEC pressures relate largely to challenges admitting patients in a timely manner which is causing overcrowding in our Emergency Department (ED) and impacting on our 4-hour, 12-hour and ambulance handover performance metrics. Planned care performance deteriorated against the Referral to Treatment (RTT) 18-week performance standard. Positive areas include strong patient initiated follow up performance, low volumes of RTT long waits (52-week wait), and strong performance against the cancer 28-day and 62-day targets in Nov-25.
- Financially, from a **Best Value Care** perspective, the Trust has reported a £10.92m year-to-date deficit, driven by cost improvement programme underperformance, industrial action, removal of deficit support funding, Mutually Agreed Resignation Scheme payments and income planning issues. Our year-end forecast remains aligned to the break-even plan.

There were five reported metrics triggering special cause variation in Nov-25 or Dec-25. One metric was displaying performance improvement:

- The number of gram-negative bloodstream infections reported in Dec-25 fell below the lower control limit and demonstrated the strongest performance year-to-date.

The following four metrics were all displaying performance challenges:

- The number of compliments received in month fell below the lower control limit in Nov-25 and Dec-25 with the lower reported numbers within the IPR data range for this metric (from Apr-22).
- Sickness absence hit the upper control limit in Dec-25 with elevated rates of sickness like levels seen in the same period in 2024/25.
- Ambulance turnaround 30-minute performance has been below the lower control limit since Oct-25 with a further drop in performance in Dec-25 to the lowest levels within the IPR data range for this metric (from Apr-22). If performance remains below the average level in Jan-26, it will trigger a control limit change due to the number of consecutive points below the average.
- 18-week RTT performance has been below the lower control limit since Oct-25 with a further small drop in performance in Dec-25 to the lowest levels since Apr-24.

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.

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Integrated Performance Report

Reporting Period: To December 2025

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Integrated Scorecard

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

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

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

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

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

Integrated Report

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

Category	At a Glance	NOF	Indicator	2024/25 Standard	2025/26 Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Quality of Care	Safe		Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.7	2.6	1.9	2.4	2.2	1.7	2.3	2.4	2.4		2.2				
			Never events	0	0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
		✓	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 2				
		✓	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 7	✗ 9	✓ 4	✗ 8	✗ 55	✗ 59				
		✓	Number of gram-negative bloodstream infections reported in month	n/a	8	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	✓ 5	✓ 3	✓ 3	✓ 2	50	✓ 35				
			HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.1	0.1				
			HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✗ 6	✗ 2				
			Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	5	13	10	2	11	10	9	5	4	17	69				
			Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 90.5%	✗ 89.6%	✗ 89.4%	✗ 88.0%	✗ 85.5%	✗ 89.7%	✗ 85.7%	✗ 86.5%	✗ 85.9%		✗ 87.8%				
	Caring		Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 1.3	✓ 1.4	✓ 1.0	✓ 1.3	✓ 0.9	✓ 1.4				
			Compliments received in month	No Standard	No Standard	155	115	141	157	109	137	98	64	38	1831	1014				
	Effective	✓	SHMI	As Expected	As Expected	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 106	✓ 106	✓ 105	✓ 107	✓ 105				
			Still birth rate	≤4.4	≤4.4	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.0	✗ 10.2	✓ 3.4	✗ 7.6	✓ 0.0	✓ 4.3	✗ 5.5				
			Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				
People and Culture	Belonging in the NHS	✓	Engagement score	≥6.8%	≥6.9%			✓ 6.8			-			-	✓ 7.1	✓ 6.8				
	Growing the Future		Vacancy rate	≤8.5%	≤8.5%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✓ 7.9%	✓ 7.8%	✓ 8.2%	✓ 8.0%	✗ 8.6%				
			Time to hire	n/a	≤53.1 days	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0	✓ 25.0	✓ 36.0	✓ 21.0	-		-				
			Turnover in month	≤0.9%	≤0.9%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.8%	✗ 1.0%	✓ 0.6%	✓ 0.6%	✓ 0.7%	✓ 0.6%				
			Appraisals	≥90%	≥90%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 88.2%	✗ 87.5%	✗ 87.4%	✗ 87.5%	✗ 89.0%	✗ 88.3%				
			Mandatory & statutory training	≥90%	≥90%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 92.9%	✓ 93.3%	✓ 93.6%	✓ 93.6%	✓ 91.5%	✓ 93.1%				
			Medical job plan compliance	n/a	≥95%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%	✗ 94.0%	✓ 95.9%	✓ 96.6%	-		-				
	Looking after our People	✓	Sickness absence	≤4.2%	≤4.2%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 4.8%	✗ 5.7%	✗ 5.6%	✗ 5.9%	✗ 5.0%	✗ 5.2%				
			Flu vaccinations uptake (front line staff)	≥75%	≥75%	-	-	-	-	-	-	✗ 35.8%	✗ 50.7%	✗ 54.3%	✗ 58.0%					
			Employee relations management	<17	<21	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✓ 20	✗ 21	✓ 20	✗ 26	✗ 21	✗ 21				
	New Ways of Working		Bank usage	≤8.5%	≤7.8%	✓ 6.3%	✓ 7.1%	✓ 6.3%	✓ 6.9%	✓ 7.1%	✓ 5.2%	✓ 4.8%	✓ 6.8%	✓ 7.5%	✗ 8.9%	✓ 6.4%				
			Agency usage	<3.2%	<1.9%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 2.3%	✗ 2.6%	✗ 2.0%	✗ 2.0%	✗ 4.0%	✗ 2.6%				
			Agency (off framework)	0.0%	0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
			Agency (over price cap)	≤40.0%	≤40.0%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 40.9%	✓ 33.4%	✓ 33.6%	✓ 39.5%	✗ 52.9%	✓ 37.6%				
Timely Care	Urgent Care		Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 82.3%	✗ 76.2%	✗ 72.8%	✗ 62.2%	✗ 91.4%	✗ 81.7%				
			Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 2.5%	✗ 3.7%	✗ 6.0%	✗ 13.4%	✗ 0.7%	✗ 3.3%				
		✓	ED 4-hour performance	≥76%	≥Plan	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 68.0%	✗ 67.4%	✗ 67.3%	✗ 67.0%	✗ 71.0%	✓ 71.6%				
		✓	ED 12-hour length of stay performance	≤2%	≤2024/25	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 5.6%	✗ 8.2%	✗ 7.2%	✗ 9.2%	✗ 3.4%	✗ 4.9%				
			Mental health patients spending over 12 hours in A&E	n/a	No Standard	18	21	19	22	24	23	27	17	9	23	180				
			Adult G&A bed occupancy	≤92%	≤92%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 96.3%	✗ 97.4%	✗ 96.1%	✗ 95.9%	✗ 94.5%	✗ 95.9%				
		✓	Average number of days between planned and actual discharge date	n/a	≤Plan	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.1	✗ 4.0	✓ 3.5	✓ 3.3	✓ 3.6	✓ 3.4		✓ 3.6				
			Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 82	✗ 72	✗ 84	✗ 89	✗ 64	✗ 74				
	Electives		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 10.9%	✓ 11.1%	✓ 11.1%	✓ 11.2%	✓ 11.2%	✓ 6.0%	✓ 10.9%				
		✓	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%	✗ 61.9%	✗ 60.4%	✗ 60.3%	✗ 59.3%		✗ 62.0%				
		✓	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	✓ 0.9%	✓ 0.9%	✓ 0.8%	✓ 1.0%		✓ 1.0%				
	Diagnostics		Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✗ 89.8%	✗ 90.4%	✗ 89.8%	✗ 92.0%	✓ 93.1%	✗ 89.8%				
	Cancer	✓	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	✓ 82.3%	✓ 80.7%	✓ 82.2%	✓ 79.4%	-	✓ 78.3%	✓ 80.6%				
			Cancer 31-day treatment performance	≥Plan	≥96%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	✗ 84.8%	✗ 88.4%	✗ 91.7%	✗ 93.6%	-	✓ 91.9%	✗ 90.1%				
		✓	Cancer 62-day treatment performance	≥Plan	≥Plan	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	✓ 72.4%	✓ 63.1%	✓ 65.3%	✓ 75.7%	-	✗ 64.4%	✗ 66.9%				
Best Value Care	Financial Performance	✓	Financial surplus / deficit	n/a	≥£0.00m	✗ -£0.90	✗ -£0.70	✗ -£0.21	✓ £0.12	✓ £0.03	✗ -£1.62	✗ -£2.37	✗ -£2.63	✗ -£2.65		✗ £10.93				
		✓	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✗ -£2.08	✗ -£2.95	✗ -£2.46	✗ -£2.34	✓ £0.01	✗ £10.81				
	Efficiency		Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✗ -£2.81	✗ -£1.83	✗ -£0.93	✗ -£0.55	✓ £0.08	✗ £10.26				
			Risk adjusted efficiency forecast to plan (%)	n/a	100%	✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%	✗ 74.0%	✗ 81.0%	✗ 82.0%	✗ 80.0%		-				
	Variable Pay		Reported agency expenditure	No Standard	No Standard	£0.75	£0.87	£1.01	£0.78	£0.78	£0.69	£0.77	£0.58	£0.60	£13.70	£6.83				
			Reported bank expenditure	No Standard	No Standard	£1.88	£1.90	£1.70	£2.09	£2.12	£1.57	£1.43	£2.02	£2.27	£30.55	£16.98				
	Rate of Productivity	✓	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✗ 0.9%	✓ 3.8%	✓ 5.0%	✓ 4.2%	✓ 5.7%	✓ 5.5%	-	-	-		-				
	Cash & Liquidity		BPPC - Number of bills paid within target	n/a	≥95%	✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 87.2%	✗ 87.5%	✗ 83.9%	✗ 50.4%	✗ 21.3%		✗ 61.7%				
			BPPC - Value of bills paid within target	n/a	≥95%	✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%	✗ 91.6%	✗ 90.6%	✗ 84.3%	✗ 81.3%		✗ 81.1%				
			Operating expenditure days	n/a	≥5	✓ 16	✓ 16	✓ 13	✓ 10	✓ 10	✓ 6	✓ 5	✗ 4	✗ 3		✓ 9				
	Capital		Capital expenditure against plan	≤£33.61m	≤£0.00m	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✗ £0.85	✗ £1.36	✗ £4.29	✗ £4.24	✓ £33.58	✗ £14.47				
Activity (for context)	Urgent Care		A&E attendances (inc. PC24)			552	562	577	582	530	550	561	563	537	547	557				
			Non-elective admissions			139	139	140	147	138	148	151	142	149	145	144				
	Electives		Average daily elective referrals			326	325	352	365	307	354	354	328	320	341	337				
			Outpatients - first appointment			318	308	335	352	281	364	334	320	290	347	322				
			Outpatients - follow up			849	802	853	907	748	891	854	819	754	852	831				
			Outpatients - procedures			257	254	267	293	247	283	280	268	256	265	267				
			Day case			114	116	123	126	114	121	125	121	115	122	119				
			Elective inpatient			13	14	15	15	14	13	16	16	13	14	14				
	Diagnostics		Diagnostics			476	464	477	494	461	478	488	481	459	479	475				

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Quality of Care

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Domain Summary: Quality of Care

Overview	Lead: Executive Chief Nurse and Chief Medical Officer

During Nov-25 and Dec-25, the Trust faced exceptional demands. We maintained patient services and safety through a period of industrial action (prior to Christmas) and days of record-high emergency attendances, creating prolonged operational pressure that strained our ability to deliver timely, safe care. Persistent delays for admission beds and overcrowding in the Emergency Department (ED) affected patients, carers and staff. Despite these challenges, our teams performed exceptionally, enabling us to continue providing safe, high-quality care.

Within the Quality of Care domain, there were three off-track metrics during Nov-25 and Dec-25:

- **Clostridioides difficile (C. diff):** During Nov-25 and Dec-25 we reported 12 hospital onset, hospital acquired (HOHA) and five community onset, hospital acquired (COHA) infections. During this period, we breached our trajectory of 65 with a total of 75. We have continued to observe an increase in our rates compared to the same period last year. This is something that is being observed across the region and nationally. Benchmarking against our peers shows we are not an outlier and sit in the middle of the group. We are working closely with the Antimicrobial Pharmacist and Consultant Microbiologists relating to the Antimicrobial Resistance action plan. We have a Trust wide Infection Prevention and Control (IPC) action plan to support the reduction in infection rates. Additional actions taken include: (1) A new alert organism meeting is held weekly to ensure all patients have the correct treatment and are being isolated appropriately; (2) All Link Professionals have been invited to the monthly operational IPC meeting to receive updates and can raise good practice or concerns.
- **Percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE**): Year-to-date compliance with inpatient VTE risk assessment is 87.8%. The Task and Finish Group commissioned to understand root causes and develop solutions, has identified a complex picture. Key findings are that the compliance problem is predominantly system-based and appears to be an unintended consequence of Electronic Prescribing and Medicines Administration (EPMA) rollout to ED. A paper detailing progress was presented to Patient Safety Committee (PSC) in Dec-25 asking the committee to support the implementation of interim mitigations while longer-term solutions are developed and to recognise that sustainable solutions will require difficult decisions about workflow and/or system configuration.
- **Still birth rate:** During Nov-25 and Dec-25, we have reported two cases of antenatal stillbirth. Each case received an individual review and has been reported through the Perinatal Mortality Review Tool (PMRT) and Maternity and Newborn Safety Investigations (MNSI) process, where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

We saw strong performance across several key metrics. In Nov-25 and Dec-25 there were zero MRSA bacteraemia, recovering from the instances we saw in Jul-25 and Aug-25. Benchmarking against our peer organisations indicates there has been an increase in cases both regionally and nationally and all trusts in our peer group have breached the trajectory. We are in a strong position for Ecoli, close to our trajectory for Klebsiella and breach the trajectory for Pseudomonas cases. Benchmarking against our peers indicates that we remain one of the three Trusts with the lowest numbers. We reported zero Never Events and zero Hospital-Acquired Pressure Ulcers (HAPU) category 3/4 during this reporting period. One Patient Safety Incident Investigation (PSII) was commissioned in Nov-25 by the Patient Safety Incident Response Group (PSIRG). Summary Hospital-level Mortality Indicator (SHMI) remains as expected.

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.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
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NHS Foundation Trust

Scorecard: Quality of Care

Quality of Care

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Safe	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.7	2.6	1.9	2.4	2.2	1.7	2.3	2.4	2.4		2.2				
	Never events	0	0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 2				
	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 7	✗ 9	✓ 4	✗ 8	✗ 55	✗ 59				
	Number of gram-negative bloodstream infections reported in month	n/a	8	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	✓ 5	✓ 3	✓ 3	✓ 2	50	✓ 35				
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.1	0.1				
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✗ 6	✗ 2				
	Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	5	13	10	2	11	10	9	5	4	17	69				
	Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 90.5%	✗ 89.6%	✗ 89.4%	✗ 88.0%	✗ 85.5%	✗ 89.7%	✗ 85.7%	✗ 86.5%	✗ 85.9%		✗ 87.8%				
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 1.3	✓ 1.4	✓ 1.0	✓ 1.3	✓ 0.9	✓ 1.4				
	Compliments received in month	No Standard	No Standard	155	115	141	157	109	137	98	64	38	1831	1014				
Effective	SHMI	As Expected	As Expected	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 106	✓ 106	✓ 105	✓ 107	✓ 105				
	Still birth rate	≤4.4	≤4.4	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.0	✗ 10.2	✓ 3.4	✗ 7.6	✓ 0.0	✓ 4.3	✗ 5.5				
	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				

Indicator in Focus: Infection Prevention and Control

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

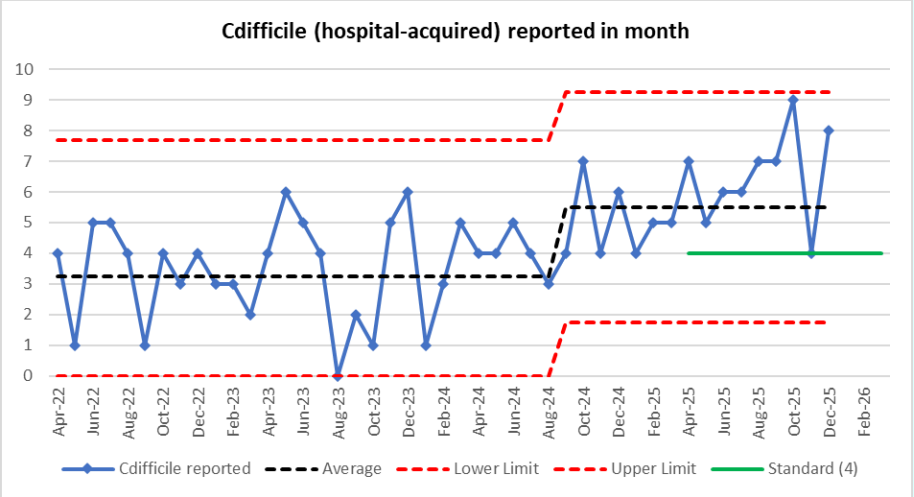
Cdifficile (Cdiff)
Our target for Cdiff this year for hospital and community onset is 65 and we have currently had 75 cases up to the end of Dec-25. There has been a national increase in cases and when reviewing our numbers against peer Trusts and we sit in the middle of the group with three other organisations also breaching their target. During Nov-25 and Dec-25, we have had 12 HOHA and five COHA infections. We have continued to observe an increase in our rates compared to the same period last year. This is something that is being observed across the region and nationally.

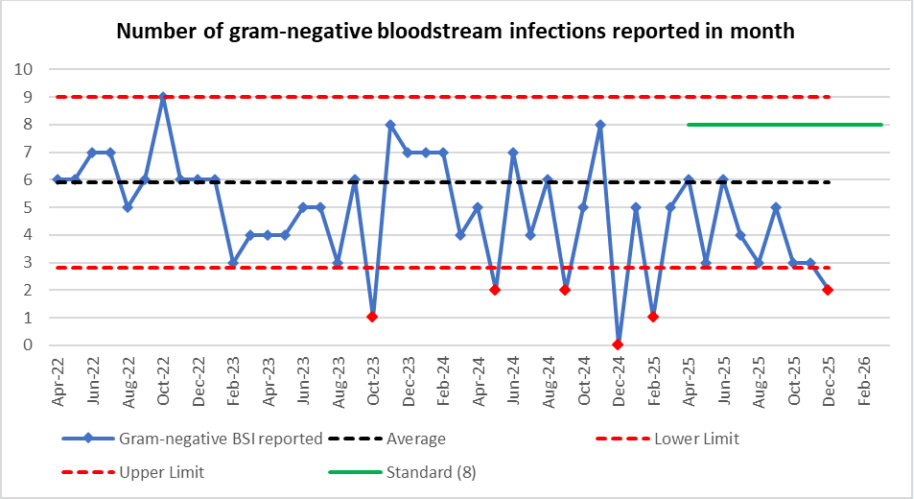
MRSA
We have had zero HOHA MRSA cases in Nov-25 and Dec-25. When considering benchmarking against our peer organisations, there has been an increase in cases both regionally and nationally and all our peer organisations have breached their trajectories.

Gram-negative bacteraemia
We have breached our Pseudomonas trajectory by three cases and are close to breaching our Klebsiella trajectory, we are not an outlier when benchmarking against our peer organisations. We are currently in a good position for Ecoli (currently 10 cases lower than the same period last year) and when benchmarking against our peers, we remain one of two Trusts with the lowest numbers.

Root causes	Actions and timescale	Impact
Increase in our rates of Cdiff	Conduct a deep dive of all Cdiff cases to be completed by 31 January 2026.	To identify any areas of improvement to support a reduction in patients acquiring Cdiff.
Increase in all infection rates	Full IPC action plan developed to support the reduction in infections, this includes actions from the Multidisciplinary Team (MDT).	Improve patient environment and reduce cross infection.
	Collaborative working with IPC, Antimicrobial Pharmacists and Consultant Microbiologists on the Antimicrobial resistance national action plan and call to action.	Promote knowledge and improve practice.

Data





Indicator in Focus: Patient Safety Incident Investigations (PSII)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

In line with SFH's Patient Safety Incident Response Plan, one PSII was commissioned (Nov-25) by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the Integrated Care Board (ICB) were present. This was in relation to the administration of opioids and insertion of an epidural prior to a patient deteriorating. There were no reportable incidents to Maternity and Newborn Safety Investigations (MNSIs) identified.

PSII with potential coronial interest	MSNI investigation	Never Events
None commissioned.	None commissioned	None reported in Nov and Dec 25

During Nov-25, there were two PSII's signed off, one of which was presented to the coroner.
1) A PSII in relation to delays to a Urology patient contributing to his death was completed and it was identified that there was a missed opportunity to upgrade the patient to the cancer pathway. Two key actions were:

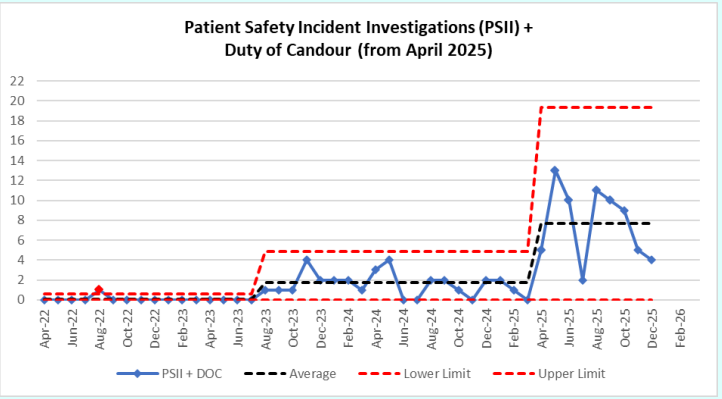
- Produce and share a patient safety alert to provide guidance to all trust staff regarding how a patient can be upgraded to the cancer pathway via ICE - completed.
- Roll out Cancer 360 across all tumour sites - target completion date of 1 May 2026.

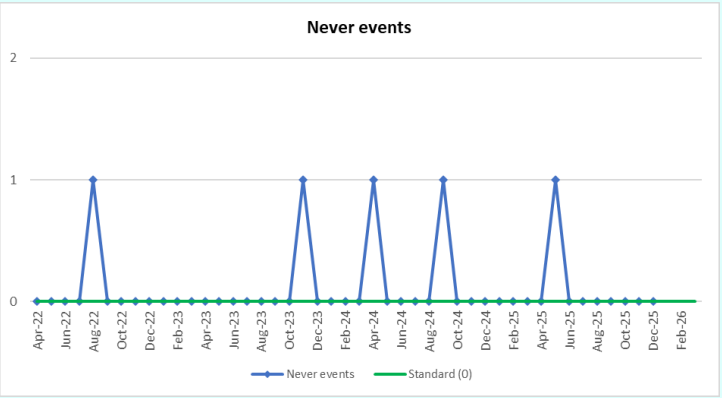
2) A PSII in relation to a missed silver trauma was completed and the patient provided positive feedback regarding being updated throughout the investigation. Two key actions were:

- Introduce a silver trauma clerking form - completed.
- Secondary survey to be incorporated into the orthopaedic clerking booklet - target completion date of 4 February 2026.

During Dec-25 one PSII was signed off:
1) A wrong site dermatology surgery never event, completed by an external investigator. An action plan with 30 actions has been developed by the speciality, and the completion of these will be monitored via the Datix system.

Data





Root causes	Actions and timescale	Impact
Administration of opioids and insertion of an epidural.	It was noted that there was new information presented which had not been discussed in the rapid review meeting which altered the decision regarding commencing an investigation. The panel recognised that the divisional panel had made a decision based on the information available to them at that time and the discussions which were held. Division to review governance processes to ensure information is consistent and reviews are compiled in a timely way.	PSII ongoing

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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

The VTE Task and Finish group have identified that the compliance problem is predominantly system-based and appears to be an unintended consequence of Electronic Prescribing and Medicines Administration (EPMA) rollout to the Emergency Department.

System Design

Previously, VTE assessment was mandatory before prescribing, enforced through a 'break glass' mechanism. The system now operates differently in ED:

- Nervecentre does not prompt for VTE assessment when clerking in ED.
- The 'break glass' safety net that previously forced assessment no longer functions in this location.
- Clinicians can prescribe without any system reminder about VTE assessment.
- When patients move to our Emergency Admissions Unit (EAU), staff must override VTE assessment to prescribe other medications.
- Completed VTE assessments do not take prescribers directly to the prescribing page, creating a disconnect between assessment and action.

Actions

Short-term Actions

While longer-term solutions are designed, the group is considering several short-term actions that may improve compliance:

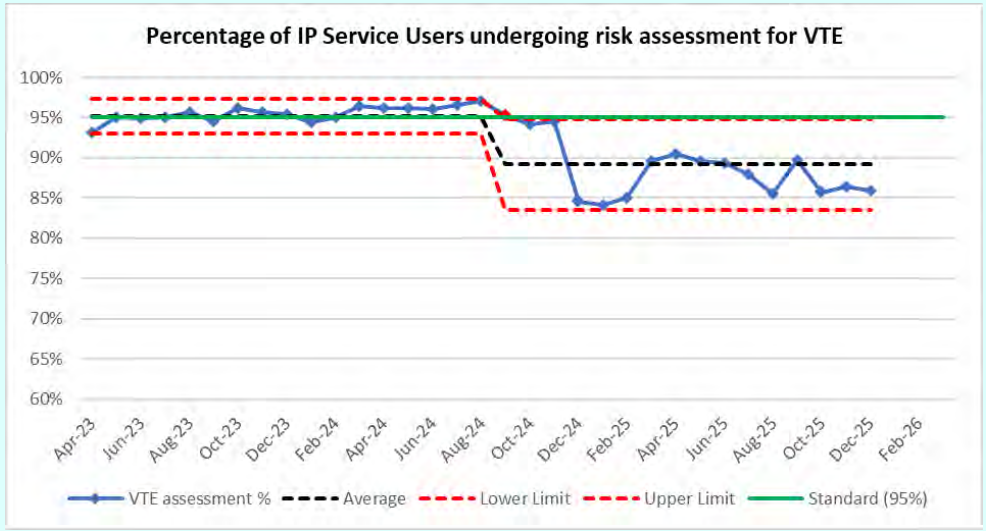
- Structured three-times-daily dashboard checks at morning handover, lunchtime board round and 3pm safety huddle.
- VTE dashboards displayed on Nurse In Charge (NIC) screens in EAU and Short Stay Unit (SSU).
- Outstanding assessments allocated to named responsible clinicians.
- Clear trust-wide communications emphasising the mandatory nature of assessment for patients.

Longer-term Solutions

The group continues to explore sustainable solutions:

- Integration of VTE assessment status into board-round view, making compliance visible during routine clinical review.
- Supplier engagement to request assessment completion automatically directing to prescribing page.
- Exploration of decision-to-admit triggers rather than location-based or time-based prompts.
- Detailed comparison with NUH and other peer organisations to understand if alternative configurations exist.
- Confirmation of timeline for Nervecentre (NC10) update which reportedly addresses repeat assessment flagging issues.
- Longer-term incorporation of VTE assessment into future Electronic Patient Record (EPR) clerking templates.

Data



Please note: Data quality issues resulted in incorrect data for Dec-25 being presented to Quality Committee and Trust Management Team in Jan-26. This erroneous data has been corrected in this report, and a root cause analysis has been requested.

Indicator in Focus: Still Birth Rate

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

During Nov-25 and Dec-25, we have reported two cases of antenatal stillbirth. Each case received an individual review and were reported through the Perinatal Mortality Review Tool (PMRT) and Maternity and Newborn Safety Investigations (MNSI) process, where they will receive a further review.

All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

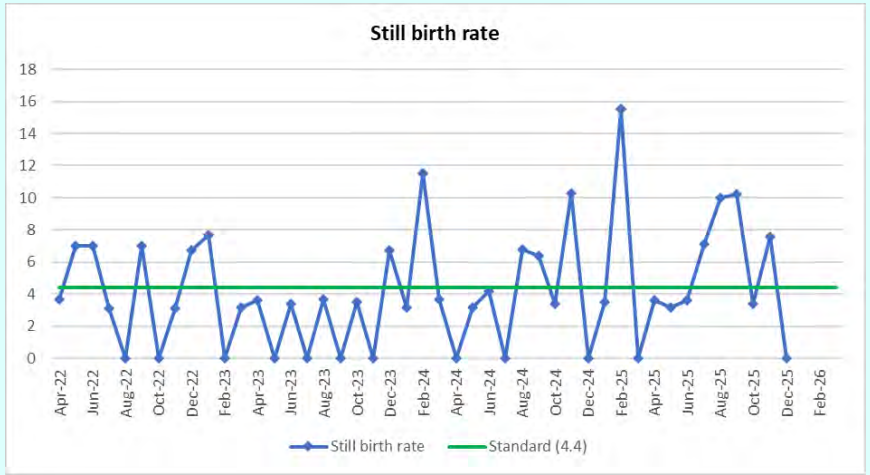
<u>Nov-25</u>

- Attend planned community midwife appointment and no fetal heart rate detected. Antenatal stillbirth confirmed on ultrasound.
- Attended triage at 36 weeks gestation with altered fetal movements, no fetal heart rate detected and antenatal still birth confirmed on scan.

<u>Dec-25</u>

- No cases reported.

Data



Outstanding Care,
Compassionate People,
Healthier Communities

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People and Culture

Outstanding Care,
Compassionate People,
Healthier Communities

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NHS Foundation Trust

Domain Summary: People and Culture

Overview	Lead: Chief People Officer

As at Dec-25, eight of fourteen People and Culture indicators were meeting or exceeding standards year-to-date (YTD), reflecting our commitment to our workforce. Key areas of compliance include turnover, which remains below the standard at 0.6% YTD. Mandatory and Statutory Training (MaST) compliance has consistently surpassed targets throughout 2025. Recruitment timelines, bank usage, and off-framework agency levels remain compliant, and vacancy levels have improved, maintaining compliance in the last reported period.

Appraisal compliance stands at 88.3% YTD prompting focused efforts to promote the benefits and ensure quality. Divisions and services, supported by Executives during Divisional Performance Reviews (DPRs), are actively challenging and addressing this position. We are attempting to boost our appraisal compliance by giving targeted support to low-performing service lines and strengthening oversight through monthly performance and People and Performance review meetings, however, the static level we have reported we considered to be a consequence of the wider hospital pressures and elevated absence levels.

Sickness absence is 5.2% YTD, above the 4.2% standard, and in line with national trends driven by seasonal illness, treatment delays and increased pressure on frontline staff. We are strengthening prevention and support through a new wellbeing information hub, a manager-focused support offer, and implementation of the NHS Sickness Toolkit.

Employee relations cases remain high due to stronger policy application, with more grievances, dignity at work concerns and disciplinaries; all cases are managed appropriately, and we are strengthening support, promoting Active Bystander training, and developing revised processes to help managers resolve issues informally.

Bank usage has increased which is likely to be related to high Operational Pressures Escalation Levels (OPEL), deployment of our Full Capacity Protocol (FCP) and Industrial Action. However, the position is within statistical control limits and is below our standard.

Agency usage remains above standard, with spikes linked to operational pressures. However, zero off-framework agency use has been maintained, and over-price-cap agency compliance achieved. Plans are in place to cease new agency bookings, with exceptions requiring Executive sign-off, and exit strategies for current agency workers are being implemented. Medical job plan compliance is a notable success, with the Trust improving to 96.9% in Dec-25 against a 95% target. Benchmarking confirms the Trust is in the upper quartile nationally.

The flu vaccination campaign is underway, with internal uptake at 54.3% against a 53.2% target, while NHS England reports 56.5% due to inclusion of external vaccinations. This is already above last year's level. The flu campaign continues until 31 March 2026; we will continue to promote vaccinations to staff and will be undertaking roaming vaccinations, we are also targeting areas of low take up by engaging with managers.

The following pages provide more detailed performance information, relating to the four areas of exception across the People and Culture domain, all of which were discussed in depth at the Trust People Committee in February 2026.

Outstanding Care,
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NHS
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NHS Foundation Trust

Scorecard: People and Culture

People and Culture

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Belonging in the NHS	Engagement score	≥6.8%	≥6.9%			✗ 6.8			-			-	✓ 7.1	✓ 6.8				
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✓ 7.9%	✓ 7.8%	✓ 8.2%	✓ 8.0%	✗ 8.6%				
	Time to hire	n/a	≤53.1 days	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0	✓ 25.0	✓ 36.0	✓ 21.0	-		-				
	Turnover in month	≤0.9%	≤0.9%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.8%	✓ 1.0%	✓ 0.6%	✓ 0.6%	✓ 0.7%	✓ 0.6%				
	Appraisals	≥90%	≥90%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 88.2%	✗ 87.5%	✗ 87.4%	✗ 87.5%	✗ 89.0%	✗ 88.3%				
	Mandatory & statutory training	≥90%	≥90%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 92.9%	✓ 93.3%	✓ 93.6%	✓ 93.6%	✓ 91.5%	✓ 93.1%				
	Medical job plan compliance	n/a	≥95%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%	✗ 94.0%	✓ 95.9%	✓ 96.6%	-		-				
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 4.8%	✗ 5.7%	✗ 5.6%	✗ 5.9%	✗ 5.0%	✗ 5.2%				
	Flu vaccinations uptake (front line staff)	≥75%	≥75%	-	-	-	-	-	-	✗ 35.8%	✗ 50.7%	✗ 54.3%	✗ 58.0%					
	Employee relations management	<17	<21	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✓ 20	✓ 21	✓ 20	✗ 26	✗ 21	✗ 21				
New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 6.3%	✓ 7.1%	✓ 6.3%	✓ 6.9%	✓ 7.1%	✓ 5.2%	✓ 4.8%	✓ 6.8%	✓ 7.5%	✗ 8.9%	✓ 6.4%				
	Agency usage	<3.2%	<1.9%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 2.3%	✗ 2.6%	✗ 2.0%	✗ 2.0%	✗ 4.0%	✗ 2.6%				
	Agency (off framework)	0%	0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
	Agency (over price cap)	≤40.0%	≤40.0%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 40.9%	✓ 33.4%	✓ 33.6%	✓ 39.5%	✗ 52.9%	✓ 37.6%				

Indicator in Focus: Appraisals

Sherwood Forest Hospitals NHS Foundation Trust

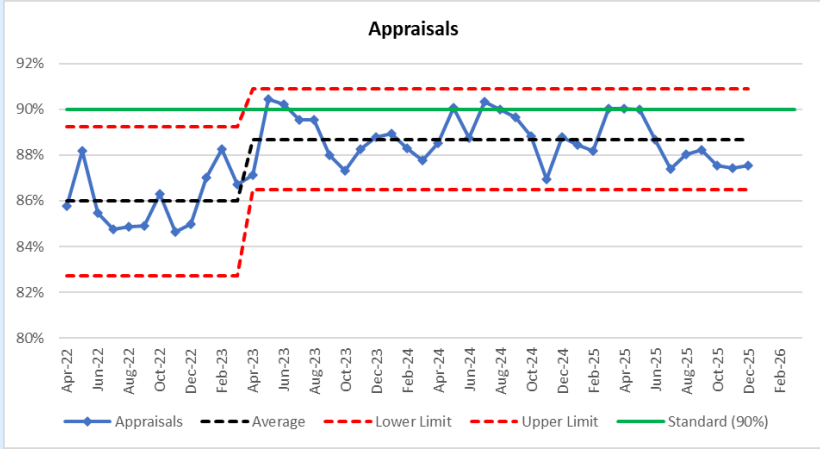
Overview and national position

Our appraisal level sits below the Trust target (90%). Performance has flattened during quarter three and has remained at a level lower than the standard. The year-to-date position is at 88.3%. Performance during 2025/26 continues to fall between the upper and lower statistical control limits demonstrating movement within usual variation. Although the position is below standard, this is a strong level compared to the wider ICB level (84% in Nov 25).

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

We are taking a focused approach to improving appraisal compliance by supporting service lines with lower rates to develop clear improvement trajectories and strengthening oversight through monthly service-line and People and Performance review meetings. These forums highlight non-compliance early and enable targeted support to address operational pressures such as patient acuity, annual leave cycles and absence levels. Through consistent challenge, clearer accountability and tailored support, we aim to steadily increase compliance and move back above the 90% standard.

Data



NHS Corporate Benchmarking (2024/25)

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

Root causes

Patient demand and hospital acuity has impacted on compliance.

Annual leave and absence levels.

Actions and timescale

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

Impact

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

Indicator in Focus: Sickness Absence

NHS Sherwood Forest Hospitals

Overview and national position

The year-to-date sickness position is reported at 5.2%, sitting above our standard (4.2%), with the monthly position being equivalent to the upper SPC limit (5.9%). We have seen an increase in sickness absence levels across all divisions, with conditions relating to cold/influenza and musculoskeletal (MSK) showing monthly increases. Anxiety is still the Trust top reasons for absence.

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

Work is underway on the development of a wellbeing information hub and we are focusing on the prevention agenda. Our initial focus is on managers to ensure they provide support, signposting and the right environment where colleague feel safe and supported. We are also working through the recently published NHS Sickness toolkit/framework.

In Dec-25 the Midlands sickness average was 6%. It is recognised by NHS England that this higher level is attributed to higher physical and emotional demands on frontline staff, greater exposure to infectious diseases and increased stress and burnout, especially in emergency and inpatient services. We have received the Trust NHS Oversight Framework (NOF) ratings across the people domain and the provider score for quarter two sickness absence is scored at 2.74 (segment three), with the peer average at 2.69 (ranked between 1-4).

Root causes

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

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

Actions and timescale

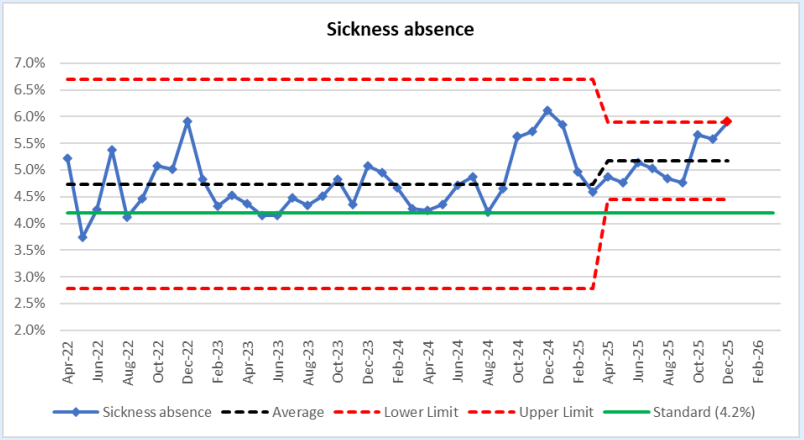
- Sickness absence support and guidance given through dedicated members of the People Services team. New process with one-to-one support from the People Service teams with sickness absence management on a case-by-case basis and in line with policy re-focusing on fundamentals.
- Medical sickness absence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

Impact

Reduce levels of sickness.

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

Data



NHS Oversight Framework – Sickness Absence

Q2 2025/26	2.74	NOF Score	Provider value

Indicator in Focus: Employee Relations Management

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

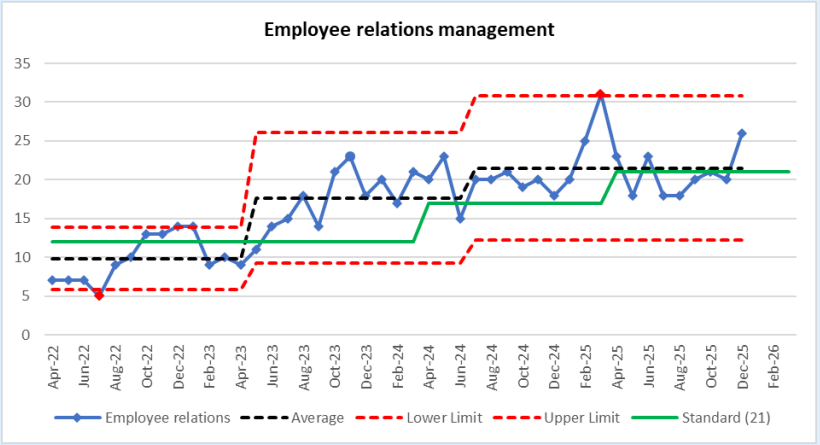
During 2025/26 the employee relations level has fluctuated between 18 and 26 cases, with the average of quarter three being 21 cases. The increased level of employee relations within Dec-25 was related to formal disciplinary processes, dignity at work and grievances cases.

We are managing in line with the Trust policy and are ensuring concerns are dealt with informally within the first instance; however, we have had several complex cases recently whereby this has not been possible. We are seeing a rise in grievances and dignity at work relating to behaviours either colleague-to-colleague and/or manager behaviours in relation to decision or actions taken towards the employee. There are also several safeguarding cases that we are finalising.

Continued actions are being put in place to ensure support is put in place for all colleagues involved in employee relations matters and we continue to promote Active Bystander training and encourage staff to speak out. To support managers in dealing with more cases informally we are developing a revised process and training, so managers feel more enabled and are confident in dealing with staff concerns informally.

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

Data



Root causes

The increases in cases are driven due to hospital pressures and the stronger application of policies. Some cases are due to strained relationships at work, that are driving poor employee behaviour.

Disciplinary investigations dignity at work and grievances cases are the key employee relations reason within the quarter.

Actions and timescale

- All cases are managed using Just Culture Principals and take a person-centred approach with additional training taking place.
- Partnership working continues with Staff Side representatives, Clinical colleagues and People Directorate colleagues in management of cases.
- Enhanced wellbeing support has been developed to support colleagues who are part of any employee relations process.
- Person-centred approach is in place in relation to Sickness Absence management.
- Re-emphasis on an informal resolution to incidents, concerns and adverse events, where possible.

Impact

The work we undertake supports our workforce as are we move into 2025/26 quarter four. We do not expect this to reduce immediately.

Indicator in Focus: Agency Usage

NHS Sherwood Forest Hospitals NHS Foundation Trust

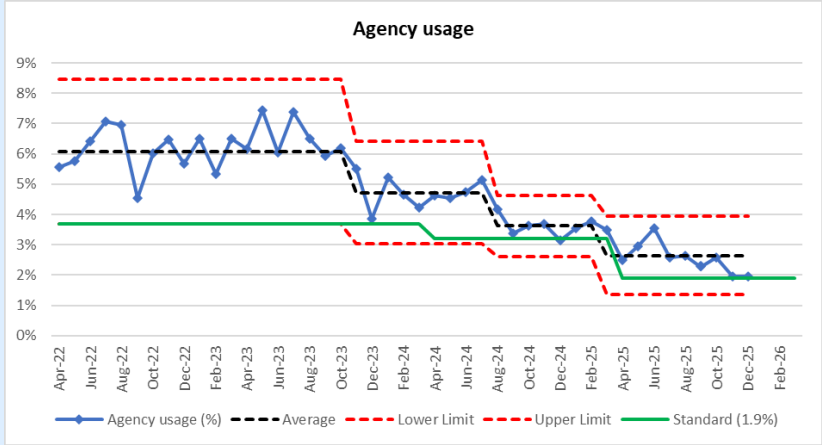
Overview and national position

The year-to-date agency position is reported at 2.6%, with the Dec-25 position at 2%. This sits above the standard (1.9%). Our current agency position for Dec-25 shows a zero usage of off-framework agencies and a strong performance within 'on-framework, over-price-cap' position (39.5%).

In Dec-25, we delivered a 47.6% reduction to agency usage from the Nov-24 baseline level. Reduction in the metrics is aligned to our workforce efficiency programmes and the work we are undertaking on the 'on-framework, over-price-cap', as key reductions in over-price-cap support reductions to the overall agency target. We are also working towards the East Midlands Acute Provider work on rate compliance by 2025/26.

The run rate chart shows a reduction to a current position in Dec-25 at 2%. In 2023/24, the average rate was 3.85% and 3.15% within the 2024/25 period, with the current year-to-date rate at 2.6%. The Trust has undertaken significant which is resulting in a sustained reduction in agency usage.

Data



Root causes	Actions and timescale	Impact
Our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services where there are national specialty shortages. There has been an increase to the agency position over the last two months that is largely due to the submission of late timesheets, which is distorting the position.	• To cease all new agency bookings, with any exceptions to be signed off by the Executive lead.	Target to reduce the agency level to 1.5%.
	• We continue to advertise and fill medical posts, that has gradually reduced our agency level. We organise medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff where possible onto direct engagement contracts.	Over the 2025/26 period, we are focusing on medical staff who are on-framework, but over the NHS England price-cap and are developing plans to exit these agency workers and replace with substantive roles.
	• Develop exit strategies with clear timescales for all agency workers to be developed and presented to Transformation Groups for agency staff and escalated to our Trust Management Team.	

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Timely Care

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Domain Summary: Timely Care

Overview

Lead: Chief Operating Officer

In recent months, the challenges within our Urgent and Emergency Care (UEC) pathway have persisted and, at times, intensified. This is reflected in our reported UEC performance metrics and in the two recent business continuity and critical incidents in early Jan-26. Accident and Emergency (A&E) 4-hour performance has continued to track below 70% since Aug-25, though was improved in Nov-25 and Dec-25 relative to the equivalent months in 2024. A&E 12-hour performance and ambulance handover times have deteriorated significantly to the most challenged levels observed in recent times. This is against a backdrop in Dec-25 of a 1% growth in attendance levels in our King's Mill type 1 service (compared to Dec-24) and a seasonal increase in acuity. Since Sep-25, the Nottingham Emergency Medical Services (NEMS) primary care 24 service has seen less patients than in the same periods in the last two years. Our Newark type 3 service continues to see increased attendance demand (10% more patients in Dec-25 compared with Dec-24). Delays in admitting patients into King's Mill Hospital in a timely manner has resulted in our Emergency Department (ED) being overcrowded at some of the most challenging levels ever observed (particularly our majors department). This overcrowding has meant that we have not always been able to accept patients arriving by ambulance as promptly as we have previously. A&E overcrowding increases the risk of delay-related harm and deteriorated patient experience. The outflow issues from ED are due to hospital flow challenges, where we have seen increased levels of medically safe patients in our hospitals since Jun-25 and high overall bed occupancy. We continue to open more beds in core hours utilising the newly created additional spaces on our wards (fifth space added to each bay on our medical wards) to provide patient care. We remain focused on actions to improve board round processes on our wards and reduce discharge delays.

In terms of planned care, our 52-week wait backlog was at 0.96% of the total Patient Tracking List (PTL) in Dec-25; below the 1% operational planning guidance target to be achieved by the end of 2025/26. Our PTL size also decreased in Dec-25 following a period of stability. However, 18-week Referral to Treatment (RTT) performance has deteriorated to 59.3% in Dec-25. Whilst we benchmark well nationally, we have fallen further from our plan which was to deliver a mandated 5% improvement on Nov-24 performance. 18-week first outpatient appointment performance has also deteriorated; this is a significant driver of 18-week RTT performance. Our deviation from our 18-week plan triggered us to be put into tiering over the summer of 2025, resulting in more intense scrutiny from the NHS England regional and national team. Actions have been developed, particularly on the non-admitted pathway, to recover performance in the closing quarter of 2025/26. We continue with strong performance providing patient initiated follow up delivering performance consistently better than the standard.

Our diagnostic DM01 performance continues to improve following a dip in the summer of 2025, closing at 92% in Dec-25. This is reflected in our benchmarking position which is consistently above the national average. Previously released insourcing capacity has been reinstated for Echocardiography and additional capacity has been generated for Sleep Studies, which have combined to support the improvement observed in Dec-25.

Our cancer performance for the 28-day faster diagnosis standard and the 62-day treatment standard remains favourable to plan, with 62-day cancer performance levels especially strong in Nov-25 and benchmarking well. Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024, closing in Dec-25 at 93%. While improved, this is below the 96% national standard, which is our operational plan. The cancer 62-day backlog continues to fluctuate, following seasonal trends. Recovery plans are in place across several tumour sites with further details included in this report.

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

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Scorecard: Timely Care

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

Timely Care

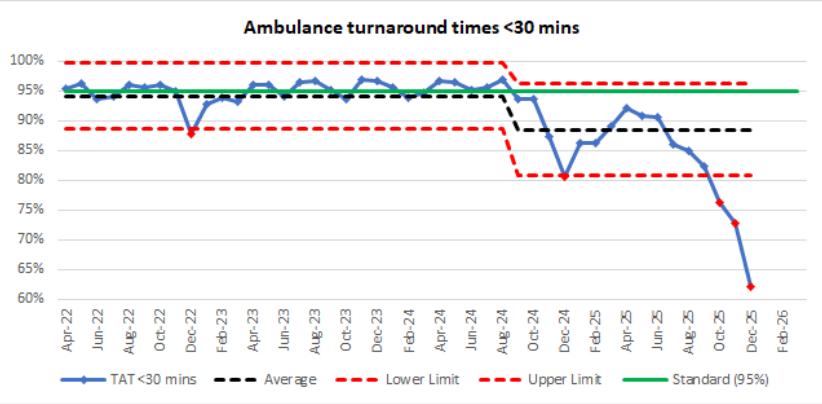
Green tick = target met/exceeded; Red cross = target not met

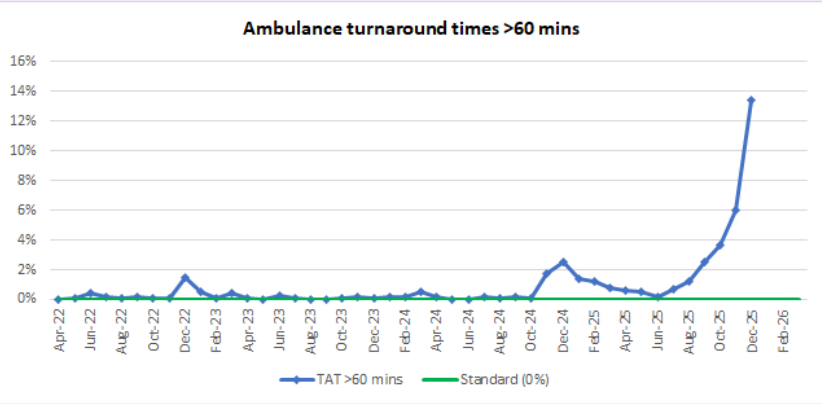
At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD	Latest Benchmark Position (Nov 25)	STAR Data Quality Assurance S	T	A	R
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗92.1%	✗90.8%	✗90.5%	✗86.0%	✗85.0%	✗82.3%	✗76.2%	✗72.8%	✗62.2%	✗91.4%	✗81.7%	✗ 108 / 176				
	Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 2.5%	✗ 3.7%	✗ 6.0%	✗13.4%	✗ 0.7%	✗ 3.3%	✗ 117 / 176				
	ED 4-hour performance	≥76%	≥Plan	✓77.3%	✓79.0%	✓76.8%	✗72.4%	✗68.8%	✗68.0%	✗67.4%	✗67.3%	✗67.0%	✗71.0%	✗71.6%	✗ 115 / 152				
	ED 12-hour length of stay performance	≤2%	≤2024/25	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 5.6%	✗ 8.2%	✗ 7.2%	✗ 9.2%	✗ 3.4%	✗ 4.9%	– 77 / 177				
	Mental health patients spending over 12 hours in A&E	n/a	No Standard	18	21	19	22	24	23	27	17	9	23	180					
	Adult G&A bed occupancy	≤92%	≤92%	✗94.6%	✗95.2%	✗95.5%	✗96.2%	✗95.9%	✗96.3%	✗97.4%	✗96.1%	✗95.9%	✗94.5%	✗95.9%	– 83 /179				
	Average number of days between planned and actual discharge date	n/a	≤Plan	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.1	✗ 4.0	✓ 3.5	✓ 3.3	✓ 3.6	✓ 3.4	3.1	✓ 3.6					
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 82	✗ 72	✗ 84	✗ 89	✗ 64	✗ 74					
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓11.1%	✓10.7%	✓10.5%	✓10.7%	✓10.9%	✓11.1%	✓11.1%	✓11.2%	✓11.2%	✓ 6.0%	✓10.9%	✓ 4 / 134				
	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	✗63.7%	✗64.0%	✗64.1%	✗62.9%	✗61.3%	✗61.9%	✗60.4%	✗60.3%	✗59.3%	64.6%	✗62.0%	✗ 96 / 150				
	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	✓ 0.9%	✓ 0.9%	✓ 0.8%	✓ 1.0%	1.3%	✓ 1.0%	✓ 46 / 150				
Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✗88.9%	✗87.1%	✗88.2%	✗87.9%	✗87.6%	✗89.8%	✗90.4%	✗89.8%	✗92.0%	✓93.1%	✗89.8%	✓ 39 / 132				
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓77.6%	✓76.4%	✓82.4%	✓83.1%	✓82.3%	✓80.7%	✓82.2%	✓79.4%	-	✓78.3%	✓80.6%	– 56 / 134				
	Cancer 31-day treatment performance	≥Plan	≥96%	✗87.6%	✗94.4%	✗91.2%	✗89.0%	✗84.8%	✗88.4%	✗91.7%	✗93.6%	-	✓91.9%	✗90.1%	✗ 85 / 136				
	Cancer 62-day treatment performance	≥Plan	≥Plan	✓65.5%	✓63.3%	✓65.3%	✓66.9%	✓72.4%	✓63.1%	✓65.3%	✓75.7%	-	✗64.4%	✗66.9%	✓ 54 / 136				

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

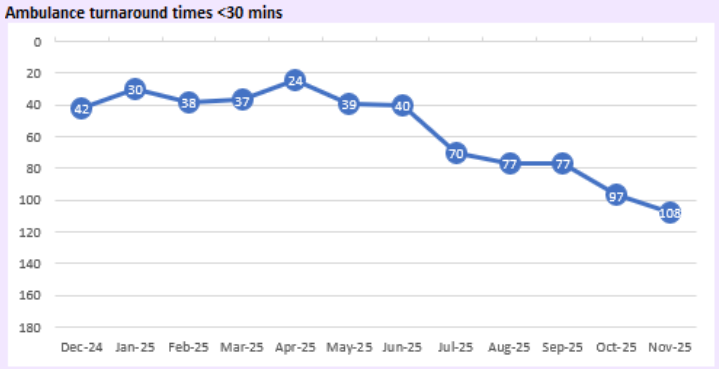
Sherwood Forest Hospitals NHS Foundation Trust

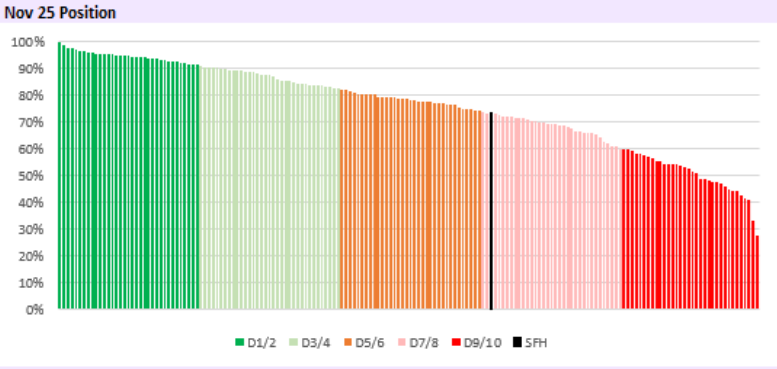
Local data (to Dec-25)

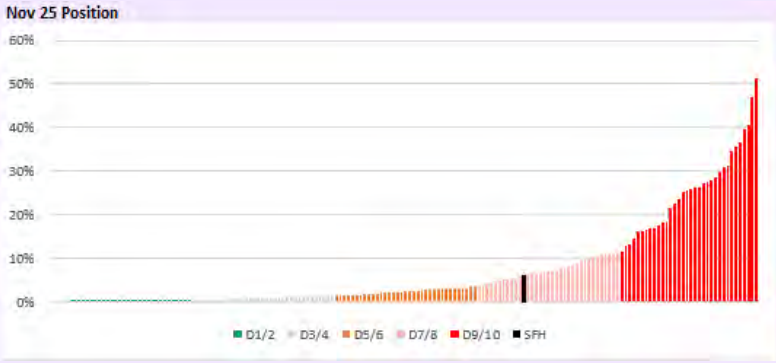




Benchmark position (to Nov-25)



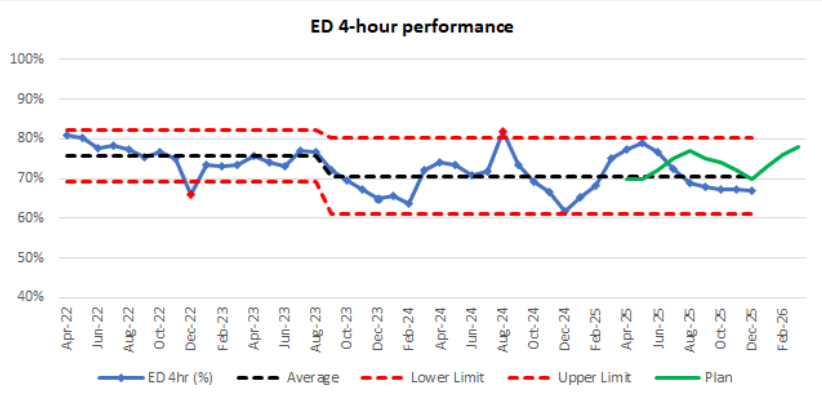


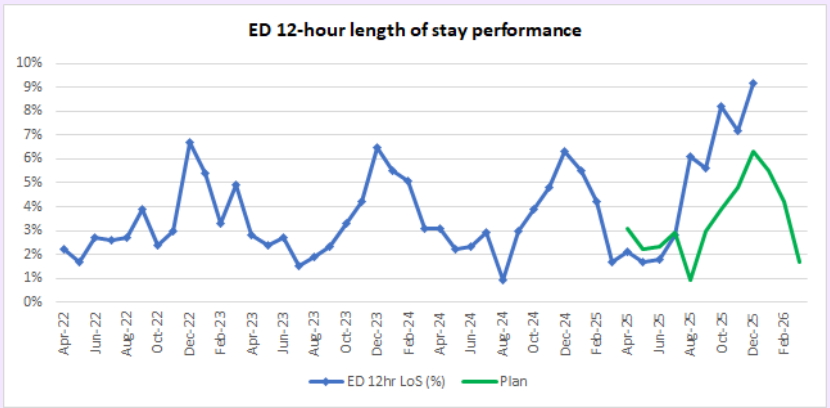


Indicators in Focus: Urgent Care – A&E (2/4)

Sherwood Forest Hospitals NHS Foundation Trust

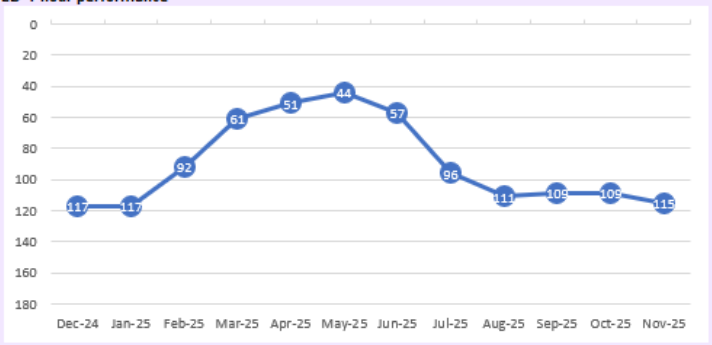
Local data (to Dec-25)



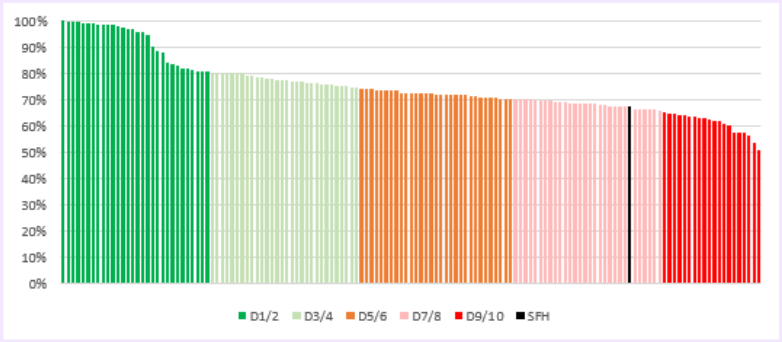


Benchmark position (to Nov-25)

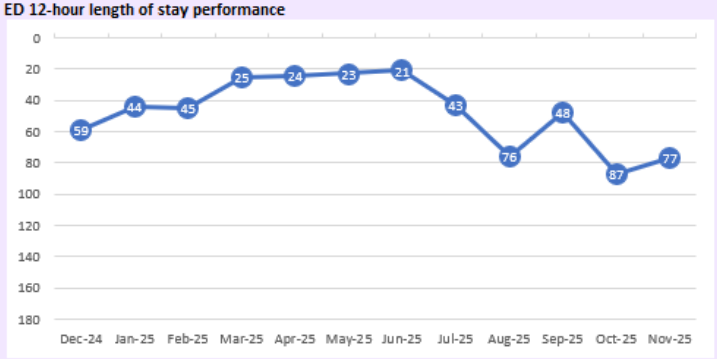
ED 4-hour performance



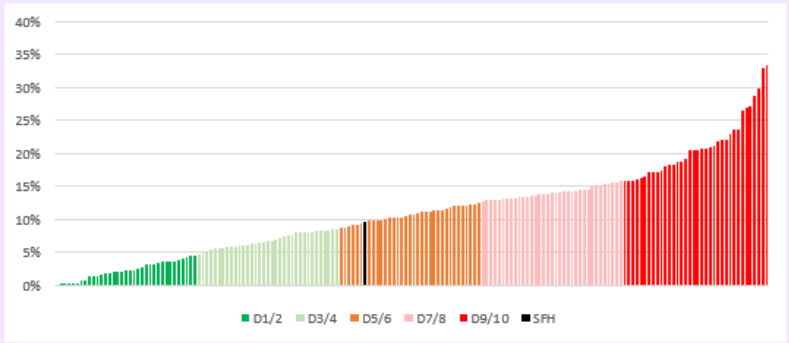
Nov 25 Position



ED 12-hour length of stay performance



Nov 25 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

As detailed on slide one of four within this section of the report, ambulance 30-minute handover performance deteriorated to 62% in Dec-25, having peaked at 92.1% in Apr-25. This drop in performance has triggered as special cause variation for the third consecutive month. Our deterioration is reflected in our benchmarking position, which has dropped into the seventh decile. Ambulance 60-minute handover performance also deteriorated, with 13% of arrivals being handed over in more than one-hour in Dec-25; our poorest performance for several years. This deterioration is also reflected in our benchmarking position trend where we have dropped into the seventh decile of Trusts nationally in Nov-25. Our average ambulance turnaround time in Dec-25 was circa 33 minutes; this is our worst value in recent years and above Dec-24 (which was circa 21.5 minutes). Comparing Nov/Dec-25 with the same period in 2024, we have seen a 2.3% growth in ambulance conveyance demand.

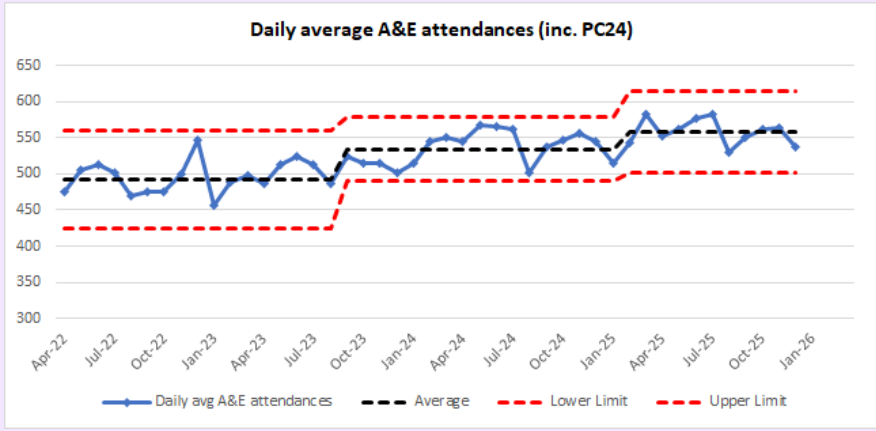
As detailed in slide two of four within this section of the report, Accident and Emergency (A&E) 4-hour performance has remained low in Nov-25 and Dec-25, below our operational plan (by circa 3% in Dec). However, our Dec-25 position was higher than the performance we achieved in the same period in the past three years. Our benchmarking position remains low, and we are 115th nationally out of 152 Trusts in Nov-25. A&E 12-hour performance deteriorated further and in Dec-25 was the highest level we have seen and worse than previous winter periods. From a benchmarking perspective, we have dropped into the fifth decile and are 77th nationally; slightly better than the national average.

Daily average A&E attendances and patient acuity (based on National Early Warning Scores) followed similar seasonal trend as in 2024 at a macro level in recent months. Overall attendance levels in Nov and Dec-25 were slightly lower than peaks in Jun and Jul-25 (see adjacent chart); however, patient acuity has been higher over the winter period (as expected). From an attendance perspective, there have been demand shifts. Newark Urgent Treatment Centre saw 10% more patients in Dec-25 than the previous year and our King's Mill type one service saw just over 1% more patients. Conversely, the Nottingham Emergency Medical Services (NEMS) run PC24 type three facility saw 24% less patients in Dec-25 than the previous year (an average of 21 less patients per day). Whilst the overall A&E patient demand was slightly lower in Dec-25 compared with the same month in 2022 and 2024, the number of patients seen by SFH-run services increased.

Hospital flow challenges are causing outflow issues in our A&E department with unprecedented levels of delays for patients waiting for admission. The difficulties in admitting patients in a timely basis results in overcrowding, which is driving the poor 4-hour and 12-hour emergency access performance and the 30 and 60-minute ambulance handover performance.

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

Additional data (to Dec-25)



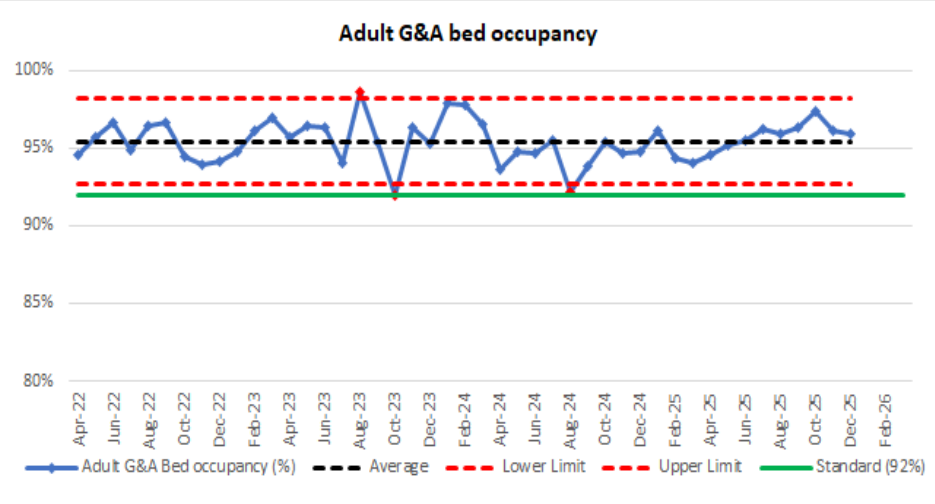
Indicators in Focus: Urgent Care – A&E (4/4)

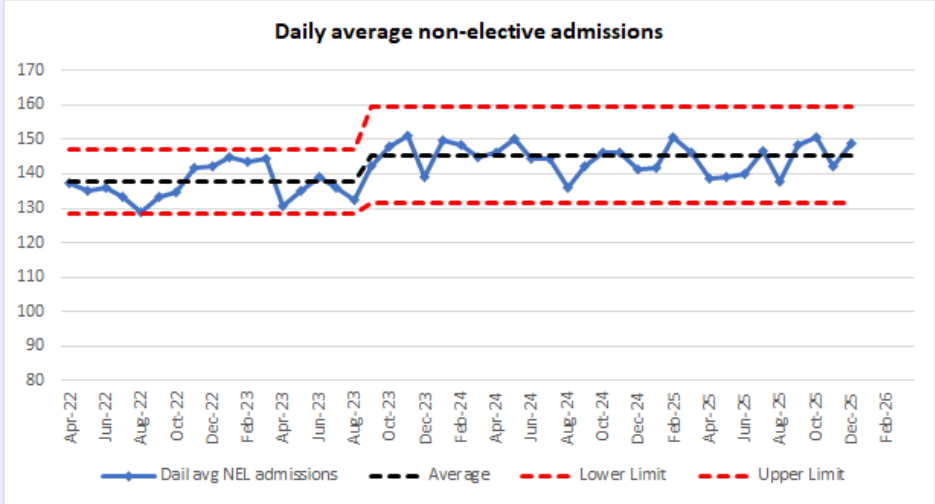
Root causes	Actions and timescale	Impact
High Accident and Emergency (A&E) attendance demand, patient acuity and ambulance conveyance levels.	• Admission and attendance avoidance with system partners include: – Regular engagement with East Midlands Ambulance Service (EMAS) to discuss out of area conveyances. – Focus on frailty attendances: Call before you convey; use of urgent care community response teams. – Development of alternatives to ED workstream in line with the Emergency Care Improvement Plan. – Redirection of patients to Urgent Treatment Centres.	• Reduction in out of area conveyances. • Reduction in category 3 ambulance conveyances. • Reduction in over 65-year-olds where length of stay is one day plus.
	• Optimise approach to Same Day Emergency Care (SDEC) for GP referral attendances across both medical and surgical pathways.	• Increase the number of patients cared in ambulatory pathways and via alternatives to ED.
	• Clinically agree and implement ambulatory pathways to reduce Emergency Department (ED) waiting across Cellulitis, DVT, Heart Failure, Anaemia and Gastroenterology in line with our Emergency Care Improvement Plan.	
	• Deliver and review a navigator streaming model.	
	• Additional clinical shifts added to our minors department in Dec-25 to protect minor and paediatric staffing and support timely patient care in these patient streams.	• Reduce the number of non-admitted breaches of the four-hour performance standard.
	• Maintain medical staffing levels at Newark Urgent Treatment Centre to support timely patient care and strong type three performance.	• Consistently deliver type three performance greater than 95% with the aim to increase to 98%.
	• Liaise with colleagues at NEMS and local commissioners to support appropriate patients to be seen and treated within four-hours in the type three primary care (PC24) service at King's Mill Hospital.	• Reduce the number of type three breaches of the four-hour performance standard within the NEMS PC24 service.
Insufficient staffing to manage A&E demand.	• Recruit five new ED Consultants following review of all vacancies with a move to Consultant on site cover until 2am and improve senior presence during evenings and weekends through rota redesign by end of Feb-26.	• Decrease in mean time in department for non-admitted patients to <180 minutes.
	• Optimise use of the Clinical Decision Unit for ambulatory patients.	
	• Implement two-hourly huddles and clear escalation triggers in ED to support stronger co-ordination.	
	• Implement ED Nervecentre to improve visibility of tasks and escalations to progress patients care journey. This action has been deferred from Nov-25 due to challenges deploying when the department is under sustained pressure. A new deployment date is to be agreed.	
A&E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Additional bed spaces created across our medical base wards in Nov/Dec-25 by installing additional curtain rails. These spaces are used during period of local escalation to allow our wards to accommodate more patients earlier in the day to help improve hospital flow. Works are planned to be concluded in early 2026 in the remaining bays.	• Reduce ED overcrowding and reduce 12-hour length of stay to less than 2%.
	• Patient flow actions detailed on the following slides.	

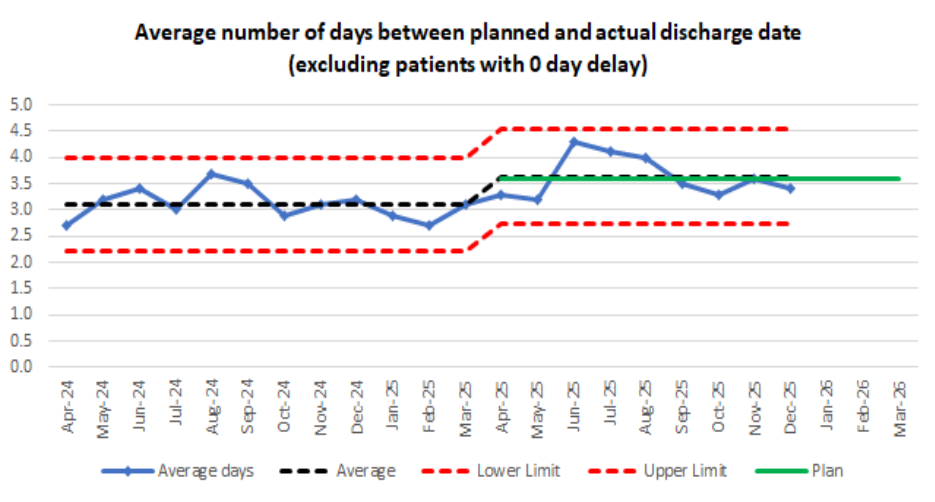
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

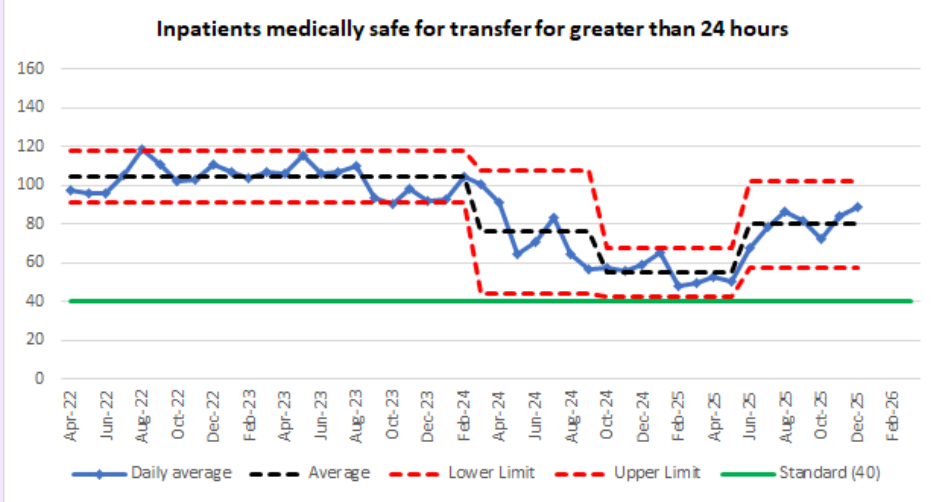
Sherwood Forest Hospitals NHS Foundation Trust

Data (to Dec-25)









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

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Performance observations

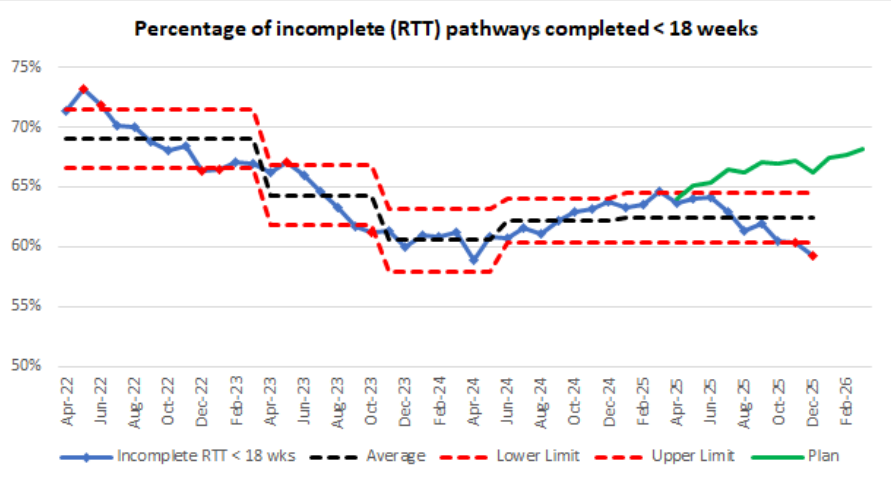
- General and Acute (G&A) bed occupancy remains high. It has been trending between the mean and the upper control limit for the past six months; if this trend continues in the next reporting period it will trigger a control limit change.
- The daily average number of non-elective admissions is trending within standard variation.
- The number of patients Medically Safe For Transfer (MSFT) for greater than 24 hours remains high and has resulted in a control limit change (increase) since our last report. The growth in the medically safe patient numbers is being seen at King's Mill Hospital, with the number of medically safe patients in our peripheral beds remaining relatively stable. Growth in the number of medically safe patients will contributed to extended patient length of stay placing pressure on our bed capacity.

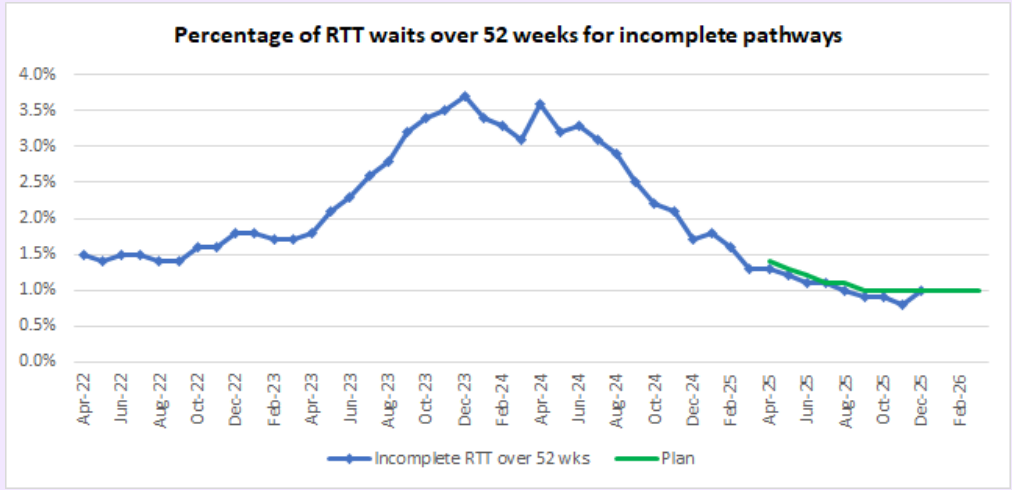
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• The 'Getting the Basics Right' programme and Trust Recovery Group championed by the Chief Operating Officer and Chief Medical Officer. Focus on effective board rounds and ward processes to reduce delays and improve patient length of stay. Wards in phases one and two are complete with phase three taking place in Jan-26.	• Reduced delays and improved patient length of stay across all discharge pathways.
	• Daily ward-level discharge targets in place since Nov-25 with work ongoing to fully embed.	
	• Increased focus on the importance of keeping our clinical systems up to date with items including the predicted date of becoming medically safe, medically safe status and home today status. Automatically generated, patient-level reports created in Nov-25 to track patients and support patient flow decisions.	
Delays to post-medically safe discharge processes.	• The discharge team undertake a daily review of all patients medically safe for greater than 24 hours to identify actions to support timely discharge. Actions are on a live patient tracking list with updates and resolutions monitored throughout the day. Shared medically safe list embedded across all Divisions, enabling timely updates of actions to assist patient discharge.	• Improve length of stay (LOS) for complex discharges across our hospitals. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges.
	• Maximising use of the discharge lounge for patients being discharged and transferred between sites.	• High utilisation of the discharge lounge.
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. EMED Group and Ambicorp conveyances continue to be under local and system-wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge.
Insufficient community capacity to meet supported discharge demand.	• Working with health and care partners (predominantly Adult Social Care) to resolve issues with a lack of Packages of Care (POCs) and delays in allocation of social workers to complex cases.	• Reduce the number of medically safe patients in our hospitals.
	• Working with Derbyshire social care to address delays in placing pathway two patients.	

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

Sherwood Forest Hospitals NHS Foundation Trust

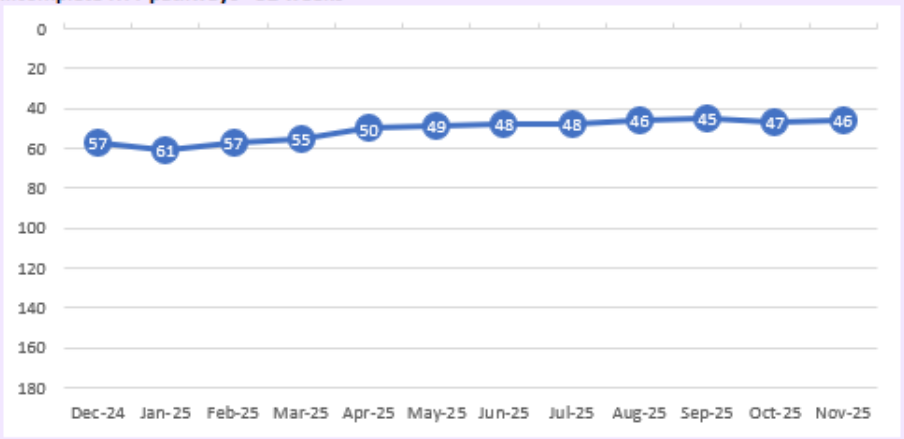
Data



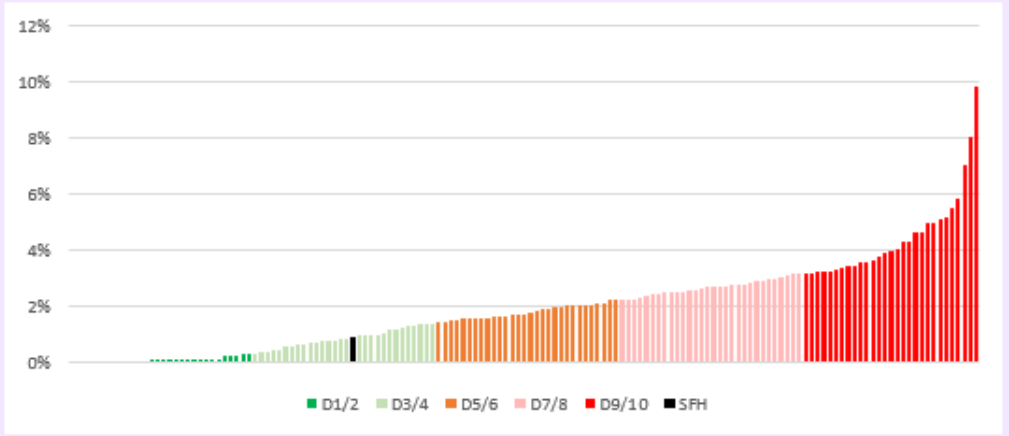


Benchmarking Position and Standings (to Nov-25)

Incomplete RTT pathways +52 weeks



Nov 25 Position



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

NHS Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

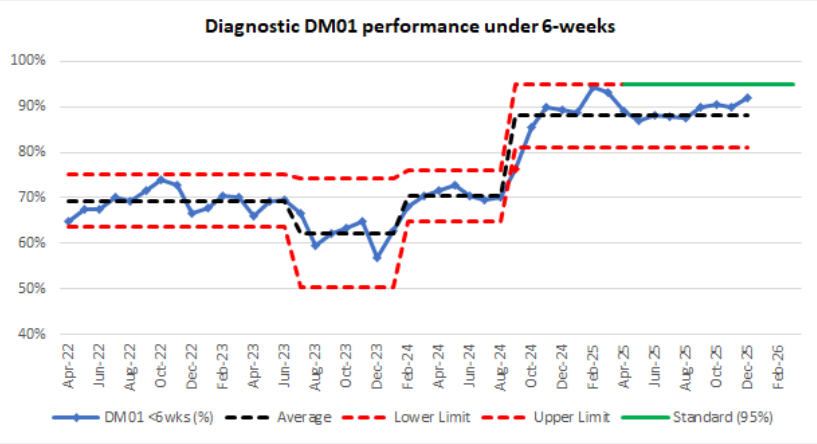
- Referral to Treatment (RTT) 18-week performance at SFH has decreased to trigger special cause variation in the last two months. Performance in Dec-25 was 6.9% below our operational plan, which is set to deliver a 5% improvement on our Nov-24 position (as mandated in the national planning guidance). This is, in part, being driven by a deteriorating position in the proportion of patients receiving a first outpatient appointment within 18-weeks. Latest national benchmarking data places us above the national median.
- 52-week wait pathways remain inside our operational plan target for the end of 2025/26 (to achieve 1% of the total incomplete PTL [Patient Tracking List]). Our benchmarking position remains strong.
- We continue to provide support to Nottingham University Hospitals through treatment of Urology long waits; which increases risk to our PTL and long wait backlog size.

Root causes	Actions and timescale	Impact
Insufficient capacity within key specialities to meet demand.	• Cross-provider PTL and support for patients in place.	• Treat longest waiting patients first regardless of provider.
	• Ongoing insourcing to increase ENT capacity.	• Reduce the number of long wait patients.
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 including: – Continue insourcing for priority areas until sustainable internal solutions are in place. – Substantive appointment made, commencing Feb-26 (additional appointments were made but candidates withdrew). Opportunities to recruit to two further posts are being explored. – Building relationships with University Hospitals of North Midlands to enhance specialist registration opportunities for neuro and cardiothoracic surgery training.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations. • Sufficient and sustainable workforce.
Insufficient baseline capacity to reduce first appointment backlogs.	• Outsourcing ENT first appointments commenced in Aug-25 and is ongoing.	• Reduce waits for first ENT outpatient appointments – 302 patients successfully transferred. • Equalise first appointment waits in ENT sub-specialties. • Mitigate a reduction in Dermatology first appointment performance, whilst increasing cancer. • Reduced waits for first Ophthalmology appointments – 184 patients successfully transferred. • Improve Trust performance against first activity trajectory.
	• Revision of ENT and Audiology capacity to increase new appointments for referrals.	
	• Dermatology locum appointment commenced Nov-25 to increase capacity for cancer and long waits. Due to unplanned sickness capacity will not be fully realised until end of Jan-26.	
	• Ophthalmology first appointment outsourcing commenced in Sep-25 and is ongoing.	
	• Additional Ophthalmology staffing in place and training underway to increase clinic capacity by Mar-26.	
	• Gastroenterology Referral Assessment Service (RAS) introduced Jul-25 and replacement locum appointment made Nov-25 to increase new capacity by appropriately directing referrals and offsetting lost capacity – to be realised in quarter four due other leavers further reducing capacity.	
PTL data quality and ability to sustain a 'clean' PTL and management of all failsafe reports due to insufficient validation resource.	• Robotic Process Automation (RPA) pilot and Federated Data Platform (FDP) project commenced in Jun-25, both supported by NHS England, deferred to go live in 2025/26 quarter four.	• PTL will be ‘clean’ and represent only those patients genuinely waiting treatment. • Reduce incomplete PTL size through validation.
	• Workforce change to increase validation capacity completed as planned in 2025/26 quarter three and recruitment to vacancies is now underway.	

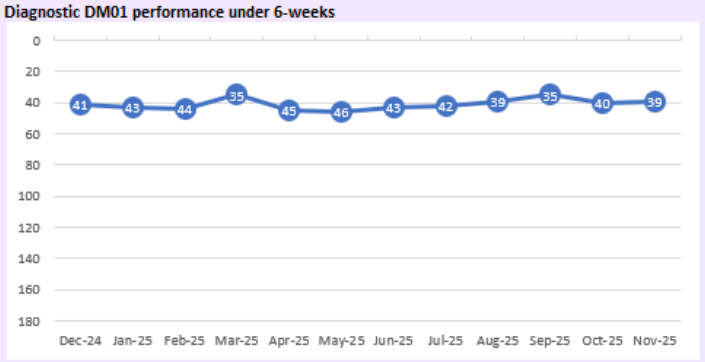
Indicators in Focus: Diagnostics (1/2)

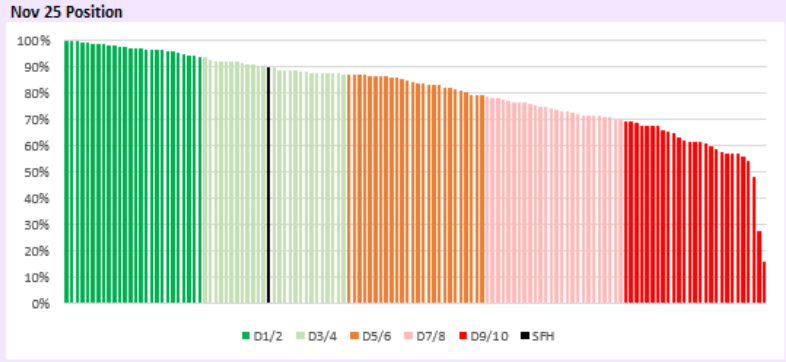
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Dec-25)



Benchmark position (to Nov-25)





Performance observations

- Our diagnostic DM01 performance has improved over the last three months and is close to achieving the peak levels observed during Feb-25, though this remains below target. This is reflected in our benchmarking position which is consistently above the national average.
- The 2024/25 improvement and subsequent deterioration in Apr-25 from Feb/Mar-25 highs was driven by Echocardiography following the introduction and then the release of insourcing capacity. Echocardiography is the main driver of overall Trust DM01 performance. Trends in the service generally result in a similar overall position trend; this includes the improved performance since Sep-25, which was driven by Echocardiography.
- Sleep studies is the second most challenged modality with performance trending in recent months between 65 and 70%. This position is also improving following extra testing capacity being in place.

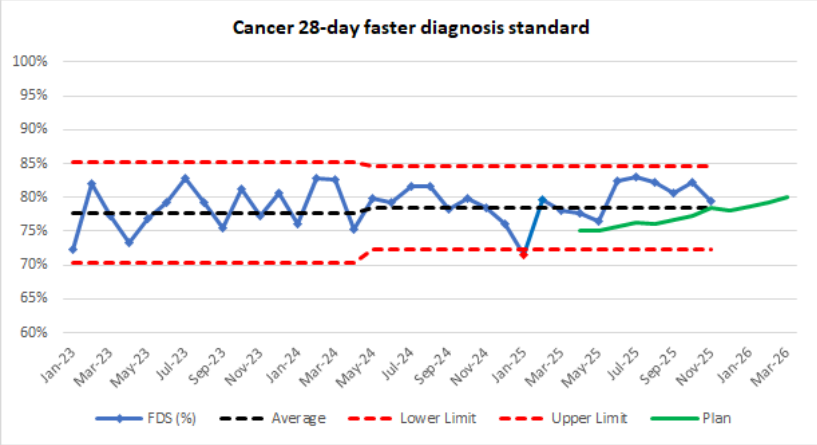
Indicators in Focus: Diagnostics (2/2)

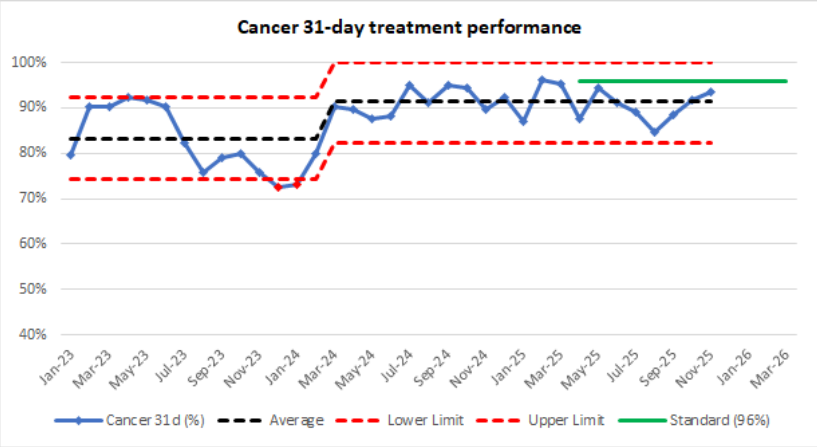
Root causes	Actions and timescale	Impact
Insufficient Echocardiography baseline capacity to reduce the number of patients waiting and reduced Administration and Clerical (A&C) capacity to manage bookings.	• Insourcing remains in place to support delivery of planned activity levels.	• DM01 performance in this modality increased to >80% in Dec-25 for the first time since Mar-25. • Reduction in long waiters by 30%.
	• Move to Health Roster for rota planning to ensure rotas are available to schedule patients a minimum of six weeks in advance is underway to be complete for quarter 1 2026/27.	• Advanced booking of appointments to enable greater patient choice, improved scheduling and better utilisation of capacity.
	• Identification of additional specialist capacity.	• Reduction in patients waiting over 13-weeks.
	• Improved booking process to enable timely patient choice.	
Insufficient baseline capacity to reduce backlogs in Sleep (backlog caused by an increase in out of area referrals throughout 2024 which has now stabilised in 2025).	• Additional backflash devices and storage lockers procured from end Nov-25. Scoping the potential to expedite Community Diagnostic Centre (CDC) is underway.	• DM01 performance in this modality increased to >70% in Dec-25 for the first time since Jun-25. • Reduction in long waiters by 28%. • Eradication of 13-weeks achieved. • Additional 16 sleep studies per week.
	• Successful recruitment to technician and physiologist capacity to increase sleep studies following a successful bid to purchase an additional 11 devices.	

Indicators in Focus: Cancer (1/3)

Sherwood Forest Hospitals NHS Foundation Trust

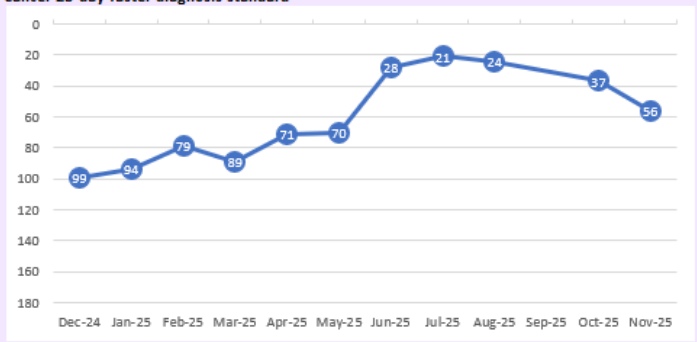
Local data (to Nov-25)



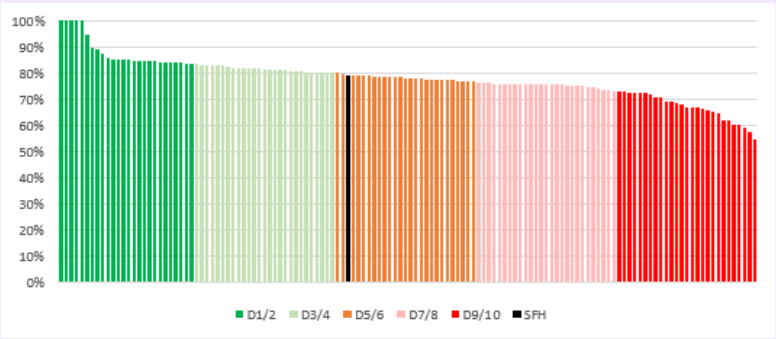


Benchmark position (to Nov-25)

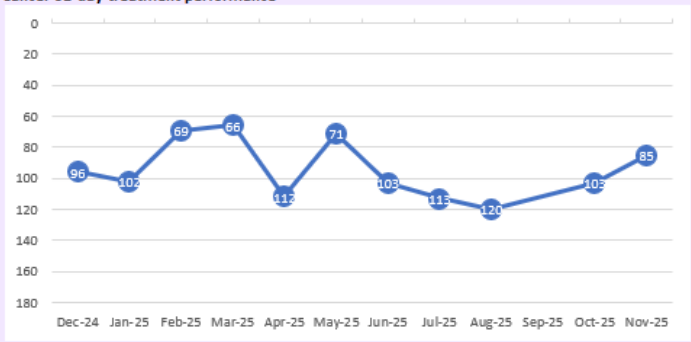
Cancer 28-day faster diagnosis standard



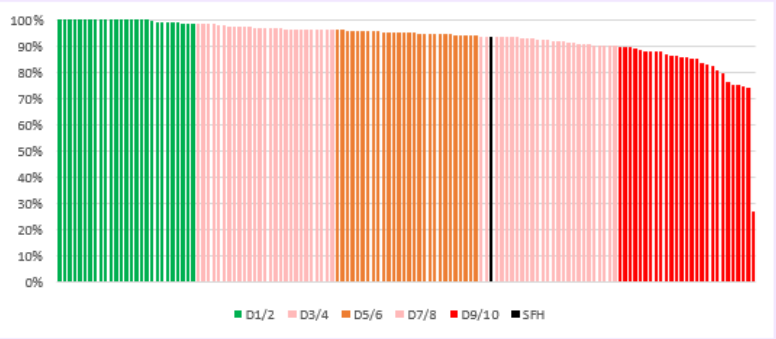
Nov 25 Position



Cancer 31-day treatment performance



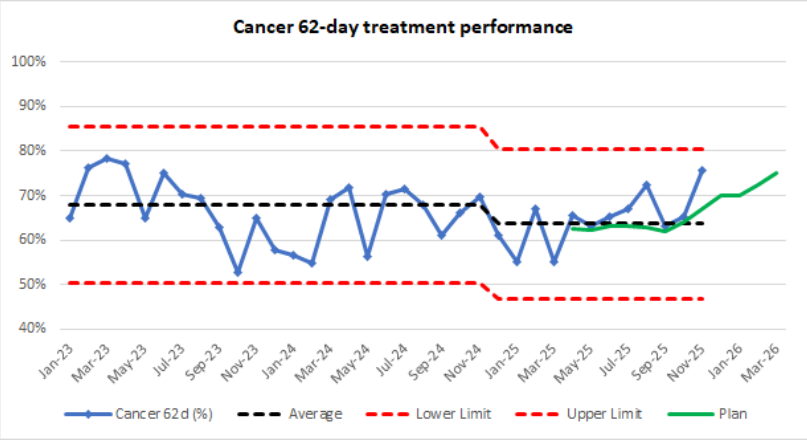
Nov 25 Position



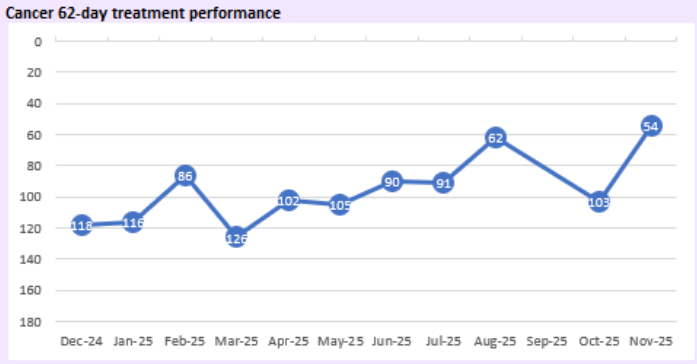
Indicators in Focus: Cancer (2/3)

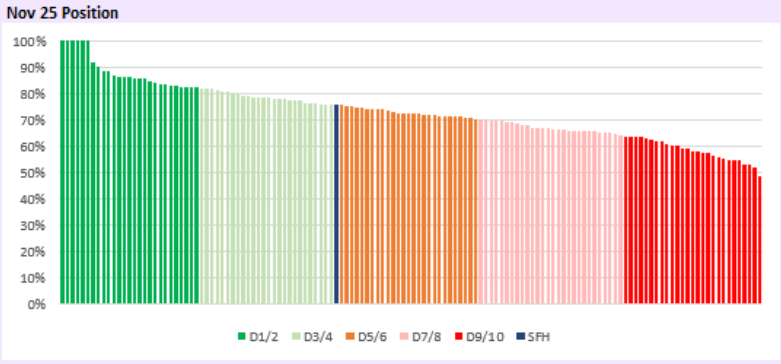
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Nov-25)



Benchmark position (to Nov-25)





Performance observations

- Cancer 28-day Faster Diagnosis Standard (FDS) is moving within statistical process control limits and is better than our operational plan, which requires performance of 80% by the end of 2025/26 as part of the national ambition. Performance has been trending between the mean and the upper control limit for the past six months; if this trend continues in the next reporting period it will trigger a control limit change due to our sustained improvement. Our benchmark position remains in the top quartile nationally.

- Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024, closing in Nov-25 at 93%. This is below the 96% national standard, which is our operational plan. Our benchmarking position remains challenged in the eighth decile. To benchmark in the upper quartile, we need to exceed the 96% national standard.

- Cancer 62-day treatment performance achieved a yearly high of greater than 75% in Nov-25 and has remained above plan all year. However, we have further work to do this year to sustain this position and achieve our plan for the remainder of 2025/26. The operational plan requires improvement to 75% by the end of 2025/26 as part of the national ambition. Our Nov-25 performance saw us rise into the fourth decile from a benchmarking perspective.

Indicators in Focus: Cancer (3/3)

Root causes	Actions and timescale	Impact
Insufficient capacity to meet Radiology reporting turnaround targets.	• Recruitment to four Whole Time Equivalent (WTE) Consultant Radiologists to commence for 2026/27 deployment. • Reporting support through East Midlands Cancer Alliance which is funding additional sessions and increased outsourcing.	• Improve Radiology reporting turnaround.
	• Review of Head and Neck ultrasound referrals and demand to understand capacity issues and increase volume. • Appointment of substantive Head and Neck Radiologist to commence in Feb-26.	• Reduce backlog.
	• Ongoing review of Lung Biopsy capacity and flexibility, noting restrictions due to specialist capacity. • Appointment of substantive Radiologist to commence Jan-26, trained in Lung Biopsy's.	• Reduce backlog and improve 62-day performance.
	• In-session capacity for CT colons is increased to five per list (from four) at King's Mill Hospital site.	
Increase in Urology demand driving insufficient capacity and complex patients requiring multiple investigations.	• Introduction of dedicated Urgent Suspected Cancer Capacity in outpatients. • Implementation of pre-diagnostic calls to reduce the number of patients that do not attend. • Implementation of pre-operative assessment and process for symptomatic and asymptomatic patients with urinary tract infections.	• Improvement in cancer waiting times standards. 62-day performance achieved >80% in Nov-25.
Insufficient Histopathology workforce to meet demand creating pathway delays across multiple tumour sites.	• Recruitment process for additional Consultant capacity complete. Nine Consultants in post (only one agency locum in place). • Successful recruitment to 9.2WTE Medical Laboratory Assistant (MLA) posts. • Ongoing pay per point scheme to support additional cancer reporting.	• Improved histopathology turnaround and increased compliance with the 10-day standard. • Turnaround increased to a high of 79% in Oct-25 from a low 45% in May-25.
	• East Midlands Cancer Alliance funding to implement seven-day working across Histopathology commenced in 2025/26 quarter three.	
	• Ongoing work with Urology and Breast to ensure volumes of biopsies taken align to national standards. • A new process in Urology implemented in Dec-25.	
	• Following successful approval of constitutional standards bid, an order has been placed for three digital scanners. Procurement timeframe to be confirmed.	
Insufficient capacity to meet demand in Lower Gastrointestinal (LGI) and patient compliance issues.	• Implementation of revised faecal immunochemical test (FIT) criteria when live in Oct-25 to align with the Nottinghamshire system agreed referral pathway. Monitoring of impact is ongoing; however, referrals appear to have reduced.	• Sustained reduced in 62-day backlog achieved for 3 consecutive months. • First seen within 7-days sustained >50%.
Consultant capacity gaps in Skin exacerbated by seasonal demand.	• Locum Consultant in Skin recruited in Oct-25.	• Improved 31-day performance to >90% in Oct and Nov-25.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Best Value Care

Outstanding Care,
Compassionate People,
Healthier Communities

Domain Summary: Best Value Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead: Chief Financial Officer

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

The Trust has reported an in-month deficit position of £2.65m in Dec-25; this was £2.34m behind the £0.31m deficit plan with the inclusion of the impact of International Financial Reporting Standard 16 (IFRS16) on the Private Financial Initiative (PFI). The year-to-date deficit is £10.92m, £10.80m behind plan. The reasons for the year-to-date position being behind plan are: three periods of resident doctor Industrial Action during July, November and December of £1.04m, £10.30m adverse Cost Improvement Programme (CIP) performance, £2.40m removal of deficit support funding, £0.81m Mutually Agreed Resignation Scheme (MARS) payments and £0.50m of income planning issues. These are offset by £3.00m benefit from rephased income, £1.20m of balance sheet benefits and £0.05m of other small benefits.

We are currently forecasting the achievement of the financial plan.

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

The annual Financial Improvement Programme (FIP) target is £45.83m in 2025/26. Month nine saw a year-to-date (YTD) delivery of £23.12m against a YTD plan of £33.38m.

The 2025/26 Capital Expenditure Plan (CEP) has been prepared and submitted as part of the overall financial plan with a current in-year plan of £41.20m. Expenditure for month nine totalled £4.24m, which was £1.96m below plan. YTD expenditure totals £14.40m, which was £11.46m below plan, with the variance relating to the quarterly phasing of the Electronic Patient Record (EPR) system and constitutional standards expenditure.

Closing cash on 31 Dec-25 was £0.98m, a reduction of £5.22m in-month and £25.54m YTD. The large opening cash balance was due to the receipt of capital funding in 2024/25 quarter four of £24.49m, additional ICB funding received in Mar-25 and working capital support of £8.31m received in Mar-25. The balance has unwound and there remains an underlying pressure on available revenue cash resource due to the requirement to deliver significant efficiency savings in 2025/26, which will be managed by extending payment terms to suppliers if required. The forecast for Jan-26 onwards assumes delivery of efficiency savings, and the receipt of significant capital Public Dividend Capital (PDC).

The Trusts agency expenditure in Dec-25 was £0.60m and YTD £6.83m, which is 38% lower than the 2024/25 YTD expenditure due to the increased grip and control in place through the workforce transformation group and the medical agency. The 2024/25 run rate was £1.14m with £1.05 in the second half of the year and £1.03m in quarter four. Total agency expenditure as a proportion of our total pay spend is 3% YTD compared to an average of 4% in 2024/25. The largest proportion of our agency spend is on medical pay.

The Trusts bank expenditure in Dec-25 was £2.27m and YTD is £16.97m, which is 26% lower than the 2024/25 YTD expenditure. This figure is inclusive of The target reduction set in the Trust plan was 15%, therefore we are significantly exceeding performance.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Best Value Care

Best Value Care

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Financial Performance	Financial surplus / deficit	n/a	≥£0.00m	✗-£0.90	✗-£0.70	✗-£0.21	✓£0.12	✓£0.03	✗-£1.62	✗-£2.37	✗-£2.63	✗-£2.65		✗£10.93				
	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✓£0.00	✓£0.00	✓£0.00	✗-£0.40	✗-£0.58	✗-£2.08	✗-£2.95	✗-£2.46	✗-£2.34	✓£0.01	✗£10.81				
Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✗-£0.81	✗-£0.72	✗-£1.30	✗-£0.83	✗-£0.48	✗-£2.81	✗-£1.83	✗-£0.93	✗-£0.55	✓£0.08	✗£10.26				
	Risk adjusted efficiency forecast to plan (%)	n/a	100%	✗46.5%	✗55.0%	✗56.6%	✗65.0%	✗68.0%	✗74.0%	✗81.0%	✗82.0%	✗80.0%		-				
Variable Pay	Reported agency expenditure	No Standard	No Standard	£0.75	£0.87	£1.01	£0.78	£0.78	£0.69	£0.77	£0.58	£0.60	£13.70	£6.83				
	Reported bank expenditure	No Standard	No Standard	£1.88	£1.90	£1.70	£2.09	£2.12	£1.57	£1.43	£2.02	£2.27	£30.55	£16.98				
Rate of Productivity	Implied productivity growth (YTD compared to last year)	3.1%	2%	✗0.9%	✓3.8%	✓5.0%	✓4.2%	✓5.7%	✓5.5%	-	-	-		-				
Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%	✗24.7%	✗33.5%	✗62.6%	✗76.6%	✗87.2%	✗87.5%	✗83.9%	✗50.4%	✗21.3%		✗61.7%				
	BPPC - Value of bills paid within target	n/a	≥95%	✗69.2%	✗75.2%	✗69.3%	✗73.3%	✗93.9%	✗91.6%	✗90.6%	✗84.3%	✗81.3%		✗81.1%				
	Operating expenditure days	n/a	≥5	✓ 16	✓ 16	✓ 13	✓ 10	✓ 10	✓ 6	✓ 5	✗ 4	✗ 3		✓ 9				
Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	✗£0.35	✗£1.10	✗£0.44	✗£0.78	✗£1.07	✗£0.85	✗£1.36	✗£4.29	✗£4.24	✓£33.58	✗£14.47				

Indicator in Focus: Financial Performance

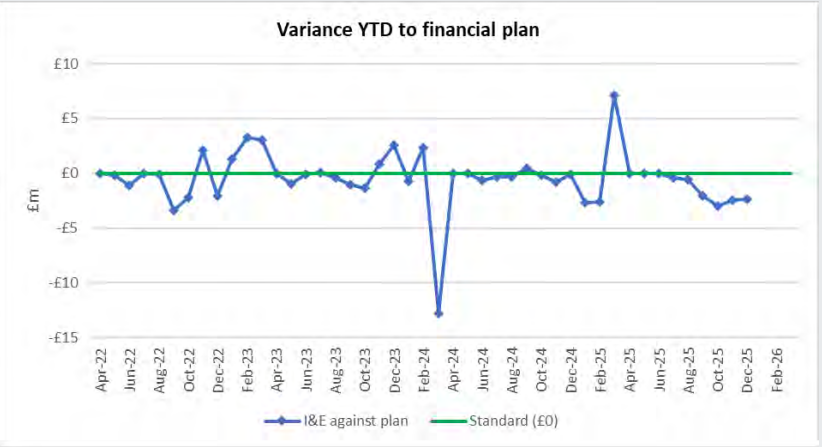
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the Trust financial plan, which is a break-even position for 2025/26. This is aligned to the Trust's share of the 2025/26 Revenue Plan Limit set for the Nottingham and Nottinghamshire ICB by NHS England.
- The Trust has a YTD £10.92m deficit, which is £10.80m behind the planned deficit of £0.12m for the YTD position at month nine.

Root Causes	Actions and timescale/areas of risk	Impact
Urgent and Emergency Care demand pressures.	• If the emergency care pathway growth is higher than the planned levels, then it will cause pressure on our income and expenditure position.	Deliver annual plan.
Non-delivery of the FIP.	• At month nine the Trust is £10.26m behind the plan. Divisional and corporate areas have been given control totals to enable the Trust to achieve a break-even position. This recovery approach combines workforce controls, divisional and corporate accountability and income recovery measures.	
Variable activity plan.	• We need to ensure as a Trust that we maintain the variable elements of our activity to ensure we maintain the level of income associated with this.	
Industrial action.	• There is no national funding available to cover this up to the month nine position and we will need to minimise costs where possible, as well as recovering the lost activity in line with the variable activity plan.	
Finalisation of 2025/26 contract with ICBs.	• Trust is still negotiating 2025/26 contract values with Nottinghamshire and Lincolnshire ICBs. If contract values are not aligned to Trust internal assumptions, then it will cause pressure on our income and expenditure position.	
Payback of 2024/25 financial support within the Nottinghamshire system.	• Current plan does not assume any payback of the financial support that delivered the 2024/25 financial position.	
	• The payback value expected from SFH is £4.1m. There is an expectation that this is transacted through a reduced contract value in 2025/26. Any payback will cause pressure on our income and expenditure position.	

Data



Indicator in Focus: Efficiency

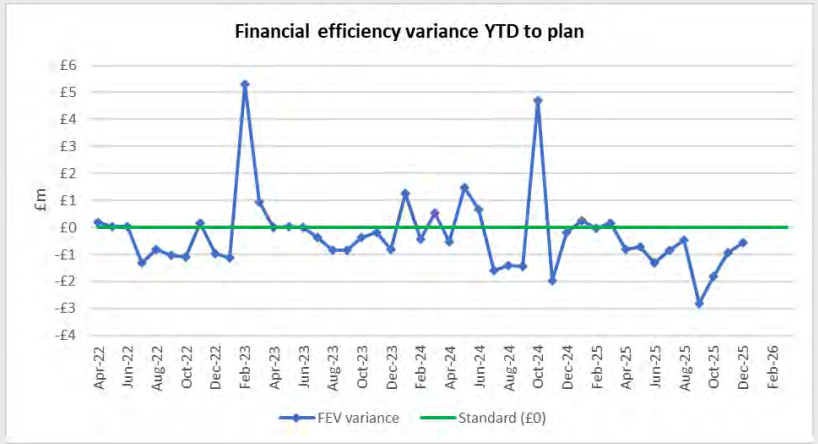
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is delivery of the Trust Financial Improvement Plan (FIP).
- The Trust has a £45.83m efficiency programme for 2025/26, which is currently £10.26m behind plan YTD.

Root causes	Actions and timescale	Impact
Non-delivery of Financial Improvement Programme.	• A financial recovery plan is in place consisting of six workstreams, covering every pound spent and received.	Deliver annual plan.
	• Control totals set for each programme and division/directorate, aligned to the Trust requirement to deliver a break-even plan.	
	• PA Consulting support has been in place; this ceased at the end of Oct-25.	
	• Increased workforce controls established. • New non-pay oversight group is being developed for implementation to create the same clarity, consistency and control environment that the HR Playbook has delivered for pay.	
	• Enhanced oversight and grip strengthened to support delivery within the financial year.	
Risk adjusted forecast.	• Currently the weighted target at month nine is £36.50m, which is 80% of the target. An increase to this is required at pace, supported by the new workstreams.	
	• The unweighted forecast reported to NHS England is full delivery of the target.	

Data



Indicator in Focus: Agency Pay

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the planned agency expenditure for 2025/26.
- The Trust has reported agency expenditure of £6.83m YTD.
- Agency expenditure accounts for 3% of our total pay bill YTD, a reduction from our 2024/25 run rate.
- Agency reduction relative to the 40% target for 2025/26 is 38% YTD.

Data

Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required 40% reduction in agency expenditure compared to our Nov-24 forecast.	Reduced agency run rate to achieve financial plan.
	• Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews and Divisional Finance Committees.	
	• Workforce performance group is in place. Weekly workforce meetings with increased workforce controls established and major interventions in place.	
	• 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.	

Indicators in Focus: Cash and Liquidity

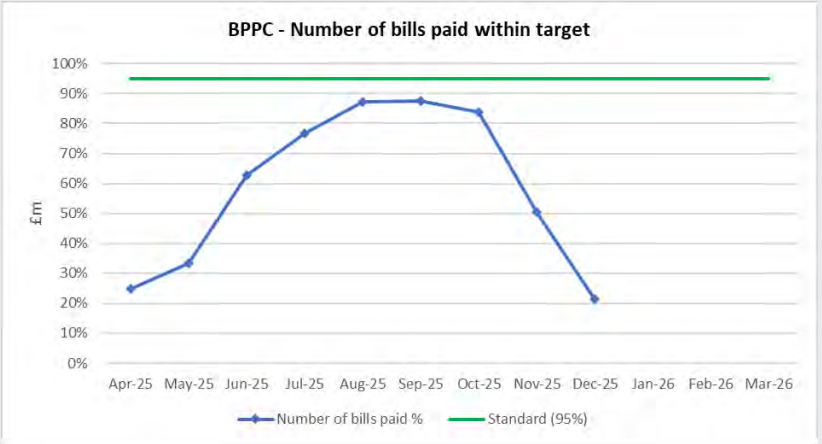
Sherwood Forest Hospitals NHS Foundation Trust

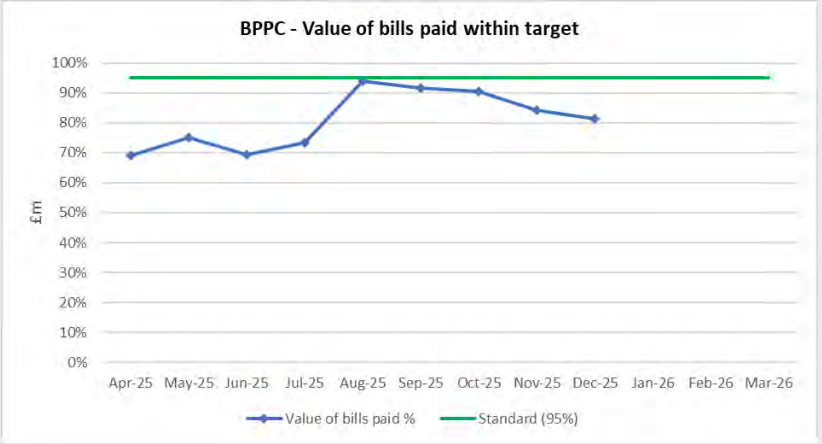
Performance observations

- The standard is the minimum cash balance (£1.45m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of Dec-25, cash in bank was £0.98m, which is below plan and below the minimum cash balance.
- The submitted plan for 2025/26 does not require revenue borrowing Public Dividend Capital (PDC). However, there is significant capital PDC planned in-year to support the ICB allocation and national schemes.

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

Data





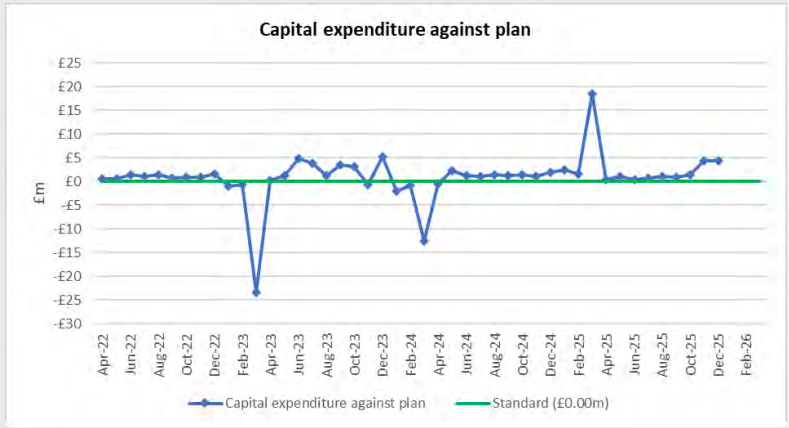
Indicator in Focus: Capital

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

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

Data



Root causes	Actions and timescale	Impact
Pre-commitments to Trust priorities limiting business as usual capital.	• Monitoring of spend to ensure pre-commitments deliver within plan. • Allocation agreed with Integrated Care System partners for 2025/26.	Delivery of Capital Expenditure Plan.
Requirement for Public Dividend Capital (PDC) to support ICB plan £15.23m and national schemes £15.77m.	• PDC request submitted 4 Aug-25 and approved Jan-26.	Spending at risk without formal approval, impacting available cash to meet revenue payments as they fall due.
Significant national funding for return to constitutional standards for which submissions are required to NHS England.	• All submissions made, further information is required in respect of ED, which will be submitted by the end of Jan-26. • Monitoring of in-year spend to ensure delivery to funding envelope.	Overspends impacting other capital delivery requirements.

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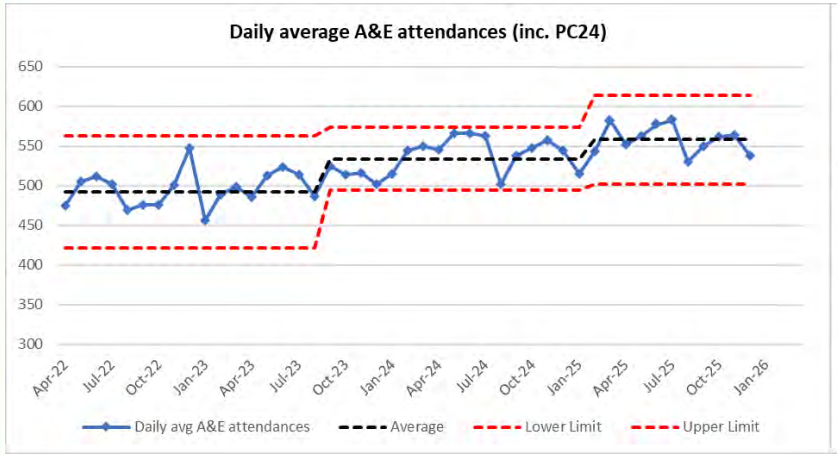
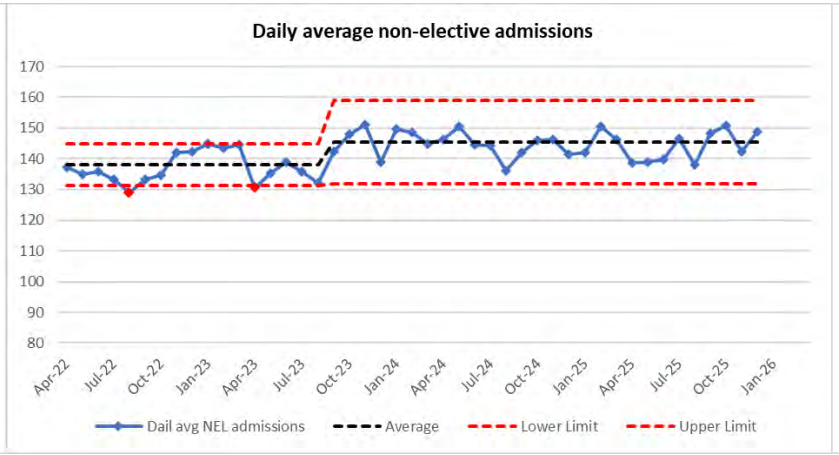
Activity Data and Trends (1/2)

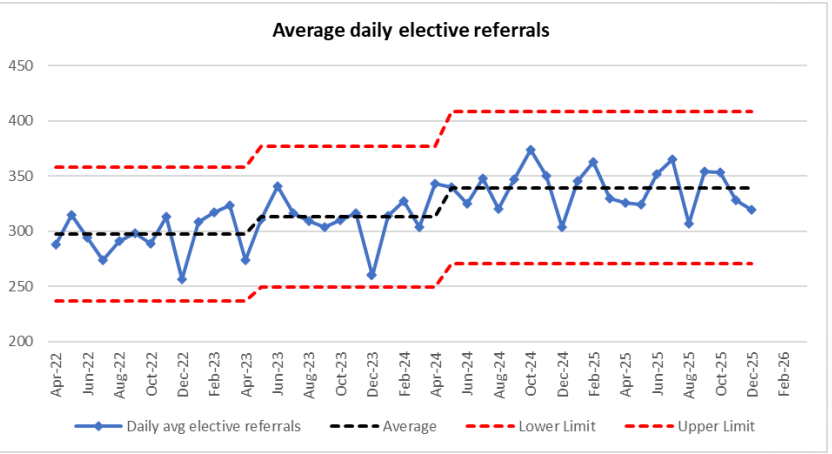
Activity (for context)

Based on daily averages

At a Glance	Indicator	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD
Urgent Care	A&E attendances (inc. PC24)	515	543	582	552	562	577	582	530	550	561	563	537	547	557
	Non-elective admissions	142	150	146	139	139	140	147	138	148	151	142	149	145	144
Electives	Average daily elective referrals	346	362	330	326	325	352	365	307	354	354	328	320	341	337
	Outpatients - first appointment	327	339	323	318	308	335	352	281	364	334	320	290	347	322
	Outpatients - follow up	875	907	855	849	802	853	907	748	891	854	819	754	852	831
	Outpatients - procedures	287	278	254	257	254	267	293	247	283	280	268	256	265	267
	Day case	127	126	116	114	116	123	126	114	121	125	121	115	122	119
	Elective inpatient	12	13	13	13	14	15	15	14	13	16	16	13	14	14
Diagnostics	Diagnostics	496	518	490	476	464	477	494	461	478	488	481	459	479	475







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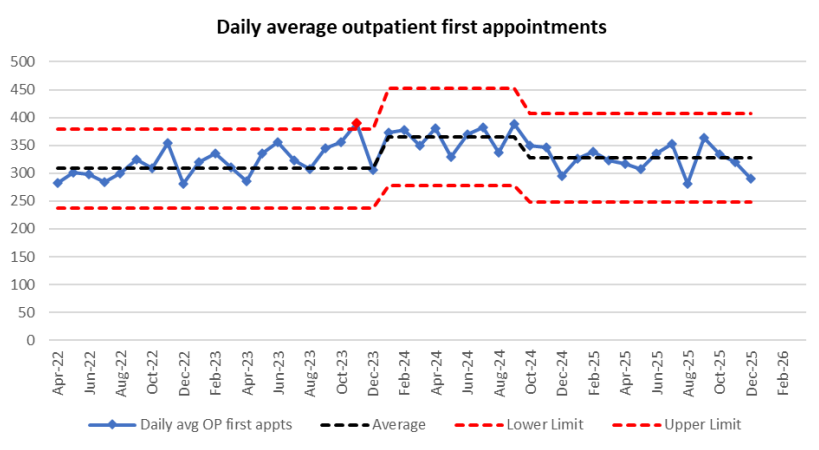
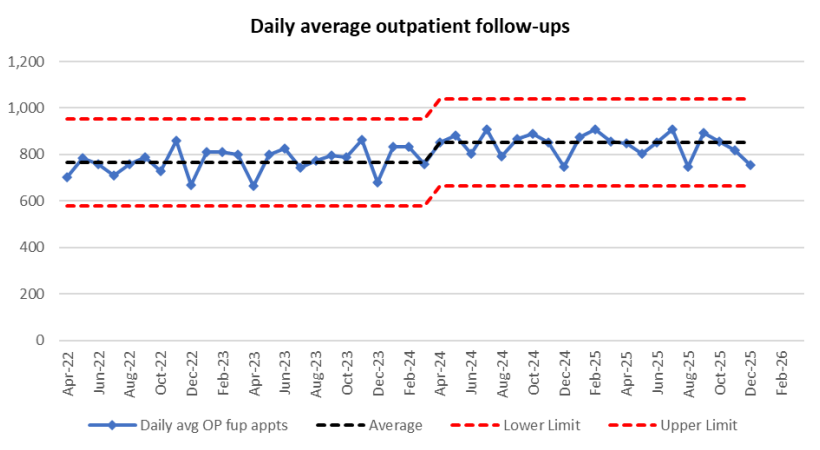
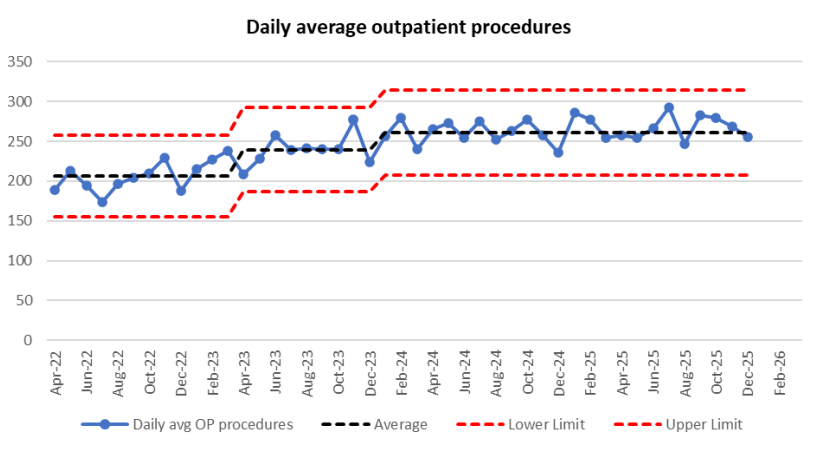
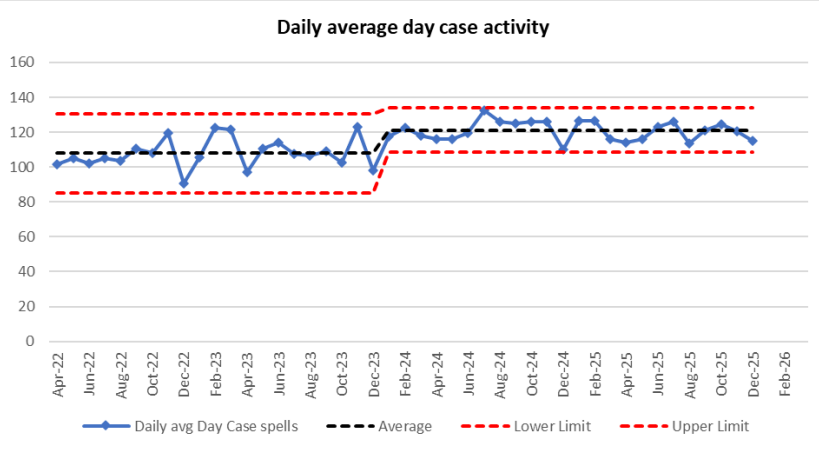
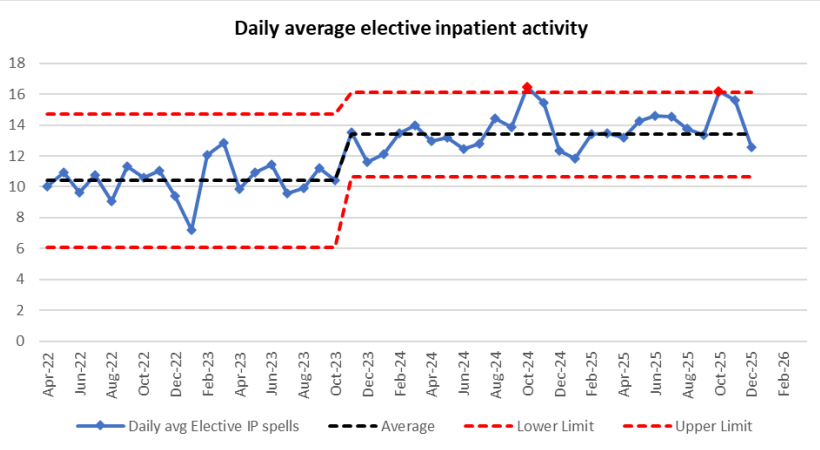
Activity Data and Trends (2/2)

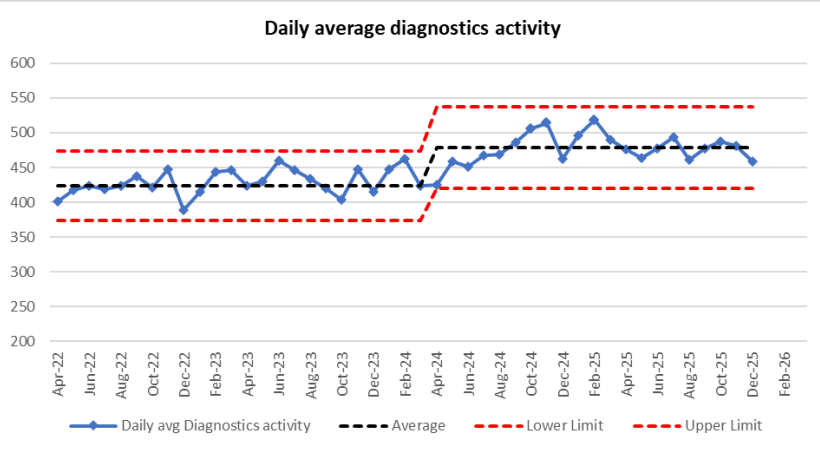












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Appendix A: Integrated Scorecard & Graphs for each indicator

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

Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

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

How are we different?

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

Why are we different?

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

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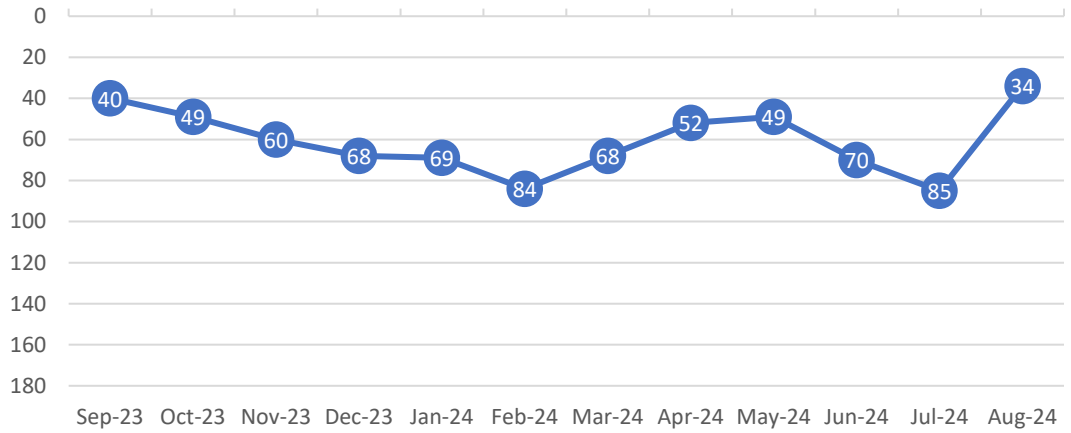
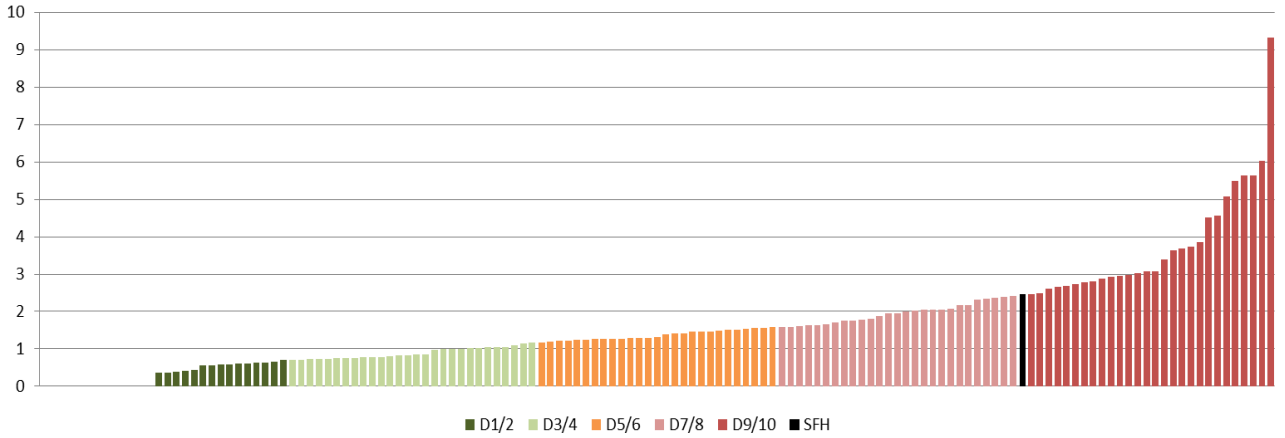
Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



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

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

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

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

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

Appendix C: Data Quality Indicator Guidance

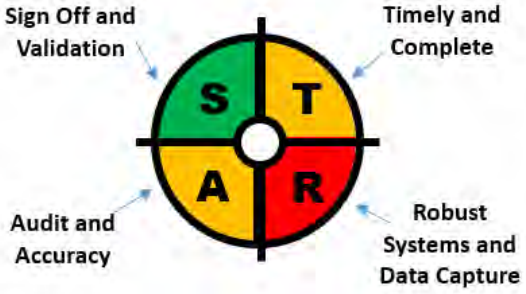
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

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



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Integrated Performance Report 2025/26

December 2025 (Qtr 3)

Cover Page | Charts | Definitions

Integrated Report

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

Category	At a Glance	NOF	Indicator	2024/25 Standard	2025/26 Standard	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Quality of Care	Safe		Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.7	2.6	1.9	2.4	2.2	1.7	2.3	2.4	2.4		2.2				
			Never events	0	0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
		✓	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 2				
		✓	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 7	✗ 9	✓ 4	✗ 8	✗ 55	✗ 59				
		✓	Number of gram-negative bloodstream infections reported in month	n/a	8	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	✓ 5	✓ 3	✓ 3	✓ 2	50	✓ 35				
			HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.1	0.1				
			HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✗ 6	✗ 2				
			Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	5	13	10	2	11	10	9	5	4	17	69				
			Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 90.5%	✗ 89.6%	✗ 89.4%	✗ 88.0%	✗ 85.5%	✗ 89.7%	✗ 85.7%	✗ 86.5%	✗ 85.9%		✗ 87.8%				
	Caring		Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 1.3	✓ 1.4	✓ 1.0	✓ 1.3	✓ 0.9	✓ 1.4				
			Compliments received in month	No Standard	No Standard	155	115	141	157	109	137	98	64	38	1831	1014				
	Effective	✓	SHMI	As Expected	As Expected	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 106	✓ 106	✓ 105	✓ 107	✓ 105				
			Still birth rate	≤4.4	≤4.4	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.0	✗ 10.2	✓ 3.4	✗ 7.6	✓ 0.0	✓ 4.3	✗ 5.5				
			Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				
People and Culture	Belonging in the NHS	✓	Engagement score	≥6.8%	≥6.9%			✓ 6.8			-			-	✓ 7.1	✓ 6.8				
	Growing the Future		Vacancy rate	≤8.5%	≤8.5%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✓ 7.9%	✓ 7.8%	✓ 8.2%	✓ 8.0%	✗ 8.6%				
			Time to hire	n/a	≤53.1 days	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0	✓ 25.0	✓ 36.0	✓ 21.0	-		-				
			Turnover in month	≤0.9%	≤0.9%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.8%	✗ 1.0%	✓ 0.6%	✓ 0.6%	✓ 0.7%	✓ 0.6%				
			Appraisals	≥90%	≥90%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 88.2%	✗ 87.5%	✗ 87.4%	✗ 87.5%	✗ 89.0%	✗ 88.3%				
			Mandatory & statutory training	≥90%	≥90%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 92.9%	✓ 93.3%	✓ 93.6%	✓ 93.6%	✓ 91.5%	✓ 93.1%				
			Medical job plan compliance	n/a	≥95%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%	✗ 94.0%	✓ 95.9%	✓ 96.6%	-		-				
	Looking after our People	✓	Sickness absence	≤4.2%	≤4.2%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 4.8%	✗ 5.7%	✗ 5.6%	✗ 5.9%	✗ 5.0%	✗ 5.2%				
			Flu vaccinations uptake (front line staff)	≥75%	≥75%	-	-	-	-	-	-	✗ 35.8%	✗ 50.7%	✗ 54.3%	✗ 58.0%					
			Employee relations management	<17	<21	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✓ 20	✗ 21	✓ 20	✗ 26	✗ 21	✗ 21				
	New Ways of Working		Bank usage	≤8.5%	≤7.8%	✓ 6.3%	✓ 7.1%	✓ 6.3%	✓ 6.9%	✓ 7.1%	✓ 5.2%	✓ 4.8%	✓ 6.8%	✓ 7.5%	✗ 8.9%	✓ 6.4%				
			Agency usage	<3.2%	<1.9%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 2.3%	✗ 2.6%	✗ 2.0%	✗ 2.0%	✗ 4.0%	✗ 2.6%				
			Agency (off framework)	0.0%	0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
			Agency (over price cap)	≤40.0%	≤40.0%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 40.9%	✓ 33.4%	✓ 33.6%	✓ 39.5%	✗ 52.9%	✓ 37.6%				
Timely Care	Urgent Care		Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 82.3%	✗ 76.2%	✗ 72.8%	✗ 62.2%	✗ 91.4%	✗ 81.7%				
			Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 2.5%	✗ 3.7%	✗ 6.0%	✗ 13.4%	✗ 0.7%	✗ 3.3%				
		✓	ED 4-hour performance	≥76%	≥Plan	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 68.0%	✗ 67.4%	✗ 67.3%	✗ 67.0%	✗ 71.0%	✓ 71.6%				
		✓	ED 12-hour length of stay performance	≤2%	≤2024/25	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 5.6%	✗ 8.2%	✗ 7.2%	✗ 9.2%	✗ 3.4%	✗ 4.9%				
			Mental health patients spending over 12 hours in A&E	n/a	No Standard	18	21	19	22	24	23	27	17	9	23	180				
			Adult G&A bed occupancy	≤92%	≤92%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 96.3%	✗ 97.4%	✗ 96.1%	✗ 95.9%	✗ 94.5%	✗ 95.9%				
		✓	Average number of days between planned and actual discharge date	n/a	≤Plan	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.1	✗ 4.0	✓ 3.5	✓ 3.3	✓ 3.6	✓ 3.4		✓ 3.6				
			Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 82	✗ 72	✗ 84	✗ 89	✗ 64	✗ 74				
	Electives		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 10.9%	✓ 11.1%	✓ 11.1%	✓ 11.2%	✓ 11.2%	✓ 6.0%	✓ 10.9%				
		✓	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%	✗ 61.9%	✗ 60.4%	✗ 60.3%	✗ 59.3%		✗ 62.0%				
		✓	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	✓ 0.9%	✓ 0.9%	✓ 0.8%	✓ 1.0%		✓ 1.0%				
	Diagnostics		Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✗ 89.8%	✗ 90.4%	✗ 89.8%	✗ 92.0%	✓ 93.1%	✗ 89.8%				
	Cancer	✓	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	✓ 82.3%	✓ 80.7%	✓ 82.2%	✓ 79.4%	-	✓ 78.3%	✓ 80.6%				
			Cancer 31-day treatment performance	≥Plan	≥96%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	✗ 84.8%	✗ 88.4%	✗ 91.7%	✗ 93.6%	-	✓ 91.9%	✗ 90.1%				
		✓	Cancer 62-day treatment performance	≥Plan	≥Plan	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	✓ 72.4%	✓ 63.1%	✓ 65.3%	✓ 75.7%	-	✗ 64.4%	✗ 66.9%				
Best Value Care	Financial Performance	✓	Financial surplus / deficit	n/a	≥£0.00m	✗ -£0.90	✗ -£0.70	✗ -£0.21	✓ £0.12	✓ £0.03	✗ -£1.62	✗ -£2.37	✗ -£2.63	✗ -£2.65		✗ £10.93				
		✓	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✗ -£2.08	✗ -£2.95	✗ -£2.46	✗ -£2.34	✓ £0.01	✗ £10.81				
	Efficiency		Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✗ -£2.81	✗ -£1.83	✗ -£0.93	✗ -£0.55	✓ £0.08	✗ -£10.26				
			Risk adjusted efficiency forecast to plan (%)	n/a	100%	✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%	✗ 74.0%	✗ 81.0%	✗ 82.0%	✗ 80.0%		-				
	Variable Pay		Reported agency expenditure	No Standard	No Standard	£0.75	£0.87	£1.01	£0.78	£0.78	£0.69	£0.77	£0.58	£0.60	£13.70	£6.83				
			Reported bank expenditure	No Standard	No Standard	£1.88	£1.90	£1.70	£2.09	£2.12	£1.57	£1.43	£2.02	£2.27	£30.55	£16.98				
	Rate of Productivity	✓	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✗ 0.9%	✓ 3.8%	✓ 5.0%	✓ 4.2%	✓ 5.7%	✓ 5.5%	-	-	-		-				
	Cash & Liquidity		BPPC - Number of bills paid within target	n/a	≥95%	✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 87.2%	✗ 87.5%	✗ 83.9%	✗ 50.4%	✗ 21.3%		✗ 61.7%				
			BPPC - Value of bills paid within target	n/a	≥95%	✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%	✗ 91.6%	✗ 90.6%	✗ 84.3%	✗ 81.3%		✗ 81.1%				
			Operating expenditure days	n/a	≥5	✓ 16	✓ 16	✓ 13	✓ 10	✓ 10	✓ 6	✓ 5	✗ 4	✗ 3		✓ 9				
	Capital		Capital expenditure against plan	≤£33.61m	≤£0.00m	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✗ £0.85	✗ £1.36	✗ £4.29	✗ £4.24	✓ £33.58	✗ £14.47				
Activity (for context)	Urgent Care		A&E attendances (inc. PC24)			552	562	577	582	530	550	561	563	537	547	557				
			Non-elective admissions			139	139	140	147	138	148	151	142	149	145	144				
	Electives		Average daily elective referrals			326	325	352	365	307	354	354	328	320	341	337				
			Outpatients - first appointment			318	308	335	352	281	364	334	320	290	347	322				
			Outpatients - follow up			849	802	853	907	748	891	854	819	754	852	831				
			Outpatients - procedures			257	254	267	293	247	283	280	268	256	265	267				
			Day case			114	116	123	126	114	121	125	121	115	122	119				
			Elective inpatient			13	14	15	15	14	13	16	16	13	14	14				
	Diagnostics		Diagnostics			476	464	477	494	461	478	488	481	459	479	475				

Sherwood Forest Hospitals NHS Foundation Trust

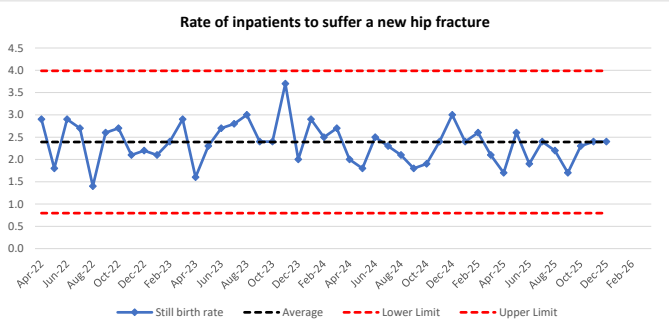
Integrated Performance Report 2025/26

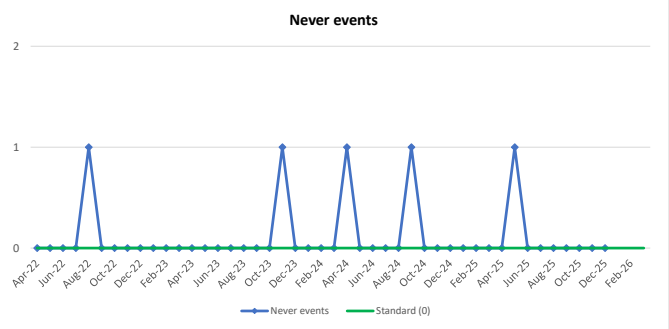
December 2025 (Qtr 3)

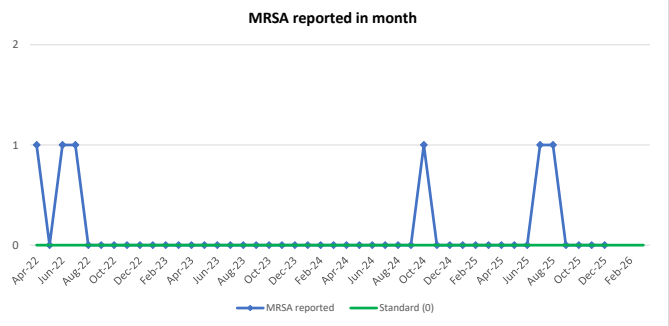
Cover Page | Definitions

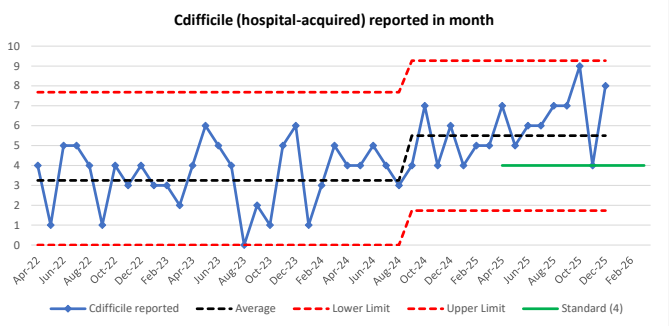
Charts

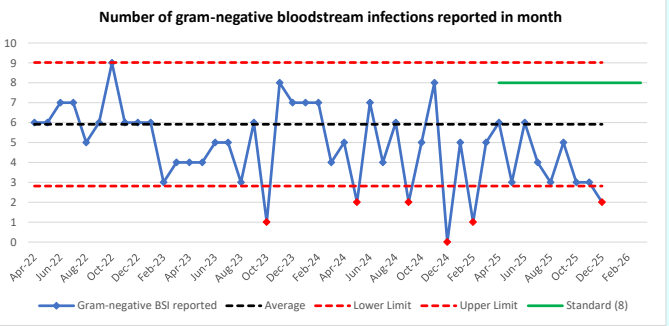
Quality of Care

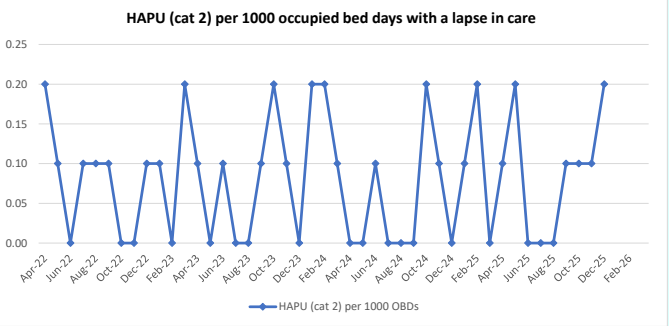


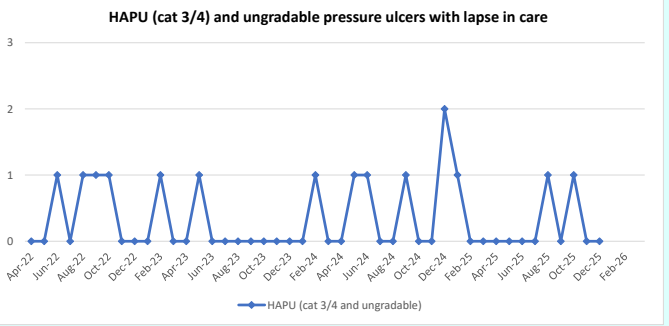


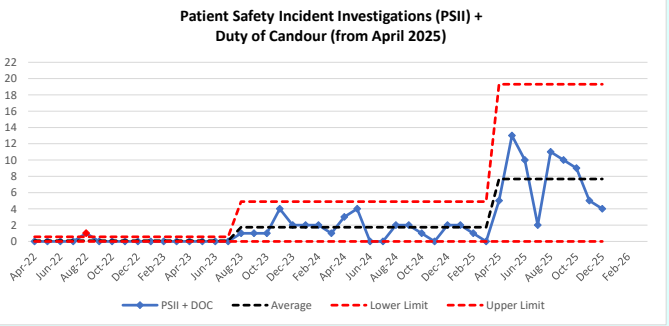


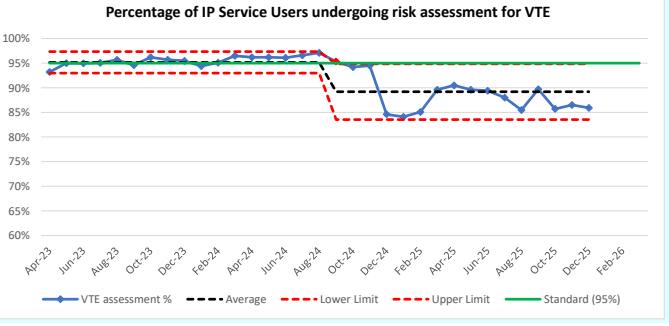


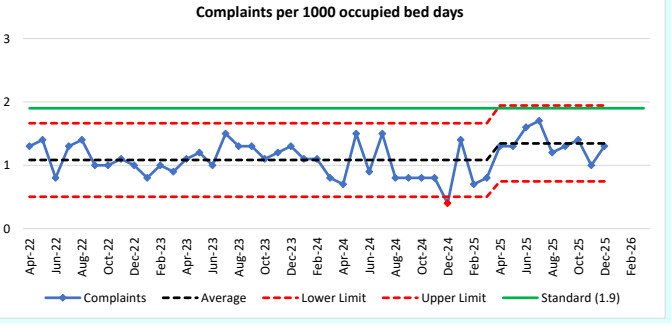


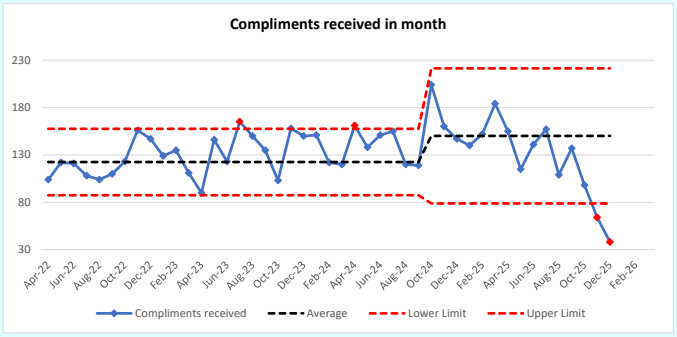


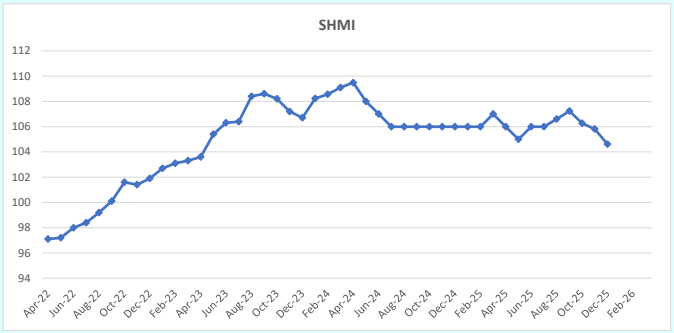


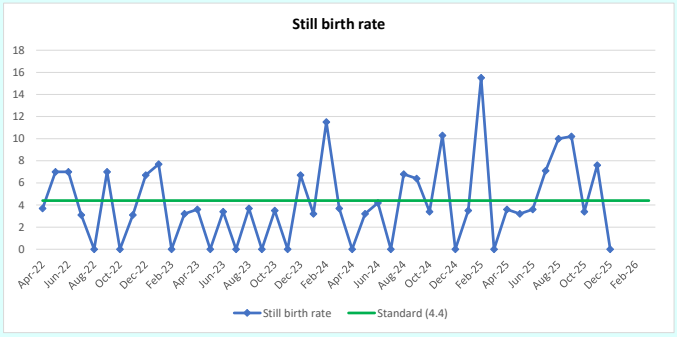


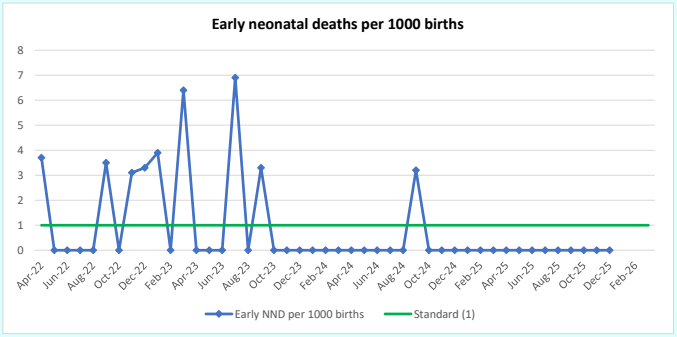




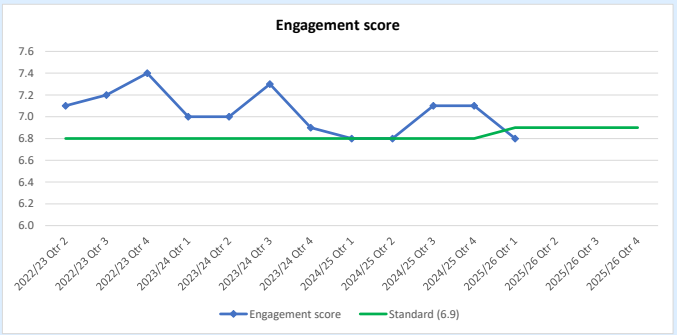


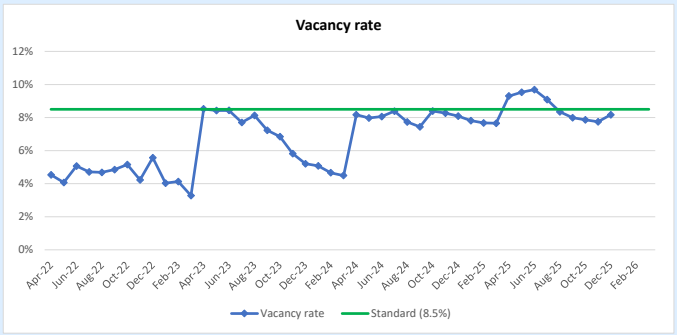


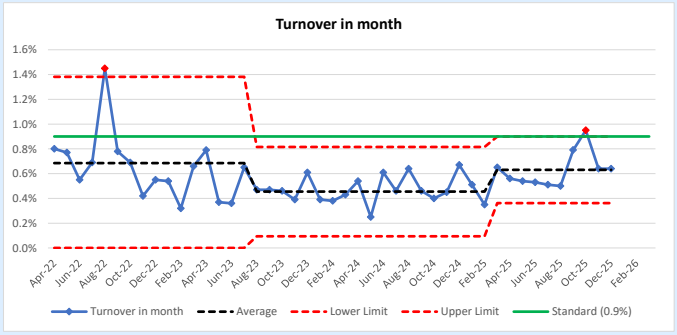


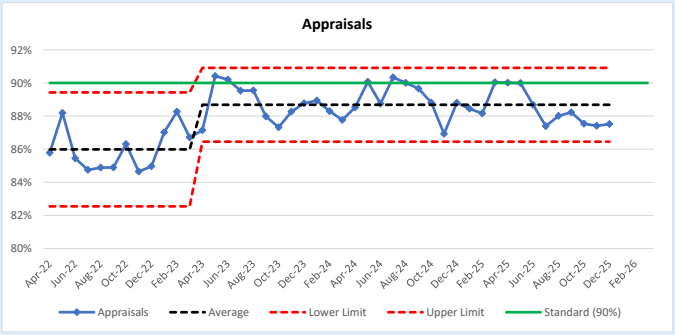


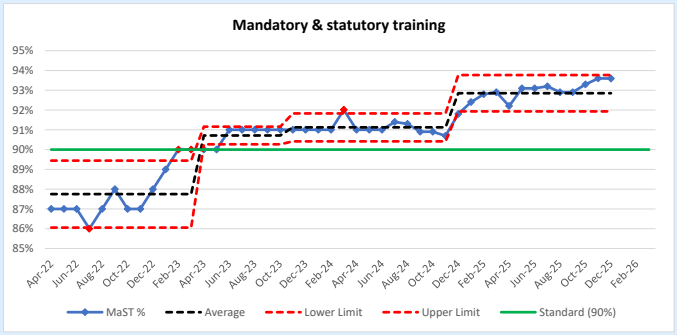
People and Culture

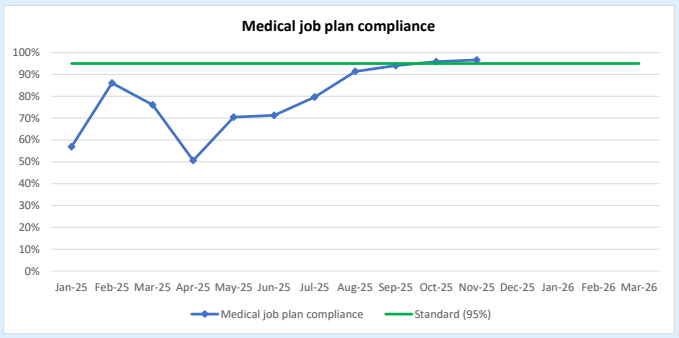


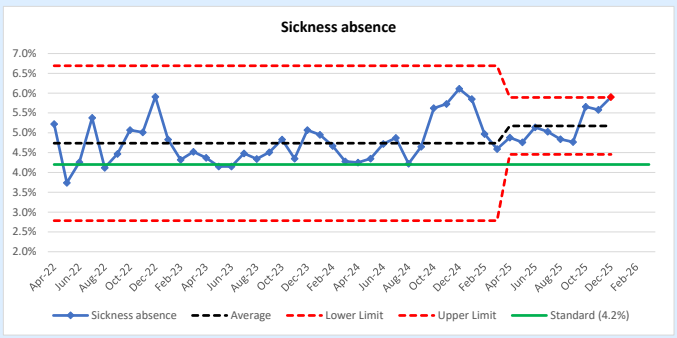


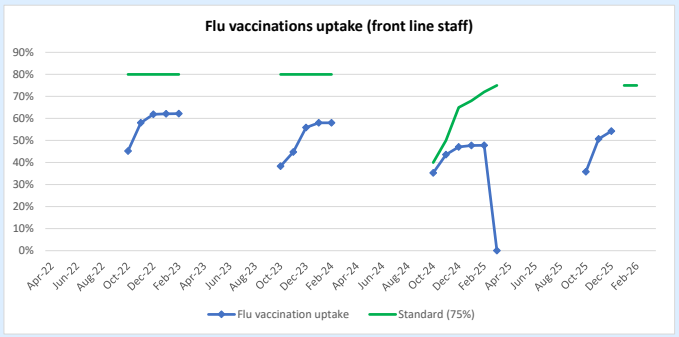


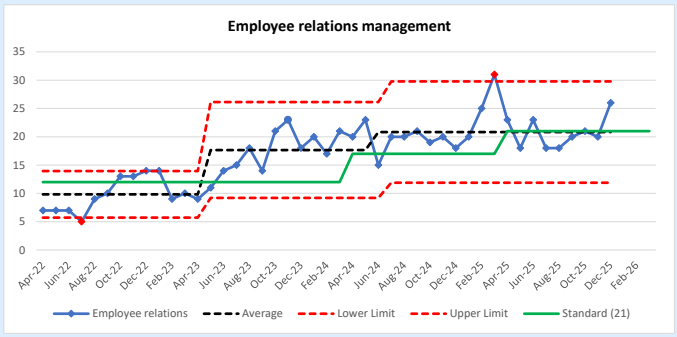


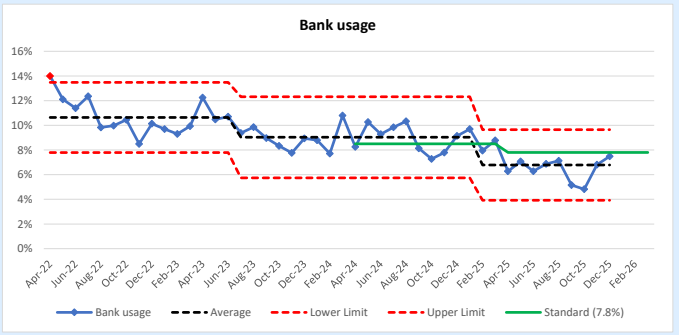


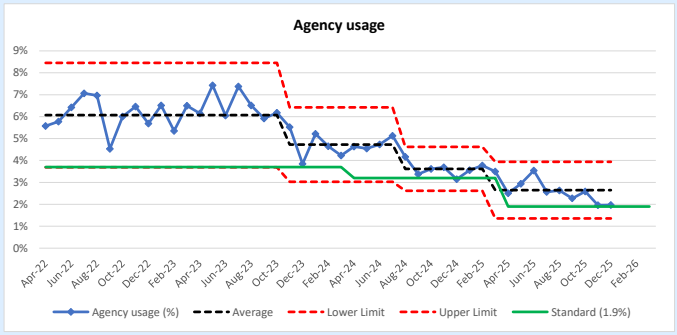

Medical job plan compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26
Medical job plan compliance
Standard (95%)

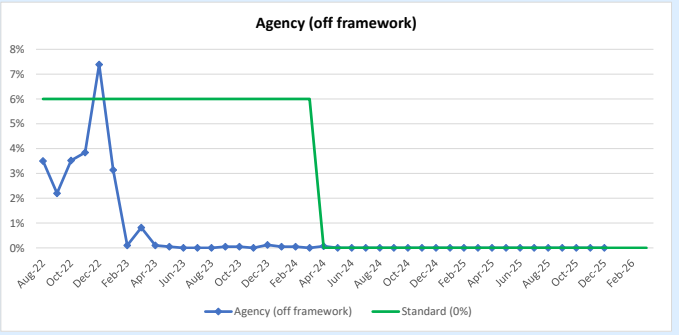

Sickness absence
7.0%
6.5%
6.0%
5.5%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
Sickness absence
Average
Lower Limit
Upper Limit
Standard (4.2%)

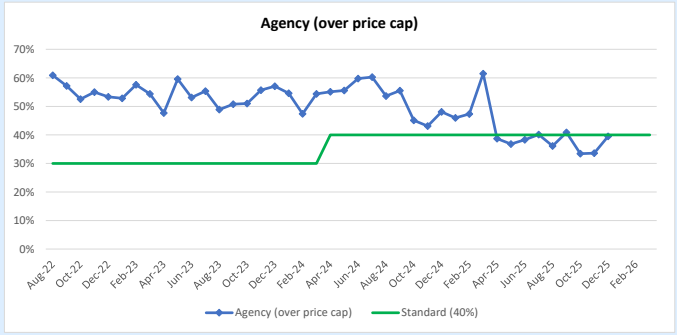

Flu vaccinations uptake (front line staff)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Flu vaccination uptake
Standard (75%)


Employee relations management
35
30
25
20
15
10
5
0
Employee relations
Average
Lower Limit
Upper Limit
Standard (21)


Bank usage
16%
14%
12%
10%
8%
6%
4%
2%
0%
Bank usage
Average
Lower Limit
Upper Limit
Standard (7.8%)

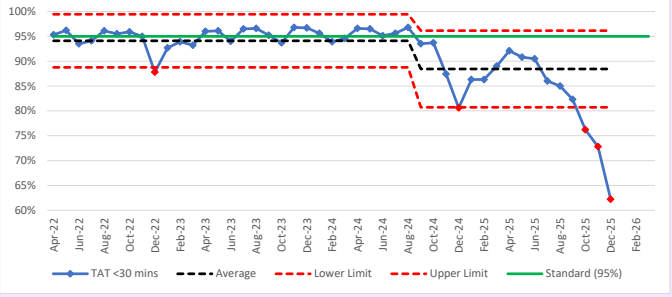

Agency usage
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Agency usage (%)
Average
Lower Limit
Upper Limit
Standard (1.9%)


Agency (off framework)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Agency (off framework)
Standard (0%)

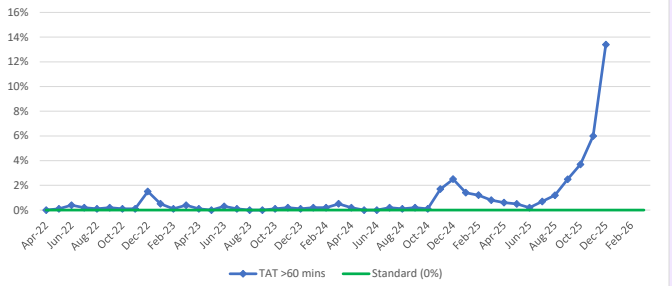

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Agency (over price cap)
Standard (40%)

Timely Care

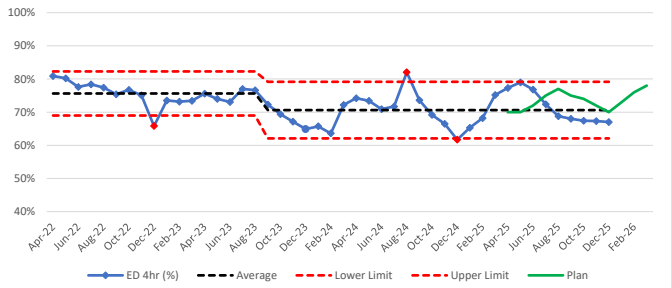
Ambulance turnaround times <30 mins



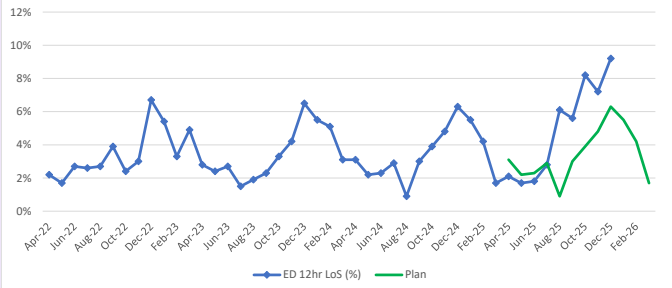
Ambulance turnaround times >60 mins



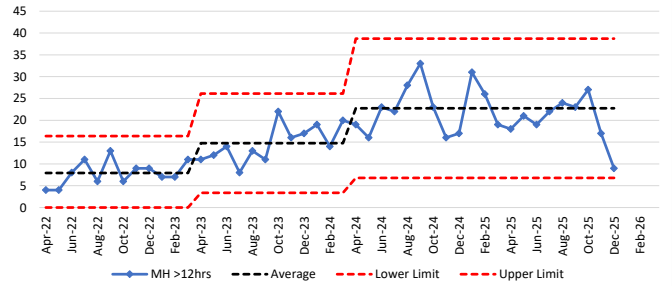
ED 4-hour performance



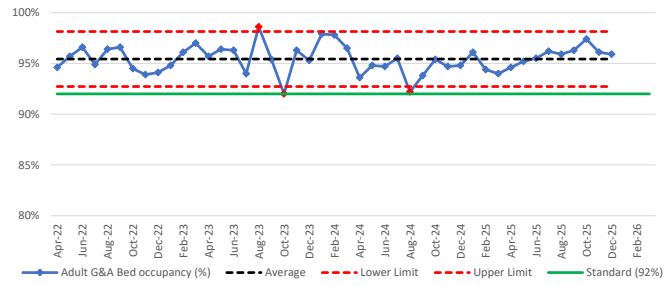
ED 12-hour length of stay performance



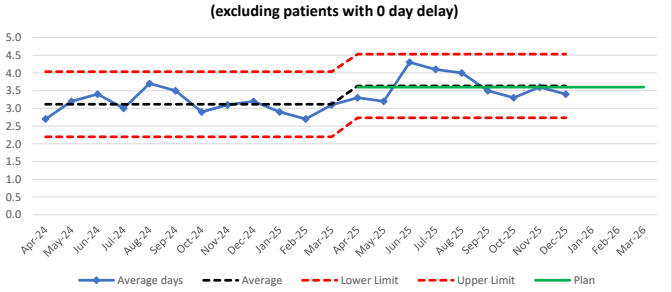
Mental health patients spending over 12 hours in A&E



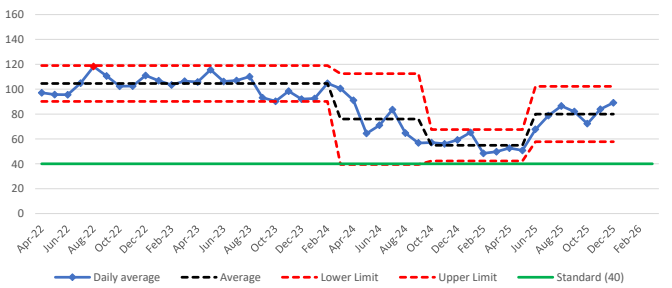
Adult G&A bed occupancy



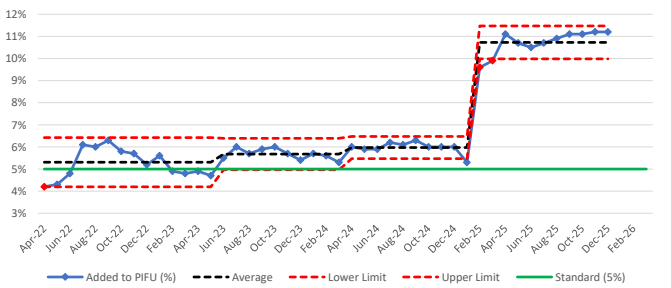
Average number of days between planned and actual discharge date (excluding patients with 0 day delay)



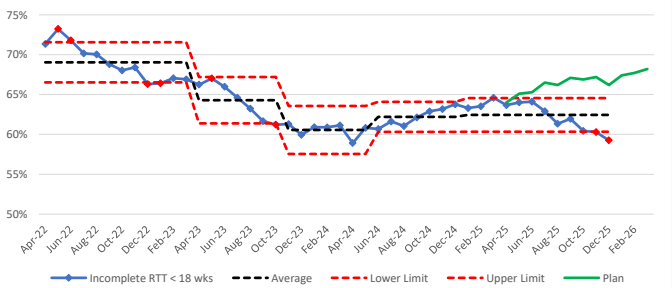
Inpatients medically safe for transfer for greater than 24 hours

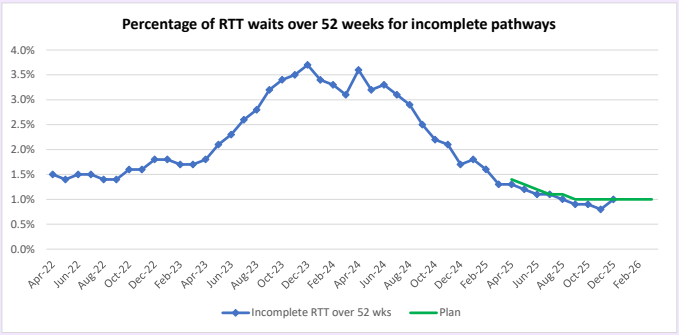


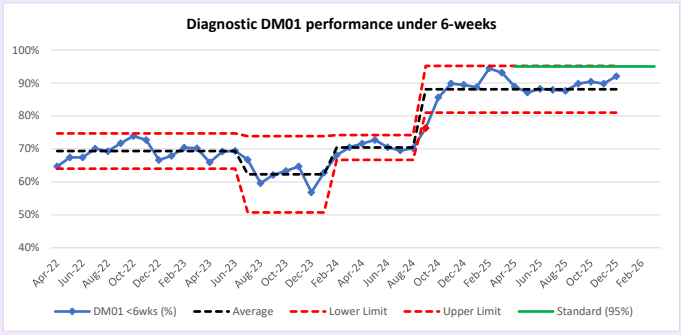
Added to Patient Initiated Follow Up (PIFU) pathway

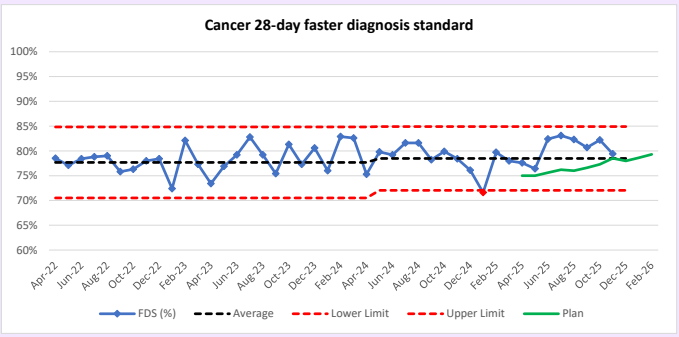


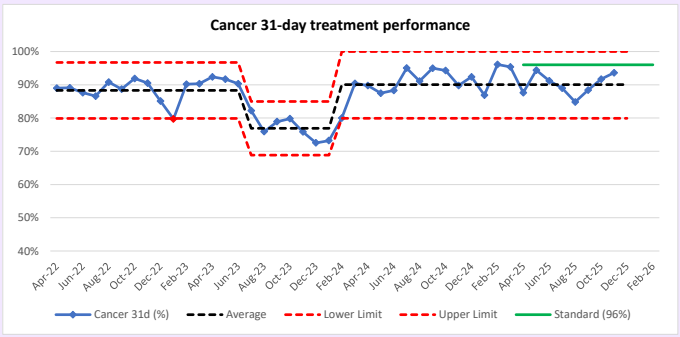
Percentage of incomplete (RTT) pathways completed < 18 weeks

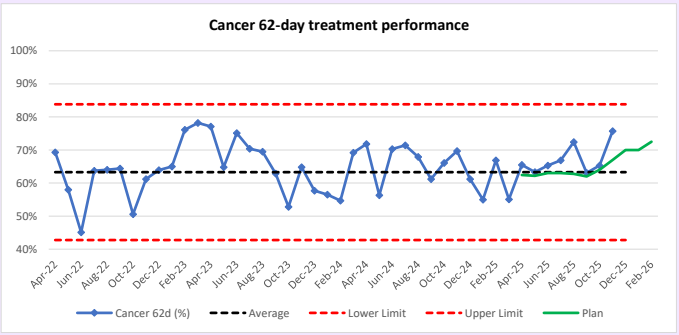




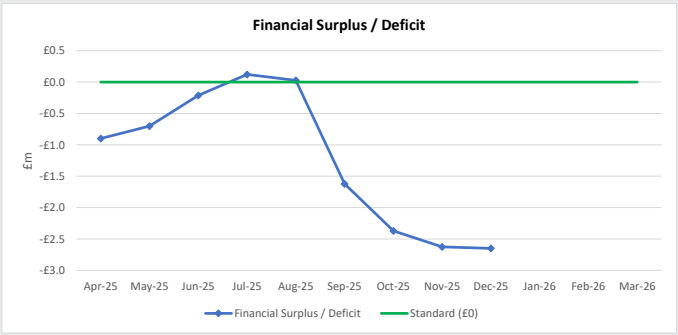


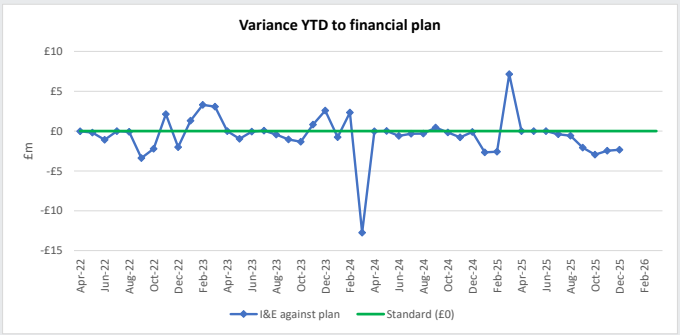


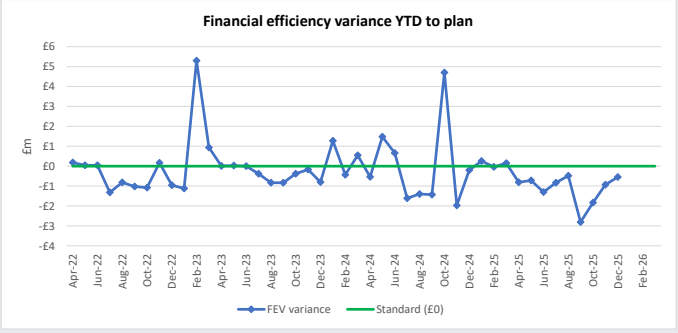


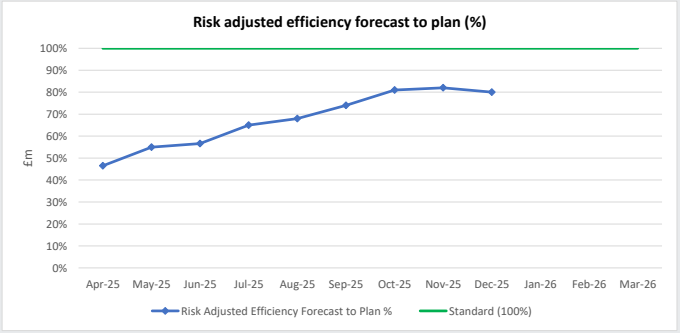


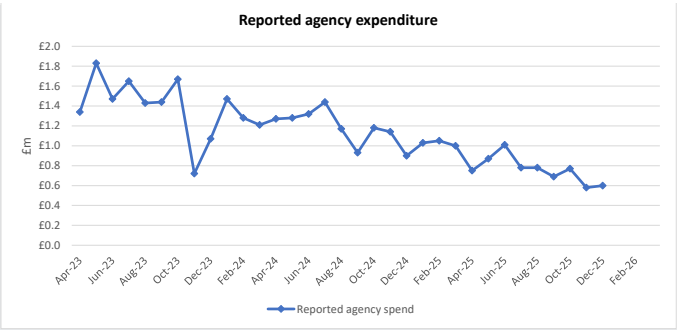
Best Value Care

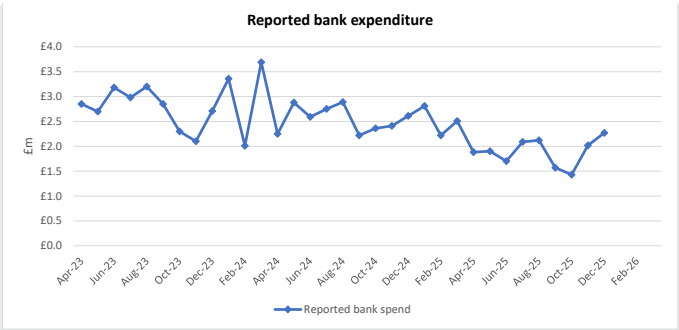


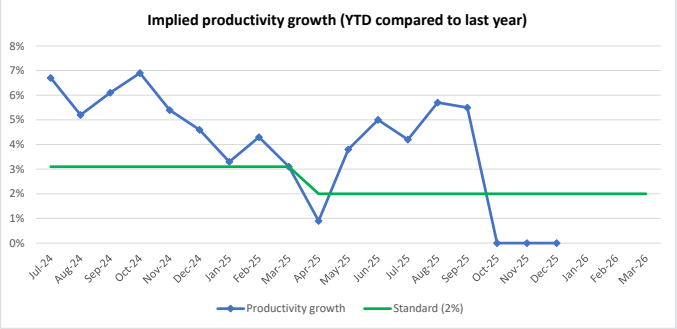


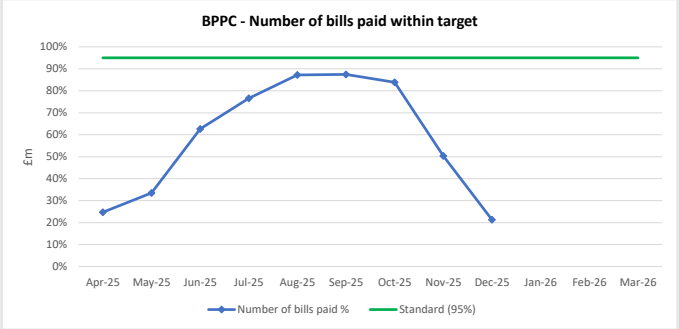


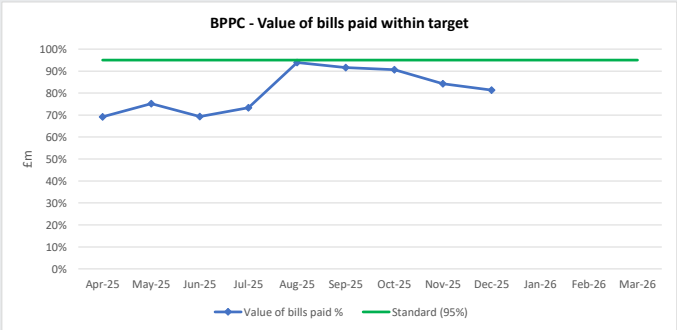


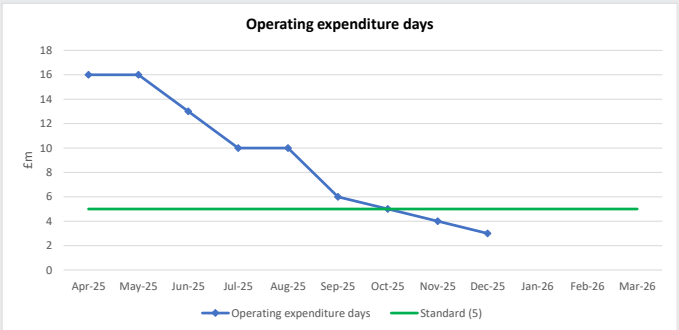

Reported agency expenditure
£m
£2.0
£1.8
£1.6
£1.4
£1.2
£1.0
£0.8
£0.6
£0.4
£0.2
£0.0
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26
Reported agency spend

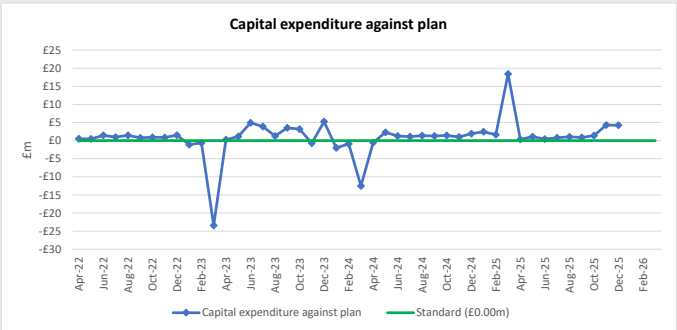

Reported bank expenditure
£m
£4.0
£3.5
£3.0
£2.5
£2.0
£1.5
£1.0
£0.5
£0.0
Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26
Reported bank spend


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


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

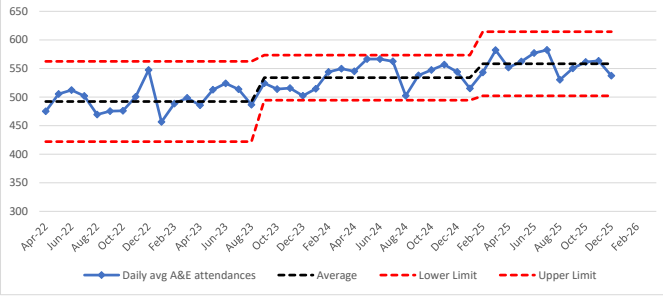

BPPC - Value of bills paid within target
£m
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26
Value of bills paid %
Standard (95%)


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

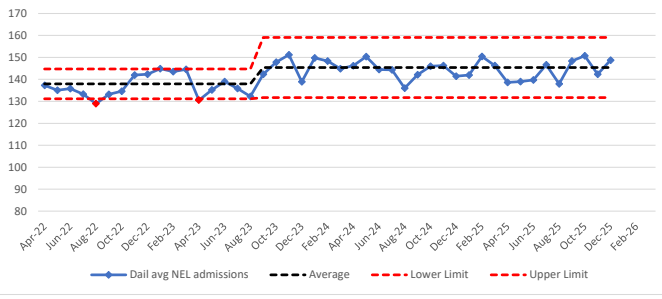

Capital expenditure against plan
£m
£25
£20
£15
£10
£5
£0
-£5
-£10
-£15
-£20
-£25
-£30
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25 Apr-25 Jun-25 Aug-25 Oct-25 Dec-25 Feb-26
Capital expenditure against plan
Standard (£0.00m)

Activity (for context)

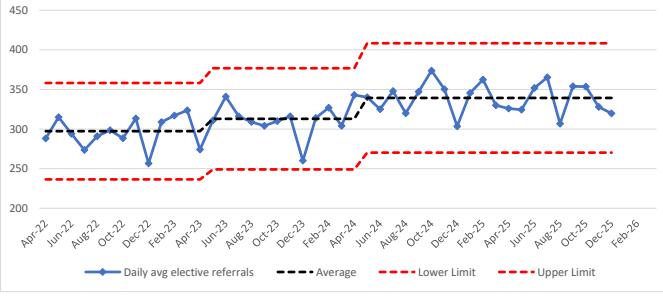
Daily average A&E attendances (inc. PC24)



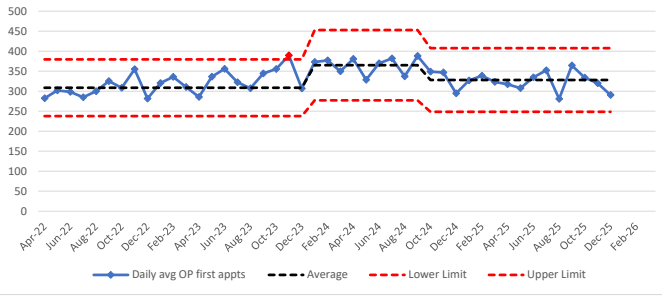
Daily average non-elective admissions



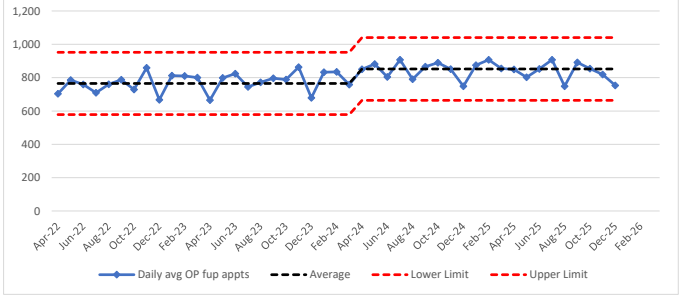
Average daily elective referrals



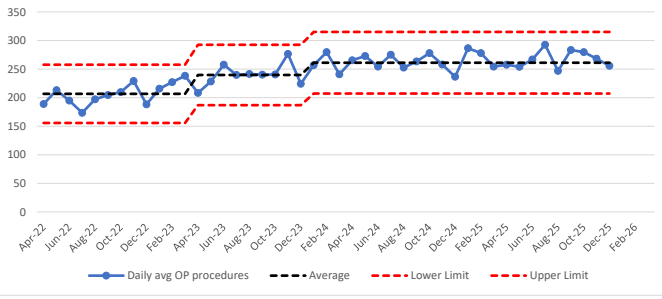
Daily average outpatient first appointments



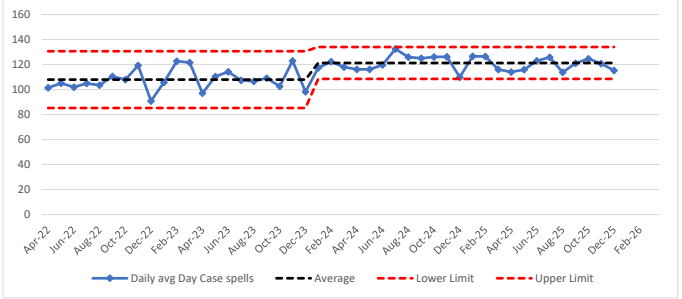
Daily average outpatient follow-ups



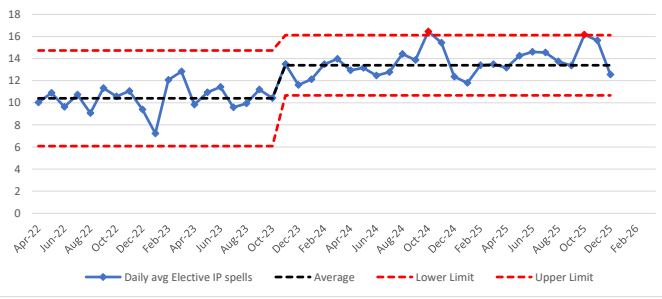
Daily average outpatient procedures



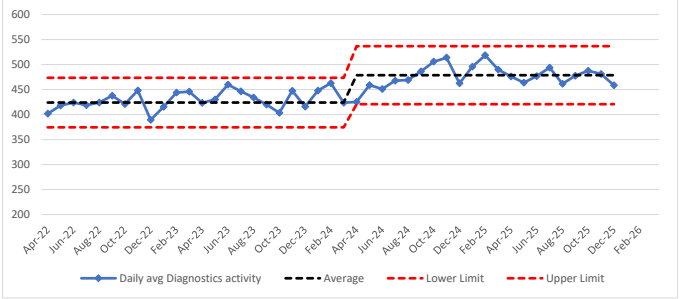
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

December 2025 (Qtr 3)

Timely Care Benchmarking

Nov-25

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	73.1%	108	176	7	Nov-25
	Ambulance turnaround times >60 mins	Summary Emergency Department Indicator Table (SEDIT)	6.0%	117	176	7	Nov-25
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	67.3%	115	152	8	Nov-25
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	9.6%	77	177	5	Nov-25
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	94.8%	83	179	5	Nov-25
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	11.3%	4	134	1	Nov-25
	Elective RTT 18-Week Performance	RTT waiting times data	60.3%	96	150	7	Nov-25
	Incomplete RTT pathways +52 weeks	RTT waiting times data	0.8%	46	150	4	Nov-25
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	88.9%	39	132	4	Nov-25
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	79.4%	56	134	5	Nov-25
	Cancer 31-day treatment performance	Cancer Waiting Times standards	93.6%	85	136	7	Nov-25
	Cancer 62-day treatment performance	Cancer Waiting Times standards	75.7%	54	136	4	Nov-25

Sherwood Forest Hospitals NHS Foundation Trust

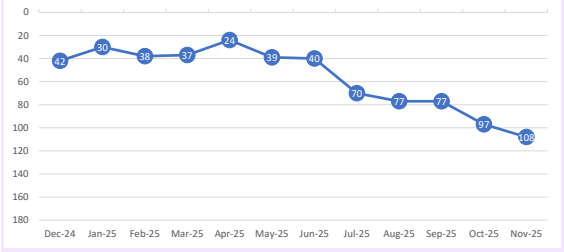
Integrated Performance Report 2025/26

December 2025 (Qtr 3)

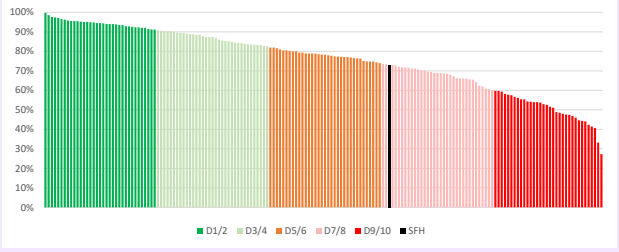
Timely Care Benchmarking Charts

Timely Care Benchmarking

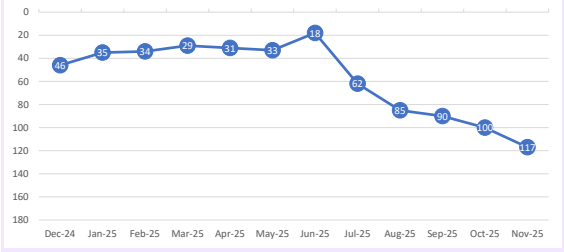
Ambulance turnaround times <30 mins



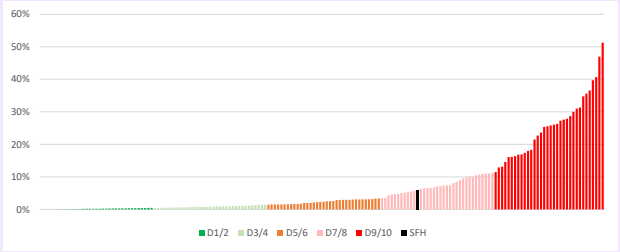
Nov 25 Position



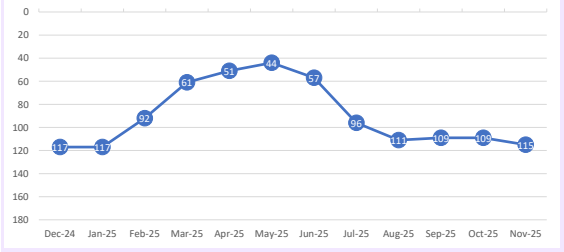
Ambulance turnaround times >60 mins



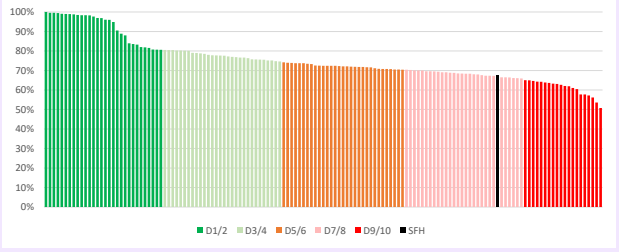
Nov 25 Position



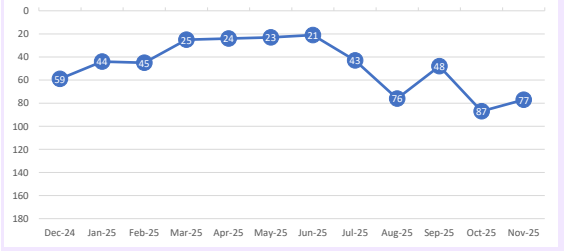
ED 4-hour performance



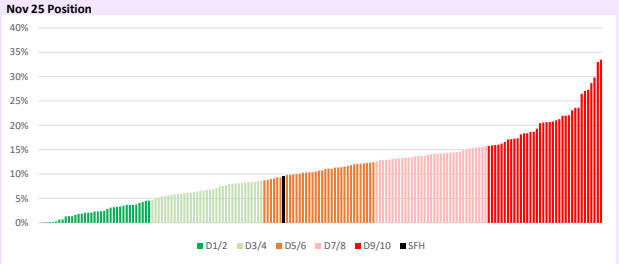
Nov 25 Position



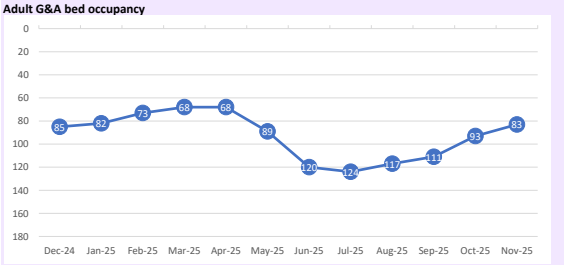
ED 12-hour length of stay performance



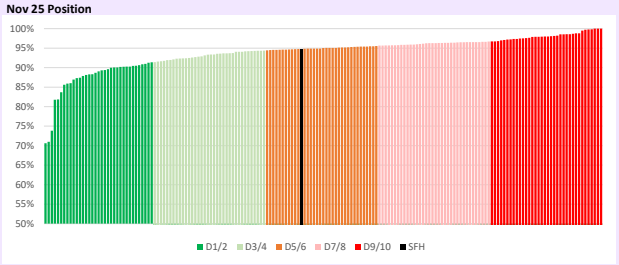
Nov 25 Position



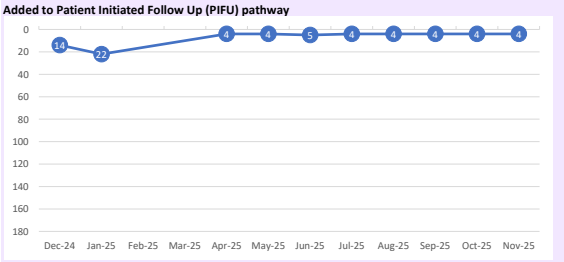
Adult G&A bed occupancy



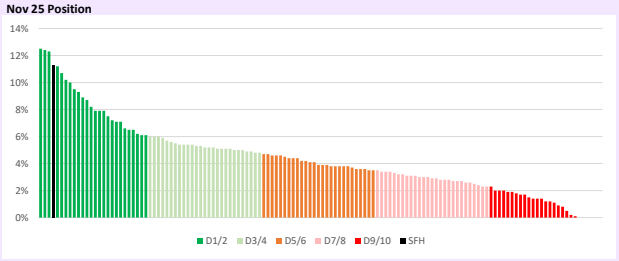
Nov 25 Position



Added to Patient Initiated Follow Up (PIFU) pathway

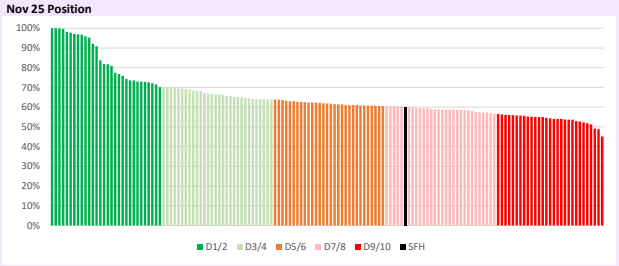


Nov 25 Position

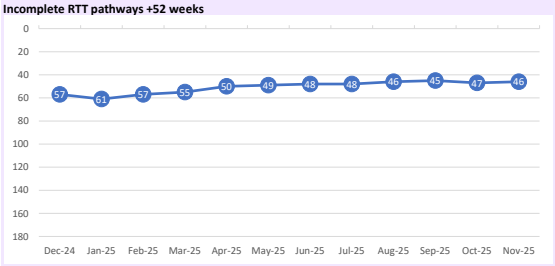


Elective RTT 18-Week Performance

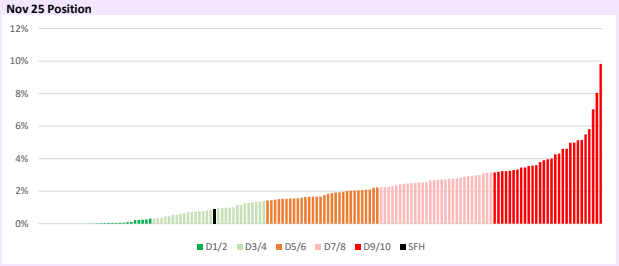
Nov 25 Position



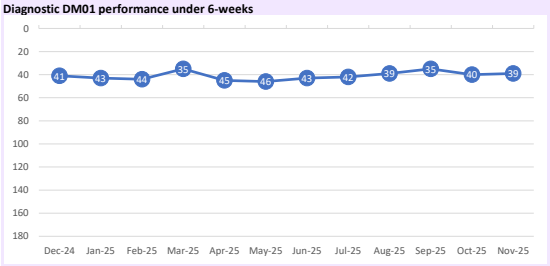
Incomplete RTT pathways +52 weeks



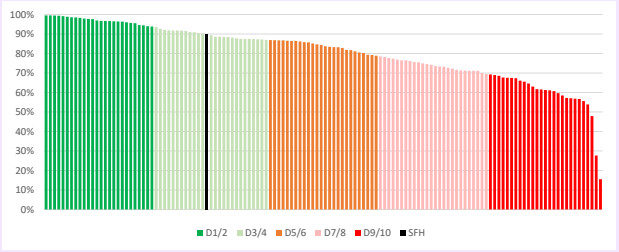
Nov 25 Position



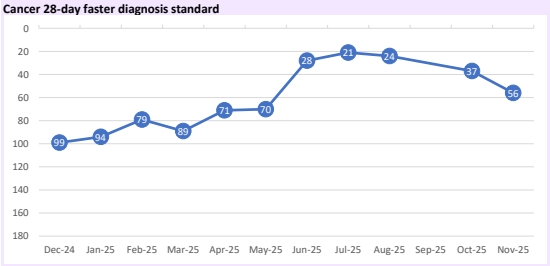
Diagnostic DM01 performance under 6-weeks



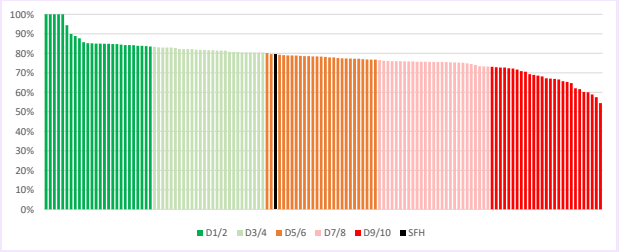
Nov 25 Position



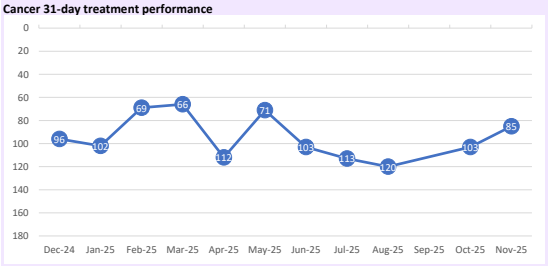
Cancer 28-day faster diagnosis standard



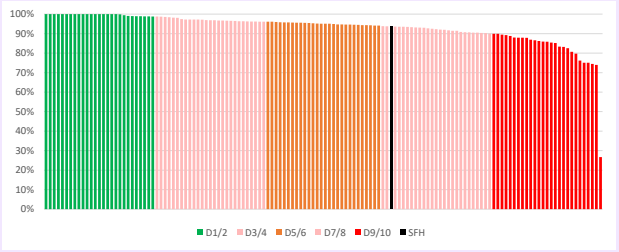
Nov 25 Position



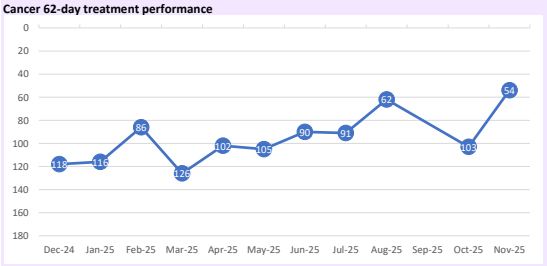
Cancer 31-day treatment performance



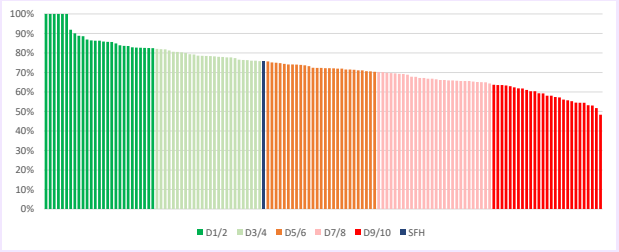
Nov 25 Position



Cancer 62-day treatment performance



Nov 25 Position



Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public – Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date:**	5th February 2026
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Jon Melbourne, Chief Executive Officer		
Presented By:	Jon Melbourne, 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 to provide oversight of significant operational risks.	**Approval**	✓
	Assurance	
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Lead Committees review individual principal risks at each formal meeting (Quality Committee; People Committee; Finance Committee; Partnerships & Communities Committee; Risk Committee).

Risk Committee reviews the full BAF, quarterly.

Acronyms

See list below

Executive Summary

Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable the Board to maintain effective oversight of strategic risks through a regular process of formal review.

Lead committees have been identified for specified principal risks and consider these at each meeting, providing a rating as to the level of assurance they can take that the risk treatment strategy will be effective in mitigating the risk.

The Risk Committee further supports the Lead Committees in their role by maintaining oversight of the organisation's divisional and corporate risk registers and escalating risks that may be pertinent to the lead committee's consideration of the BAF.

To provide Board oversight, a report detailing 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 meeting on 13th January 2026, and the respective principal risks on the Board Assurance Framework to which they apply.

The Risk Committee reviews all significant risks recorded within the Trust's risk register every month. This process enables the Committee to take assurance as to how effectively significant risks are being managed and to intervene where necessary to support their management, and to identify risks that should be escalated.

Proposed amendments to the BAF, agreed by the respective Lead Committees, are on the attached document - additions to the text are in red type and removals are in blue type (struck out).

The following scheduled reviews have taken place since the BAF was last received by the Board of Directors on 2nd October 2025:

- Quality Committee: PR1, PR2 and PR5 – October and November 2025 and January 2026
- People Committee: PR3 – November 2025
- Finance Committee: PR4 and PR8 – October and December 2025 and January 2026
- Partnerships and Communities: PR6 – October 2025
- Risk Committee: PR7 – November 2025 and January 2026

PR1, PR2, PR3, PR4 and PR7 remain significant risks. All risks except PR5 are above their tolerable risk ratings.

As this report was prepared before the 3rd February 2026 People Committee, there may be further changes agreed at those meetings that are not on the attached BAF report.

Board members are requested to:

- Review the principal risks in the context of proposed changes agreed by the respective lead committees
- Consider the implications of any current risk ratings being above tolerable levels
- Identify any further changes
- Approve the BAF including any further changes identified

Acronyms used in the Board Assurance Framework

Acronym	Description
AHP	Allied Health Professional
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BSI	British Standards Institution
CAS	Central Alerting System
CBRNe	Chemical, biological, radiological, nuclear, explosive
CFO	Chief Financial Officer
CQC	Care Quality Commission
CYPP	Children and Young People's Plan
DoF	Director of Finance
DPR	Divisional Performance Report
ED	Emergency Department

Acronym	Description
EoLC	End of Life Care
ePMA	Electronic Prescribing and Medicines Administration
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
eTTO	Electronic To Take Out (medications)
FC	Finance Committee
FIP	Financial Improvement Plan
FM	Facilities Management
GIRFT	Getting it Right First Time
HQIP	Healthcare Quality Improvement Partnership
HSE	Health and safety Executive
HSIB	Healthcare Safety Investigation Branch
HSJ	Health Service Journal
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IGAF	Information Governance Assurance Framework
IPC	Infection prevention and control
JAG	Joint Advisory Group
LGBT	Lesbian, gay, bisexual and trans
MEMD	Medical Equipment Management Department
MFFD	Medically fit for discharge
MHRA	Medicines & Healthcare products Regulatory Agency
MSFT	Medically safe for transfer
NEMS	NEMS Community Benefit Services (formerly Nottingham Emergency Medical Services)
OD	Organisational development
PC&IC	People, Culture and Improvement Committee
PCI	People, Culture and Improvement
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-Led Assessments of the Care Environment
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): January 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

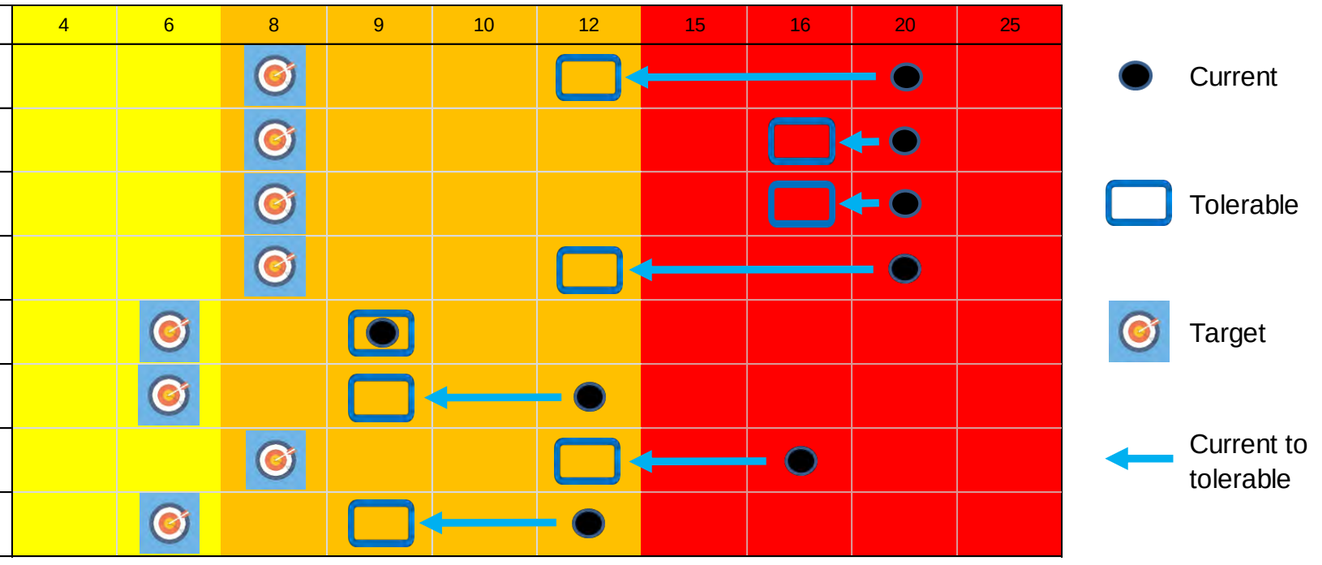
Red = Limited assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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:

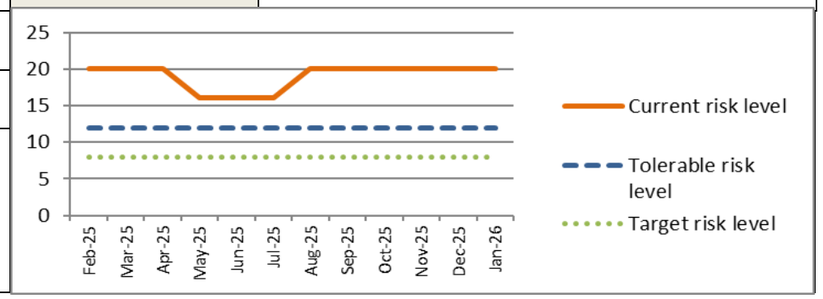
		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Chief Medical Officer Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Chief People Officer	People
PR4	**Insufficient financial resources available to support the delivery of services**	Chief Financial Officer	Finance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Chief Medical Officer	Quality
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	Partnerships and Communities
PR7	**Major disruptive incident**	Chief Executive Officer	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance



Board Assurance Framework (BAF): January 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						
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	12/01/2026	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**		
Last changed	12/01/2026						

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



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to maintain patient safety and quality of care leading to increased incidence of avoidable harm and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ IPR metric reviewed annually and agreed by Board ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Patients Safety Incident Response Framework (PSIRF) ▪ Review, oversight and learning from patient safety incidents Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC quarterly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight	Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care Lack of real time data collection, including information on overcrowding in ED Insufficient capacity, particularly beds, to maintain safe standards of care	Review the existing reporting metrics used to monitor patient safety and identify improvements to ensure consistency of the values used across different reports across governance groups, including the development of a quality dashboard **SLT Lead:** Chief Medical Officer / Chief Nurse **Progress:** Dashboard in ongoing development, but making progress **Timescale:** ~~December 2025~~Complete Continue to develop information systems to provide a unified position of flow across the organisation **SLT Lead:** Chief Medical Officer / Chief Nurse / Chief Operating Officer **Timescale:** March 2026 Further development and implementation of the UEC improvement plan, tracked through the Emergency Care Steering Group, with escalation to the Patient Safety Committee as necessary **Progress:** Structured plan in place, to be reported to Board in February 2026 **SLT Lead:** Chief Medical Officer / Chief Nurse **Timescale:** ~~November 2025~~Complete Roll out Nervecentre in ED **SLT Lead:** Chief Digital Information Officer **Timescale:** March 2026 Review of bed capacity and conversion of unconventional bed space **SLT Lead:** Chief Medical Officer / Chief Nurse **Progress:** ~~Scoping work completed – paper to be presented to TMT~~Transitional Care unit	**Management:** Learning from deaths Report to Quality Committee and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board quarterly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC - Sepsis report to Quality Committee and Patient Safety Committee quarterly Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports; Digital risks reported to Risk Committee 6-monthly and DSG monthly **Risk and compliance:** Quality Dashboard and IPR to Quality Committee bi-monthly; Quality Account Report qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC quarterly; Significant Risk Report to RC monthly; Exception reporting to System Quality Committee bi-monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services	~~Running at OPEL4 for a protracted length of time and full capacity protocol, exceeding full capacity protocol and system-wide critical incidents~~ Despite a significant number of actions being undertaken, there is still significant overcrowding in ED on a daily basis 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	Moderate Last changed January 2025

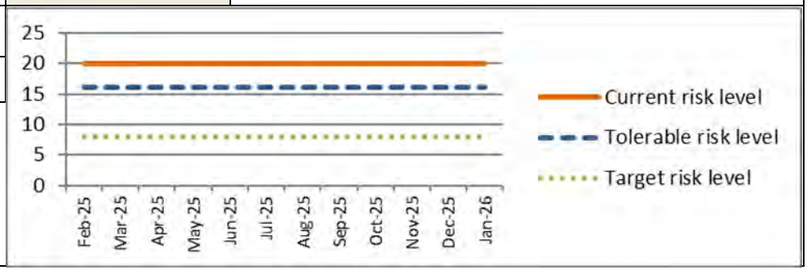
Board Assurance Framework (BAF): January 2026

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
	▪ 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	Lack of knowledge and application of skills and behaviour related to the treatment of children and young people	operationalised, which forms part of the winter plan **Timescale:** ~~October 2025~~Complete	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	Potential impact of industrial action on quality operational performance and finances	
An outbreak of infectious disease that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza ~~and Covid~~ vaccination programmes ▪ Reintroduction of enhanced respiratory virus testing during winter ▪ Public communications re: norovirus and infectious diseases ▪ Infectious disease identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions ▪ Dedicated ward (Chatsworth) for decant to maintain capacity			**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan; NHSE external review Sep 25 which will be used to support existing action plan	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): January 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						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely		
Last reviewed	20/01/2026	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	20/01/2026						

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



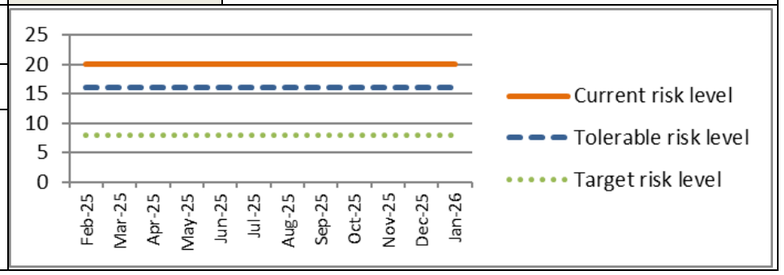
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population and increasing complexity of health needs • Further waves of admissions driven by Covid-19, flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ System programme boards with responsibility for oversight and delivery of transformation programmes that include Frailty, End of Life, Long Term Conditions, and Care Coordination aim at demand management and pathway improvements ▪ UEC Improvement Programme focussing on internal flow, and Getting the Basics Right with internal oversight at the Emergency Care Steering Group ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Emergency admission avoidance schemes across the system under oversight of the Urgent and Emergency Care (UEC) Board and the System Oversight Group ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with Nottingham Emergency Medical Services (NEMS) ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework and Full Capacity Protocol ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ SFH annual capacity plan with specific focus on the Winter period via the Winter Planning Group ▪ Referral management systems shared between primary and secondary care ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Planned Care Steering Group with oversight of performance and improvement activities (including work of the Cancer Steering Group) ▪ System support in place (mutual aid) with regular meetings via the System Elective Hub	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our full capacity protocol e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Operationalise the Acute Frailty Unit **SLT Lead:** Chief Operating Officer **Timescale:** ~~October 2025~~Complete Undertake an options appraisal to increase bedded capacity at King's Mill Hospital **Progress:** ~~Full appraisal of inpatient bed capacity to be presented to TMT in September~~Transitional Care unit operationalised, which forms part of the winter plan **SLT Lead:** Chief Operating Officer **Timescale:** ~~September 2025~~Complete Continue to work with local partners on collaborative working to address peak demand periods **SLT Lead:** Chief Operating Officer **Timescale:** Throughout 2025/26 Re-design of the hospital flow processes **Progress:** to review processes and outputs from GIRFT, and determine the action required **SLT Lead:** Chief Operating Officer **Timescale:** ~~November 2025~~ Superseded	**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 2025/26	Moderate Last changed September 2024

Board Assurance Framework (BAF): January 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
Constraints in availability of hospital bed capacity caused by elevated numbers of MSFT (medically safe for transfer) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group ▪ Multidisciplinary Transfer of Care Hub in place that undertakes twice-daily reviews of patients awaiting Nottinghamshire packages of care ▪ Full use of our bed base across our 3 sites with further capacity purchased from Ashmere Group Care Homes (at reduced levels in 2024 and 2025) ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Re-introduction of Discharge Co-ordinators across inpatient wards		Increase escalation calls between the hub, social care and SFH to daily **Progress:** following the recent Critical Incident, a comprehensive bed escalation plan is in place, which allows the Trust to utilise all available capacity effectively **SLT Lead:** Chief Operating Officer **Timescale:** ~~December 2025~~ Complete	**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 **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	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			**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:** ~~throughout 2025~~ June 2026	Moderate Last changed January 2025

Board Assurance Framework (BAF): January 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	20/01/2026	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	20/01/2026								



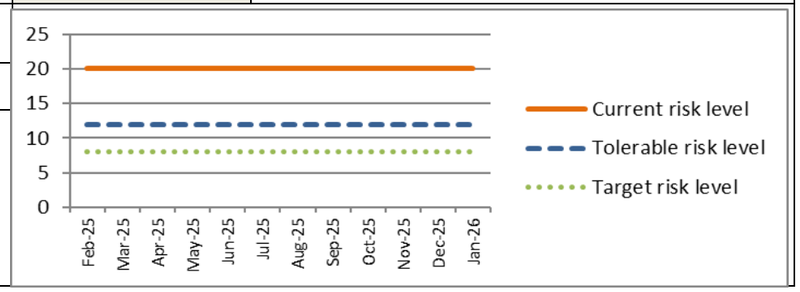
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 ~~2022~~ 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 ▪ Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, which may impact on the quality and standard of care Lack of consistency across the system about recruitment and retention, creating competition and not maximising opportunities Fragile services, including workforce gaps, in some services/specialties	Deliver the 2025-29 People Strategy – Year 1 **SLT Lead:** Chief People Officer **Timescale:** March 2026 Develop processes to minimise the use of premium pay and deliver the agreed workforce plan expenditure and whole-time equivalent reduction **SLT Lead:** Chief People Officer **Timescale:** March 2026 Develop a Clinical Services Strategy, including an associated workforce plan **Progress:** Review of Strategy under way, to be followed by divisions developing their associated workforce plans **SLT Lead:** Chief Medical Officer **Timescale:** ~~December 2025~~June 2026	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to People Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People and Culture to People Committee; Recruitment & Retention report monthly; Strategic People Plan to People Committee May24; Employee Relations Quarterly Assurance Report to People Committee; People Plan updates to People Committee bi-monthly; Leadership Development Strategy Assurance Report to People Committee quarterly; NHSE Planning – Workforce Perspective Report to People Committee May 24, Strategic Partnership Compact SFH & WNC Mar 25 **Risk and compliance:** Risk Committee significant risk report monthly; HR & Workforce planning report Risk Committee; IPR – Workforce Indicators to People Cabinet (monthly) - quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Recruitment of agency staff audit report Jun 23; Appraisals internal audit report Jun 24; e-Rostering internal audit Sep 25	Support teams across the Trust to deliver the workforce plan and the potential associated impact on staff morale **SLT Lead:** Chief People Officer **Timescale:** March 2026 Potential impact of an anticipated decline in staff survey results, resulting in reduction of staff retention, recruitment and organisational reputation Potential impact of industrial unrest due to the job matching and profile review for Nursing and Midwifery staff Engage with regional groups to ensure consistency of approach principles **SLT Lead:** Chief People Officer / Chief Nurse **Timescale:** March 2026	Moderate Last changed September 2024

Board Assurance Framework (BAF): January 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
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Wellbeing Champions) ▪ Schwartz rounds ~~▪ Learning from COVID~~ ▪ Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and Restorative culture ▪ Influenza vaccination programme ~~▪ COVID-19 vaccination programme~~ ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including ~~dedicated~~ 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	Implement the WRES and WDES action plans **SLT Lead:** Chief People Officer **Timescale:** March 2026 Revise the ToR for the Violence Reduction and Prevention Working Group to incorporate both clinical and people elements of the plan **SLT Lead:** Chief People Officer **Timescale:** ~~December 2025~~Complete Review/ redesign of conflict resolution and restrictive practice training, with an options paper being reported to Safeguarding Committee **SLT Lead:** Chief Nurse **Timescale:** ~~December 2025~~ Complete Detailed action plan to be developed and monitored by an assurance group chaired by a non-Executive Director **Progress:** Theatres Assurance and Performance Group established, chaired by the CMO with NED invited **SLT Lead:** Chief Nurse **Timescale:** ~~March 2026~~Complete Implement the detailed action plan via the Theatres Assurance and Performance Group **SLT Lead:** Chief Medical Officer **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 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Jul 24; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to People Committee Mar 25; NHS Long Term Workforce Plan to People and Culture Committee Sep 23 and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar24; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22; Staff Wellbeing internal audit report Jan 24	Potential impact of cost-of-living issues, and the impending job matching and profile review for Nursing and Midwifery staff, on staff morale and wellbeing Impact on staff morale and engagement, potentially leading to increased sickness levels, due to increasing capacity and demand issues, and perceived reduction in resources to undertake roles ~~Palpable~~ 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 Implement the 10 principles of the NHS Sexual Safety Charter **SLT Lead:** Chief People Officer **Timescale:** ~~December 2025~~Complete ~~Potential~~Ongoing industrial action, including strike action, of resident doctors	Moderate Last changed March 2025

Board Assurance Framework (BAF): January 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	13/01/2026	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**			
Last changed	13/01/2026							

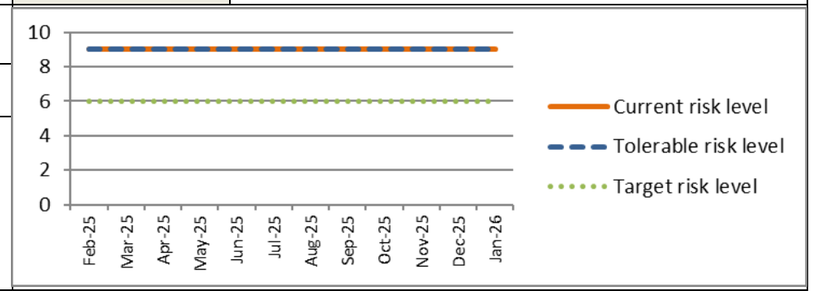


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return, monthly regional finance lead meetings, and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established ▪ Financial Resources Oversight Group (FROG) meeting monthly ▪ Executive level Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Financial Recovery Cabinet (monthly) meetings		Review of NHSE 2025/26 Financial Management expectations tools, interventions and oversight guidance **SLT Lead:** Chief Financial Officer **Timescale:** ~~October 2025~~Complete	**Management:** Monthly Finance Report to Finance Committee; Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); NHSE updates to Finance Committee; Monthly efficiency programme reports to Financial Recovery Cabinet; divisional representation at Finance Committee on a cyclical basis **Risk and compliance:** Review of NHSE 2025/26 Financial Management expectations tools, interventions and oversight guidance to Finance Committee Oct 25 **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2023/24 NHSE Performance Assessment Framework and Risk of Non-Delivery Assessment (RONDA) Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Key Financial Systems – Pay Expenditure (Jul 23) - ~~Financial Governance –~~ Financial Ledger and Reporting (~~Mar-24~~Jan 26) - Budget Setting, Reporting and Monitoring (Jun 24) - Operational Planning (Jun 24) - Financial Improvement Plan – Efficiency & Productivity (Jun 24) - System Financial Controls (Jun 24)	2025/26 Financial Plan includes a number of challenges and risks, including under-developed efficiency plans. The plans require de-risking in 2025/26 Quarter 1 **Progress:** Financial Efficiency Delivery & Sustainability team established and work-programme in development De-risking exercise continues to reduce the risk-adjusted forecast gap and is regularly reported to Finance Committee ~~PA Consulting engaged to support this work~~ **SLT Lead:** Chief Financial Officer **Timescale:** ~~November 2025~~Complete	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 ▪ No Purchase Order, No Pay policy in place ▪ Escalation process to CFO/Deputy CFO for suppliers indicating restrictions on supply		NHSE Cash support guidance received late August. Review of requirements and cash forecast scenario and sensitivity analysis to be completed **SLT Lead:** Chief Financial Officer **Timescale:** ~~September 2025~~Complete	**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 Payable and Treasury and Cash Management (Mar-24)~~Accounts Receivable and Asset Register (Jan 25) - ~~Financial Governance –~~ Financial Ledger and Reporting (~~Mar-24~~Jan 26) - Cash Management (Oct 25)	~~Limited access to additional cash support~~ Internal Audit on Cash Management scheduled for 2025/26 Q2 **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~January 2026~~Complete	~~Moderate~~ Significant Last changed ~~May~~ November 2025

Board Assurance Framework (BAF): January 2026

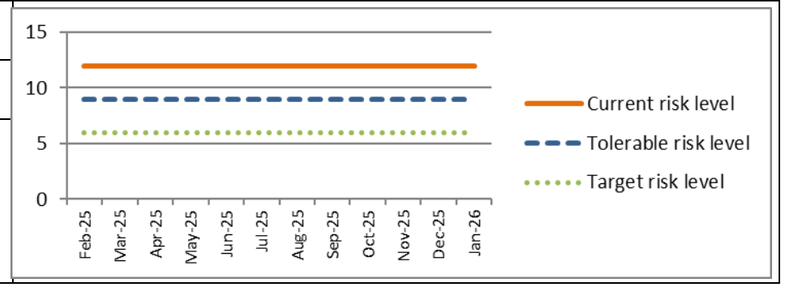
Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to 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
	▪ Weekly creditors report reviewed by Deputy CFO ▪ Risks relating to the cash position reported to Risk Committee monthly					
ICB system financial performance challenge leads to disinvestment in SFH	▪ 2025/26 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ICS Financial Recovery Group meeting weekly ▪ ICS System Delivery & Efficiency Group meets bi-weekly, with SFH representation ▪ ICS Operational Finance Directors Group established and attended by SFH Deputy Chief Financial Officer ▪ ICB Financial Framework ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions	~~2025/26 NHS Standard Contract not yet signed between SFH and ICB~~	NHS Standard Contract to be signed by all parties, providing security on financial flows and expected service delivery **Progress:** Contract negotiation meetings ongoing. **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~September 2025~~Complete	**Management:** Income Maximisation Programme established and reporting into Financial Recovery Cabinet **Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun 24)	Potential misalignment between ICB funding and expected contract income to the Trust Forecast outturn contract reconciliation exercise to be concluded **SLT Lead:** Chief Financial Officer **Timescale:** February 2026	Moderate Last changed January 2025
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks ▪ Approved 2025/26 Capital Expenditure Plan			**Management:** Board approved 2025/26 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team; Divisional risk reports to Risk Committee (bi-annually); Monthly Finance Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report **Independent assurance**: Capital Int'l Audit report Jul 24 Capital Audit Report (May 25) – Limited Assurance		~~Moderate~~ Significant Last changed ~~May~~ 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	Medium-term financial plan to be developed, to cover 36-month period **SLT Lead:** Deputy Chief Financial Officer **Timescale:** March 2026	**Management:** Monthly Finance Report to Finance Committee includes details on financial efficiency; Divisional Performance Reviews (bi-monthly); Divisional risk reports to Risk Committee bi-annually; Improvement Cabinet highlight reports to Trust Management Team and Finance Committee **Independent assurance**: Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Financial Improvement Plan – Efficiency and Productivity (Jun 24)	2025/26 Financial Plan includes a number of challenges and risks, including under-developed efficiency plans. The plans require de-risking in 2025/26 Quarter 1 **Progress:** Financial Efficiency Delivery & Sustainability team established and work-programme in development De-risking exercise continues to reduce the risk-adjusted forecast gap and is regularly reported to Finance Committee ~~PA Consulting engaged to support this work~~ **SLT Lead:** Chief Financial Officer **Timescale:** ~~November 2025~~Complete	Significant New threat added July 2024

Board Assurance Framework (BAF): January 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							**Strategic objective**	Continuously learn and improve
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Chief Medical Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	14/01/2026	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	14/01/2026								

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**
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 it Right First Time (GIRFT) Oversight Group	Continuous Quality Improvement Strategy not yet approved	Develop a process for improving clinical input and for better engagement with patients and the ~~for~~ public ~~and colleague engagement~~ 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) ~~Recruited to key roles~~ In addition, three Clinical Transformation Leadership Roles have now been recruited to support the process for improving clinical engagement ~~and plans in place to complete the documented process~~. ~~To~~ The impact of these actions will be reviewed to ensure they encompass the pending recommendations in the Darzi report ~~3 clinical transformation leads appointed~~ **SLT Lead:** Chief Medical Officer **Timescale:** January 2026 Develop and roll out a Continuous Improvement Strategy **Progress:** We will now 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. Report due February 2026 **SLT Lead:** Chief Medical Officer **Timescale:** ~~November 2025~~~~February 2026~~May 2026	**Management:** ~~Monthly~~ Bi-monthly Improvement report to Quality Committee ~~bi-monthly;~~, including update on NHS Impact Self-Assessment **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:**	Availability and capacity of staff to undertake improvement activities due to financial challenges~~,and~~ vacancy control~~s~~ processes, MARS and operational pressures Independent external review to be commissioned to determine the required model of Quality Improvement Support for the Trust based on priorities and expectations **Progress:** Proceeding through the procurement process – work expected to take 6-8 weeks Aqua review will be completed bu the end of January – report expected in February **SLT Lead:** Chief Medical Officer **Timescale:** ~~October 2025~~January 2026~~February 2026~~	Moderate Last changed October 2022

Board Assurance Framework (BAF): January 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**							**Strategic objective**	Work collaboratively with partners in the community
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	05/01/2026	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	05/01/2026								

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**
Competing priorities within SFH could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Alignment of Trust's Strategy with the ICS Joint Forward Plan ▪ Clinical Services Strategy established guiding principles and priorities ▪ Partnership Strategy and delivery plan with oversight on delivery by ~~Strategy and~~ the Partnerships ~~Cabinet~~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 and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ NUH/SFH Committee in Common oversees partnership working between the two trusts, supported by the Acute Services Oversight Group ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities and agreed actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources	Structure not yet in place to respond to the new format of commissioning intentions	Agree a governance structure with partners **Progress: C**ommissioning intentions on hold while new Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster designs its governance structure **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~November 2025~~April 2026	**Management:** ~~Strategy and~~ Partnerships ~~Cabinet~~Oversight Group chair's report to PCC Provider collaborative effectiveness updates to PCC Partnership Delivery Plan updates to ~~Strategy and~~ Partnerships ~~Cabinet Supporting~~Oversight group; supporting strategy reporting to relevant sub committees 6-monthly MNPBP highlight reports to Health Inequalities Steering Group quarterly Monthly HISG chair's report to ~~Strategy and~~ Partnerships ~~Cabinet~~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

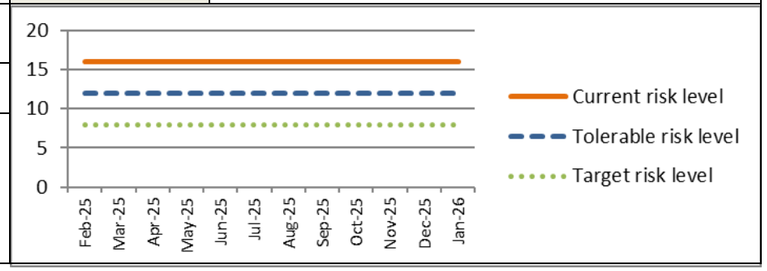
Board Assurance Framework (BAF): January 2026

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**
Competing priorities within our partners could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ NUH/SFH Committee in Common oversees partnership working between the two trusts, supported by the Acute Services Oversight Group ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities, aligning resources and agreeing actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources ▪ Formal partnership arrangements with Vision West Notts College, Nottingham Trent University and Universities of Nottingham	Structure not yet in place to respond to the new format of commissioning intentions	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:** ~~November 2025~~April 2026	**Management:** Partnership Delivery Plan updates to ~~Strategy and~~ Partnerships ~~Cabinet~~Oversight group MNPBP highlight reports to Health Inequalities Steering Group as appropriate HISG chair's report to ~~Strategy and~~ Partnerships ~~Cabinet~~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
Limited SFH partnership engagement capacity could result in a missed opportunity to bring in a wider patient and citizen voice to shape future healthcare services	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the Mid-Nottinghamshire PBP (MNPBP) and the district level Place Boards. ▪ ICS Clinical Services Strategy and Quality Strategy set priority re coproduction and personalised care ▪ ICS Health and Equality Strategy ▪ Nottingham and Nottinghamshire Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ SAIU dashboards and themed reports to focus on key priority areas for inputs and provide assurance of outputs and outcomes ▪ Clinical Directors and PCN Directors clinical partnership working ▪ Partnerships and Communities Committee (PCC) oversees delivery and receives assurance ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ SFH Health Inequalities Steering Group (HISG) linked to Mid Notts Health Inequalities Oversight Group to build relationships, share population health information and agree priorities and ICS Health Inequalities Steering Group, which facilitates sharing of patient/citizen voice and provides oversight of delivery			**Management:** ~~Strategy and~~ Partnerships ~~Cabinet~~Oversight Group chair's report to PCC Partnership Delivery Plan updates to ~~Strategy and~~ Partnerships ~~Cabinet~~Oversight Group; supporting strategy reporting to relevant sub committees MNPBP highlight reports to HISG as appropriate HISG chair's report to ~~Strategy and~~ Partnerships ~~Cabinet~~and Communities Committee **Independent assurance**: None currently in place		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 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						
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	05/01/2026	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	05/01/2026						

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



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & 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 updates to Cyber ~~Delivery Group~~Programme Board ▪ High Severity Alerts issued by Cyber Operations at NHS ~~Digital~~ 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 3rd party provider (Maple) ▪ Medical equipment cyber screening tool ▪ 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 ▪ Regional Organised Crime Unit (ROCU) ran a session for Cyber Board attendees in relation to Cyber Security	~~Upgrades to Windows 11 not completed on all devices~~ Lack of full audit trail due to the use of Generic Accounts	Implementation of Maple (logging monitoring system) **SLT Lead:** Director of NHIS **Timescale:** ~~September 2025~~Complete Implementation of ControlUp (network health tool) **SLT Lead:** Director of NHIS **Timescale:** ~~September 2025~~Complete Connection to the National Cyber Security Centre to enable real-time monitoring of devices on our systems **SLT Lead:** Director of NHIS **Timescale:** ~~September 2025~~ Complete Complete the programme of updates to Windows 11 **SLT Lead:** Director of NHIS **Timescale:** Complete Cyber Security session to be delivered by Gartner to the Trust Board **SLT Lead:** Director of NHIS **Timescale:** March 2026 Develop a plan for work in relation to shared accounts (Generic) to ensure they can be completely eradicated **SLT Lead:** Chief Digital Information Officer **Timescale:** March 2026	**Management:** Data Security and Protection Toolkit submission to Board Jul 24 - compliant on all 113 elements; DSPT updates to Information Governance Committee bi-monthly and Risk Committee 6-monthly; Hygiene Report to Cyber Security Board bi-monthly; Cyber Security Assurance Highlight Report to Cyber Security Board bi-monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; 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 245; 360 Assurance Data Security and Protection Toolkit audit Jun 25 – high assurance; Cyber Essentials Plus accreditation (NHIS) Dec 245	NHS-targeted cyber-attacks continue to be increased and there are inherent risks which are almost impossible to fully mitigate Gap analysis conducted with InterForensics to identify priority areas for Cyber mitigations **SLT Lead:** Director of NHIS **Timescale:** March 2026 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:** April 2026	Limited Last changed January 2025

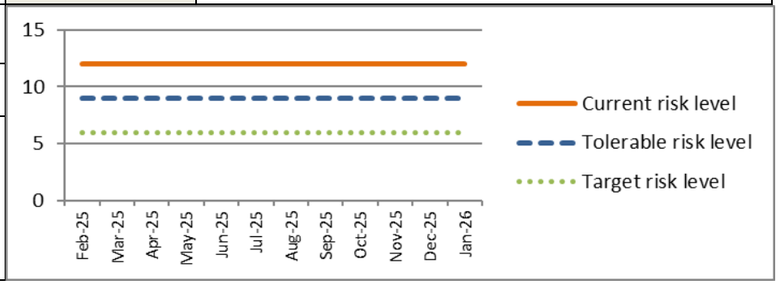
Board Assurance Framework (BAF): January 2026

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
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 ~~is~~ compliant with fire regulations **Progress:** ~~It has now been agreed by Project Co. that the existing cladding will be replaced in full, programme currently being updated to take into account the new Building Safety Act (BSA). (BSA approval still awaited) – decision extended by 2 months~~ Fire Alarm Cause and Effect works complete at KMH, BSA Wall Type 4 and 5 approved to be replaced and fire stopping to works at KMH PFI progressing **SLT Lead**: Director of Estates & Facilities **Timescale:** ~~October2025~~ April 2026 Determine the remedial work required to ensure that the buildings achieve the required standards for the environment and condition is maintained to appropriate standards. **Progress:** WSP Surveys have been issued for S38, NH and MCH **SLT Lead**: Director of Estates & Facilities **Timescale:** ~~January 2026~~Complete	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; ~~severe~~ adverse weather; evacuation; CBRN~~e~~) ▪ 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 ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three-yearly internal audit of EPRR arrangements with report to Board ▪ Incident Response and command and control training to all tactical and strategic leads across the organisation carried out annually ▪ Testing and exercising of service level plans carried out annually ▪ Health Risk Management Group for EPRR			**Management:** Monthly Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating 2024~~5~~ – Substantial Compliance; EPRR Business Continuity internal audit report Nov 24 – Significant assurance; CBRN Audit carried out in ~~March 2024~~ Feb 25 by EMAS		Significant New threat added May 2023

Board Assurance Framework (BAF): January 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						
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious
Initial date of assessment	22/11/2021	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely		
Last reviewed	13/01/2026	**Risk rating**	**12. High**	**9. Medium**	**6. Low**		
Last changed	13/01/2026						

Strategic objective	Improve health and wellbeing within our communities



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 ~~2021-~~2026~~5~~-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)	~~Insufficient capital resource available to realise Trust ambition~~ Support from our PFI partners in developing 'green' solutions	Continue to work with partners to maximise opportunities for green solutions for life-cycle replacements in both the retained areas and the PFI estate **Lead:** Director of Estates and Facilities **Timescale:** ~~throughout 2025/26~~March 2026	**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board ~~Apr 21~~ Dec 25; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Implement the schemes we have in place for 2025/26 to help to reduce our energy consumption including LED lighting, building management system controls and smart metering **Progress:** Capital works initiated and completion expected in 2025/26 **Lead:** Sustainability Officer **Timescale:** ~~October 2025~~March 2026 ~~Refreshing of the Green Plan following new guidance from NHSE – strategy being developed~~ **Progress:** Plan updated, to be submitted to Finance Committee in November and Board in December **Lead:** Sustainability Officer **Timescale:** ~~September 2025 January 2026~~Complete	Moderate Last changed December 2023

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors - Cover Sheet

Subject:	Well Led Action Plan – Update	**Date:**	5th February 2026
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

This paper provides a further update on the responses to the actions from the Grant Thornton LLP developmental Well-Led Review that incorporates Executive Committee feedback and records sign off by the nominated Committee of the Board. The Board is invited to review the responses and provide its feedback prior to the final version of the Action Plan being presented to the Board for approval at its meeting in public on 2nd April 2026.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

Identify which Principal Risk this report relates to:

PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	**X**
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Failure to achieve the Trust's financial strategy	**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

Board
Executive Committee
Board Committees

Acronyms

STC – subject to confirmation
TBC – to be confirmed
FTSU – Freedom to Speak Up

Executive Summary

The findings from the Developmental Well Led Governance Review conducted by Grant Thornton LLP in January 2025 were reported to the Board at its meeting on 6th February 2025 at which the action plan and associated progress monitoring arrangements were approved. The Actions fell into five categories: Leadership, Improvement, Strategy, Partnerships and Freedom to Speak Up.

The table below summarises the position when the Action Plan was most recently presented to the Board on 12th December 2025:

Action section	Total Number of actions	Number previously approved by the Board	Action requiring Board review
Leadership	4	2	Action Nos. 1 and 4
Improvement	5	0	All 5 actions
Strategy	7	3	Actions 1 – 4, inclusive
Partnerships	6	0	All 6 Actions
Freedom to Speak Up	11	4	The remaining Actions Nos. 2, 5-9, inclusive, and 11

Since the Action Plan was last presented to the Board some necessary changes to the action responses and task leads have been updated. The Plan has also been updated throughout to reflect agreement that completion of all actions be brought forward to 31st March 2026 at the latest to enable the full response to the Action Plan to be approved by the Board in April 2026 on the basis of recommendations from its sub-committee and Executive Committee. Unavoidably, two of the planned meetings to do this were stood down in the recent critical incident.

Appendix 1 to this paper comprises the updated Action Plan covering all its five sections against which current progress has been recorded for discussion and approval. The scheduled full Executive discussion was unable to take place on 14th January 2026, so instead individual Executives responses have been consolidated in the Action Plan.

Leadership section
The responses to Actions 2 and 3 have been previously signed off by the Board with numbers 1 and 4 recommended by the Executive team to the Board for its approval to complete the section.

Improvement section
With the benefit of contributions from all Executives, the responses to all five Actions are presented for review and approval.

Strategy section
Likewise, with the benefit of contributions from all Executives, the responses to the remaining Actions 1-4 are presented for review and approval noting the Board previously signed off those to Actions 5-7.

Partnerships section
The Director of Strategy & Partnerships has provided responses that have been reviewed by the full Executive team against all six actions. The action updates were scheduled for signed off by the Partnerships Committee on 13th January 2026, however that meeting was cancelled, and they will be formally presented to the next meeting on 14th April 2026. As that meeting is after the planned final approval of the Action Plan responses by the Board on 2nd April 2026, a written submission will be circulated to Committee members seeking approval to recommend the action updates to the Board, so the final approval is not delayed.

Freedom to Speak Up
Actions 1, 3, 4 and 10 (of 11) were approved by the Board at its meeting on 7th August 2025 on the recommendation of the People Committee. The progress being made against the remaining seven FTSU actions was also reported to the People Committee, and these are now brought forward to the Board for approval. With the People Committee's meeting to consider its sign-off and recommendation to the Board of the responses to the remaining Actions 2, 5-9 and 11 not being held until 3rd February 2026, verbal feedback, including any further updates suggested, will be given at the Board meeting.

Evidence and future plans
The need to ensure evidence of the changes implemented as a consequence of the actions is vital. The Director of Corporate Affairs has established a central repository to enable rapid one stop access. Executive colleagues are sighted on the need for them to send supporting information through so it can be saved for future use, particularly in the event of an inspection.

As change will inevitably occur in the identified development areas it is essential that the Action Plan is maintained as a live resource and record for the assigned committees from whom on-going feedback can be provided to the Board via their meeting Highlight Reports.

The next and final scheduled paper about the Action Plan from the developmental Well-Led report is to the Public Board meeting on 2nd April 2026 at which Board approval will be sought to confirm the Actions have been completed.

Recommendations

The Board is asked to:

1. Review and approve the progress updates in relation to the Actions in the Leadership, Improvement, Strategy, and FTSU sections of the Action Plan.
2. Review the progress updates to the Partnerships sections ahead of their recommendation for approval from the Partnerships and Communities Committee at the April Board meeting.
3. Note the arrangements made for the provision of supporting information and for on-going use of the Action Plan to promote continuous improvement.
4. Note the full plan will be presented to the April 2026 Board meeting in public to record and approve the completion of the full suite of actions from the developmental Well-Led review
5. Note that consideration will be given to the commissioning of a further developmental Well-Led review in 2027/28.

Sherwood Forest Hospitals
NHS Foundation Trust

Well-Led Review January 2025
Action plan for development areas

KEY:

ACE	Acting Chief Executive (ended 27/10/2025)
DCE	Deputy Chief Executive (ended 06/11/2025)
CE	Chief Executive (from 27/10/2025)
COO	Chief Operating Officer
DSP	Director of Strategy & Partnerships
CPO	Chief People Officer
DoCA	Director of Corporate Affairs
FTSUG	Freedom to Speak Up Guardian
NGO	National Guardian's Office
	Action signed off by the Board

Actions – Leadership

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
1	Unitary Board development	The Chair and ACE/DCE should design a structured board development plan to include actions and activities that support effective onboarding and integration of the new NEDs and other directors. The plan should include protected time to invest in "team building" and softer skills to ensure the Trust maintains a unitary board.	Chair and CE	CE	31/10/2025	In September 2025 an application was submitted for the NHSE Board Development Programme. Unfortunately, the response to it was that NHSE had taken a decision to pause the Programme for the remainder of the financial year 2025/26. We maintain and regularly update a planner of Board development activities, time for which has been enhanced by the move to bi-monthly formal Board meetings in the even numbered months and a greater focus on developmental activities in odd numbered months. We hold an annual Board Development event in November. In 2025 this included a half day session led by PTS Insight that provided protected team building time and from which commitments to on-going development actions have been shared. In 2025 the Chair's appraisal included 360-degree feedback for the first time. Building on that success, this feedback is being rolled out to all Board	Executive Committee January 2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
						members, NED and Executive for appraisals in 2026/27.	
2	Unitary Board development	Review and agree how appropriately detailed information on Trust performance/issues is shared with NEDs between committee meetings, to ensure NEDs are kept up to date in a timely manner.	ACE/DCE	ACE/ DCE and COO	30/06/2025	NEDs now receive at least monthly updates. IPR reporting to the Board has now increased from quarterly to bi-monthly at public Board meetings. Additional performance information is shared at the Executive & NED Update meetings in the "odd" numbered months when no public Board meeting is convened.	Executive Committee 30/07/2025
3	Unitary Board development	The Chair and NEDs should agree the schedule of regular NED group catch-ups, given the context of new NED member appointments over the next few months.	Chair	DoCA	30/06/2025	The Board's decision to move to bi-monthly formal meetings in the "even" months from June 2025, has enabled the "odd" months to be focussed on NED catch ups, including workshops. Positive feedback received from NEDs following the changes. A forward plan for 2025/26 has been agreed with the Chair.	Executive Committee 30/07/2025
4	Skills and experience	The Trust's effective succession planning arrangements have ensured that the Board has remained stable following key Board changes over the last year. There remain recognised gaps at board level covering the areas of improvement, transformation and research. The Trust is recruiting to a Director of Improvement and NED	CE	All Exec Dirs.	31/03/2026	Following an unsuccessful recruitment exercise to the Executive Director of Improvement and Change role the new Chief Executive, who took up the post on 27th October 2025, has reviewed the position resulting in agreement to proceed, the launch of the	Executive Committee January 2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
		recruitment is planned. The Chair and ACE/DCE should consider how experience and skills gaps can be closed as part of the ongoing Executive and NED recruitment process and as part of the board development programme.				advertisement/search and a recruitment decision by the end of February 2026. The planned NED recruitment took place and wef 6th February 2025 two NEDs one a finance specialist and the other with a background in nursing and quality have been recruited. Both NEDs have since succeeded as the respective chairs of the Finance Committee and the Quality Committee following induction to these roles. In addition, an exceptionally well qualified and experienced Associate NED recruit (the first for the Trust) is focused on the support and development of the Trust's research function.	

Actions – Improvement

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	Prioritise and monitor	Establish buy in and support from the Board on the Trust improvement strategy and approach. This would include agreeing key improvement priorities and what can be achieved by when, and setting out key terms and definitions (e.g. improvement – quality, operational and financial, transformation, multi-year etc)	Chair	All Exec Dirs.	31/03/2026	The Trust strategies refresh cycle is being used as an opportunity to define and prioritise improvement targets. Sub-board committees hold the reins on these plans. Segmentation reports that are presented to relevant subcommittees also support visibility. In terms of improvement strategy, the key areas are the AQUA review of the Improvement Faculty, that is in progress, and the appointment of the Executive Director of Improvement scheduled in February 2026.	Quality Committee STC
2	Embedding improvement culture	Revisit and reset governance processes and groups for developing and monitoring improvement work across the Trust. This would include consideration of the role of the Financial Improvement Cabinet/Improvement Cabinet and Quality and Safety Committee.	DoI	All Exec Dirs.	31/03/2026	Separation of Financial Improvement and Quality Improvement. Revised arrangements implemented for financial governance via the Financial Recovery Cabinet. Regular improvement updates provided to Board along with other related events supported by Board members including Improvement Week events, Improvement Showcases, Step into the NHS events and Celebrating Excellence events. The GIRFT oversight group -	Quality Committee STC

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						supports key GIRFT workstreams across the organisation	
3	Embedding improvement culture	The Trust should develop a clear and detailed plan to share learning from improvement projects and agree the approach widely communicate improvement activities.	DoI	DSP	31/03/2026	NMAHP Committee receives dissertation research from funded degrees. The Chief Nurse Fellowship quality improvement shared with a wide audience. The Ward Sisters and Matrons Development Days are an environment to discuss quality improvements. The Chief Nurse Bulletin published quarterly has examples of quality improvements. Nominations to national conferences (Nursing Times, HSJ and British Journal of Nursing) demonstrate the ongoing development of quality improvement in NMAHP.	Executive Committee STC
4	Embedding improvement culture	The Trust should consider how all senior leaders at the Trust can input into the Trust improvement programme and activities, to drive and support delivery and send a message that improvement work is a responsibility of all leaders.	DoI	DSP	31/03/2026	Chief Nurse Fellowship actively promoted the QSIR programme and has a taster day on the programme. All Fellowships have to undertake a quality improvement project. All senior leaders within NMAHP and significant amount of the workforce now have the QSIR programme.	Executive Committee STC

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						All Ward/Dept conduct at least 1 QI project as part of ward accreditation.	
5	Developing capability and capacity	The Trust should consider how it can ringfence clinical and operational staff time to ensure improvement work is given more priority and focus.	DoI	DSP	31/03/2026	Senior leaders within NMAHP have QSIR practitioner training. QI project now built into annual ward accreditation for all ward/Dept areas. 8 PAs of clinical time have been recruited to support the improvement faculty. However, the faculty is approximately 20% smaller than it was a year ago as a result of staff reductions through MARS/holding vacancies so this does impact on what the team can deliver as it is under resourced in terms of specialist improvement skills. PMO staff resources have been deployed into the Finance team to support the Corporate Optimisation Programme. The AQUA review of the Improvement Faculty is in progress.	Executive Committee STC

Actions – Strategy

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	Long term trajectory	Build a clear and detailed plan based on the Board development day sessions to build longer term strategy	ACE/DCE	DSP	31/10/2025	All Board development sessions and private board updates have led towards a plan to become an Integrated Health Organisation, with a strong Place and neighbourhood offer. This will be transacted into the Trust Strategy 'Improving Lives' for years 3-5 (2026-2029) with a delivery plan in place by April 2026. Enabling actions underway through inviting external partners to the November 2025 Board development session and taking a leadership role in the PBP.	Executive Committee
2	Long term trajectory	Link actions into three pillars of NHS plan alongside ICB plans and strategy, in particular PLACE based delivery.	ACE/DCE	DSP	31/10/2025	ICB plans and strategy are under review due to national guidance requiring a population health and neighbourhood plan in early 2026 (plus change to clustering). The Trust are actively involved in this process and translating plans back into the Trust through the strategy refresh for 2026-2029. This includes a co-developed Mid & North Notts Neighbourhood plan led by the Trust. All refreshed plans to be in place in April 2026.	Executive Committee

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
3	Long term trajectory	Identify and release capacity to develop strategy, considering broader input/leadership at Board level and wider organisation.	ACE/DCE	DSP	31/10/2025	The Strategy Steering Group has met monthly during 2025 including Exec directors and NEDs, led by the Director of Strategy and Partnerships to inform strategic direction. Additional 1 day a week resource identified to co-develop neighbourhood plan with partners across the Mid and North Notts area. A new delivery plan due April 2026 will review resources and leadership required for success.	Executive Committee
4	Long term trajectory	Establish governance processes and groups for monitoring delivery, development and engagement of strategy.	ACE/DCE	DSP	31/10/2025	Strategy steering group has met monthly over 2025. Group on pause whilst 'Improving Lives' strategy refresh is transacted for 2026, which will identify most appropriate governance route once deliverables are clear, due in April 2026. Commercial strategy group has met monthly over 2025. All supporting strategies (partnership, clinical services, finance, people, quality) have governance routes into the appropriate Board committee which then feeds a 6 monthly overarching strategy update at Board.	Executive Committee

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
5	Underpinning strategies	Reset, align and further develop underpinning strategies that enable the delivery of the longer-term strategy.	ACE/DCE	DSP	31/03/2026	All supporting strategies (partnership, clinical services, finance, people, quality) are aligned to the Improving Lives strategy including same end dates (2029). Further work underway on Digital and Estates strategies to align to the Improving Lives Trust strategy.	Executive Committee 30/07/2025
6	Underpinning strategies	Develop a long-term financial strategy that demonstrates the financial sustainability of the Trust which links into the system plans and strategy.	ACE/DCE	CFO	31/03/2026	Finance strategy developed and approved during 2025. Aligned to the Improving Lives and ICS strategies.	Executive Committee 30/07/2025
7	Underpinning strategies	Ensure clinical, operational, workforce and financial strategies are further developed and aligned.	ACE/DCE	DSP	31/03/2026	Operational, workforce and financial plans are enacted through the national planning round and aligned to the appropriate supporting strategy.	Executive Committee 30/07/2025

Actions – Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	External perceptions and relationships	Continue to push as being active player in system and develop system working and approach with ICB on financial improvement in particular.	CE	DSP	31/03/2026	The Partnerships and Communities Committee's role and work is developing and maturing. The Trust contributes to the ICB as a provider representative. Establishment of Executive-to-Executive meetings with NUH. Committee in Common with NUH. East Midlands Acute Providers Network collaboration initiatives. In relation to financial improvement, we are actively involved in the Cluster Financial Recovery Group and the Provider Recovery Assurance Group.	Partnerships (unavoidably deferred to 14/04/2026)
2	External perceptions and relationships	Take leadership responsibilities on key areas of system development plans and pushing PLACE.	CE	DSP	31/03/2026	Director of Strategy & Partnerships is the SRO for the Ageing Well workstream and contributes to the development of the PBP. The Associate Director of Strategy & Partnerships attends the Place Boards. We have contributed to the development of the Health and Wellbeing Board development.	Partnerships
3	Strategic alignment	Use development of long-term strategy as basis of discussion, direction and leadership on system and ICB plans.	CE	DSP	31/03/2026	Our Partnerships and Clinical Services Strategy includes aspects of population health and our Trust Strategy "Improving Lives" aligns to the 5-year strategy of the ICS. Year 3 plans for the Trust's strategy for 2026/27 will be updated to include neighbourhood working.	Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
4	Strategic alignment	Fully engage with ICB on development of strategic plans and underpinning strategies.	CE	DSP	31/03/2026	As noted above, the Trust's Strategy is aligned to that of the ICS. We are a part of the ICS strategic approach to population health. All our supporting Strategies align to the ICS Strategy – Clinical Services, Partnerships, Finance, People Plan and Quality. The ICB were participants at our November 2025 Board Development Workshop with positive feedback received.	Partnerships
5	Collaborate and co-develop	Work jointly with partners (system and wider) to co-develop and deliver plans and strategies which support the delivery of agreed long term plans.	CE	DSP	31/03/2026	The Nottinghamshire Directors of Strategy Group meets to review and avoid duplication of plans in order to maximise resources and achieve outcomes. The EMAP Network works on shared plans. The Trust is integral to the PBP.	Partnerships
6	Governance	Use the Partnerships and Communities Committee to monitor actions and ensure strategic alignment.	CE	DSP	31/03/2026	A specific duty of the Partnerships and Communities Committee is to "Receive and assess key updates from Strategic forums in the System and provide assurance to the Board that the Trust is championing those aspects of its overall strategy that are executed through strategic partnerships." The partnership landscape is rapidly changing across the health and care sector, the committee ensures a regular agenda item on the state and	Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						pace of change, and impact/risks for the Trust. This action plan is updated and approved via the committee.	

Actions – Freedom to Speak Up

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
1	Governance route	Review and streamline the governance route to Board for FTSU ensuring accountability at Committee level is clear.	DoCA	DoCA	30/06/2025	Following a thorough review a schedule of quarterly reporting has been agreed and implemented that sees FTSU reports presented to the People Committee and the SFH Board on an alternate cycle each quarter with reports to People Committee in January and July and to the Board in April and October.	People 29/07/2025
2	Governance route	Create time and space for discussion of FTSU concerns e.g. FTSU sub-cabinet.	DoCA	DoCA	31/08/2025	The Executive Lead and FTSUG meet fortnightly to discuss concern themes and support as required. Outstanding concerns are passed to the FTSU Operational catch-up Meetings, attended by the Chief People Officer, the Director of Corporate Affairs and the FTSUG, for discussion. The FTSUG has established regular Divisional catch ups with Divisional Triumvirates in the Women's & Children's, Surgery and Medicine Divisions to create space and ownership of FTSU themes and current concerns. The outputs from these meetings are reported up to the People Committee and Board in the FTSUG's reports that are presented to those forums on the agreed alternating 3-monthly cycle.	People 29/07/2025 Progress noted

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
3	Governance route	Divisional leads to sit on this sub-cabinet (along with Executive Lead) to secure buy in from divisions which is currently variable. Consider whether the Executive Lead should be within the triumvirate to strengthen engagement across the divisions.	DoCA	DoCA	30/06/2025	An alternative approach to convening a FTSU Sub Cabinet has been agreed. Instead, a FTSU Operational catch-up meeting has been established that had its inaugural meeting on 25/06/25 and is developing its membership and purpose with reviewing outstanding FTSU cases and support for resolution its current focus.	People 29/07/2025
4	Governance route	Consider implementing a tenure for the FTSU Guardian and Champion role, with an option to extend if both parties agree.	DoCA	DoCA	31/05/2025	This recommendation is not practical, affordable or appropriate in the context that the FTSUG is a substantive member of staff with long service, the growth in FTSU referrals and the cost & quality implications of buying in an external service (that would not include pro-active support and services) which is the only current alternative option as neither NUH nor NH is currently willing and able to support a shared service.	People 29/07/2025
5	Responsiveness	Review concerns raised to understand trends and activity and use this intelligence to redesign and promote pathways supported by clear support for managers to enable resolution.	DoCA	DoCA	30/09/2025	Collaborative work with NHIS enabled the development and launch of a new FTSU database platform that went live in September 2025 to replace the previous Excel spreadsheet. The FTSU has retrospectively populated the FTSU database with all the information on cases opened in Q1 & Q2 2025/26 so that the full year's reporting is available to provide information to support managers and enhance	People 29/07/2025 Progress noted

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
						reporting of trends, themes and activity and enable presentation of bespoke reports, as required. The introduction of the FTSU Process & Timescale Guidance (in September 2025) is supporting managers in their handling of concerns and sharing learning.	
6	Responsiveness	Develop a communications plan – to include promotion of FTSU, sharing of success stories, and also promote other existing routes.	DoCA	DoCA	30/09/2025	A FTSU Communications document for 2025/26 has been prepared by the FTSUG. Progress against it will monitored, including feedback from the Chief People Officer, at the regular operational catch-up meetings with the FTSUG and DoCA.	People 29/07/2025 Progress noted.
7	Responsiveness	Establish a triage system to determine how concerns of varying natures will be dealt with, including expected response and resolution timeframes. This should be communicated to staff so there is a mutual understanding.	DoCA	DoCA	30/09/2025	The FTSU Process and Timescale Guidance was approved by the JSPF in May 2025. Its roll out was cascaded through TMT and Divisional communications, with support from the FTSU Champions and went live in September 2025. It is being utilised when FTSU escalations are required. We agreed to review the operation of the Guidance after 6 months in operation and feedback has been sought from TMT generally and specifically on 1. whether it should be separated into two, one for concern raisers and the other for line managers, and 2, on whether the timescales should be aligned to the Grievance Policy and 3. Triage of what NGO	People 29/07/2025 Progress noted

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
						category concerns fall into to assist with their prioritisation.	
8	Responsiveness	Identify training requirements for managers and determine frequency to empower and support managers to resolve concerns.	DoCA	DoCA	30/09/2025	Training requirements are an integral part of the FTSU Operational Group meeting's discussions building on the learning from the way in which cases are handled and how this can be improved. The Chief People Officer's perspective is key to the Operational catch-up meetings and will influence the manner and pace at which training can be shaped and delivered in collaboration with the FTSUG. The FTSUG has submitted a request to the Mandatory and Statutory Learning Group for FTSU training to be mandated for line managers as currently there isn't a mandatory training plan for leaders who handle concerns. Meanwhile, via the Trust's e-learning platform, Sherwood e-academy, there is direct access to e-learning for health (elfh), which provides three FTSU training packages: Speak-up, Listen-up and Follow-up. At 28th January 2026 the following training, that started in December 2025, had been completed:	People 29/07/2025 Progress noted

<table>
<tr><th>No.</th><th>Area of Development</th><th>Action</th><th>Action Owner</th><th>Task Lead</th><th>Due Date</th><th>Progress Update</th><th>Committee sign off</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><th>Freedom to Speak-up training:</th><th>Number of staff: Dec 25</th><th>Jan 26</th></tr>
<tr><td>Speak up</td><td>149</td><td>175</td></tr>
<tr><td>Listen up</td><td>25</td><td>124</td></tr>
<tr><td>Follow up</td><td>16</td><td>73</td></tr>
</table>

By 31st December 2025, all Band 7 staff, Matrons, Divisional Directors of Nursing, Divisional General Managers and non-operational teams had been sent the links for the three e-learning packages, that they were asked to disseminate through their teams to all line managers. The resulting increase in uptake is noted in the table. The Executive and Deputy Directors were also sent the links to complete their training, in line with the recommendations</td><td></td></tr>
<tr><td>9</td><td>Support</td><td>Ensure appropriate training is provided to managers to ensure they are supported in listening to and resolving concerns raised.</td><td>DoCA</td><td>CPO</td><td>30/09/2025</td><td>In addition to the comments above, an FTSU e.Learning training module for leaders on Speaking-up is available for all staff.
Discussions with the Corporate Director of Nursing have enabled three online courses - Speak-up, Listen-up and Follow-up - to be made available to all line managers via the Sherwood e-academy. The DoCA and FTSUG have completed them with the plan that all Executives and TMT members will follow suit.</td><td>People</td></tr>
</table>

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
10	Support	Divisional buy-in/engagement through FTSU sub-cabinet – this will provide opportunity to close feedback loops, identify trends and share learning more widely.	DoCA	DoCA	30/06/2025	The FTSU sub-cabinet was progressed through People Committee, but TMT agreed an alternative approach being taken (see 3 above).	People 29/07/2025 Action closed
11	Support	Consider how to make best use of FTSU Champions – e.g. signpost, triage, cover/alternative point of contact for FTSUG.	DoCA	FTSUG	30/09/2025	We aim to maintain a network of around 25 FTSU Champions. Five new Champions were trained in October and November 2025 to maintain that number of FTSU Champions. Champions are encouraged and recruited from services where clinical pressure is consistently high – e.g. ED and Maternity. This helps promote speaking up visibility and to signpost workers to appropriate routes. Champions and the FTSUG have forums at 6 weekly intervals that enable the FTSUG to pick up soft intelligence and proactively engage with those leaders / teams. FTSU Champions are informed when the FTSUG is taking annual leave and are briefed appropriately so they can support signposting during absences.	People

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Committee Chair's Highlight Report to Board of Directors

Subject:	Finance Committee ("FC") Meeting	**Date:**	16th December 2025
Prepared By:	Marie McAllister, Corporate PA		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Cotton, Finance Committee Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee (Core) meeting of 16th December 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Month 8 Financials: • M8 deficit £2.63m (Plan deficit £0.16m). M8 YTD £8.28m (Plan surplus £0.19m); drivers £0.8m Industrial Action; £0.8m MARS payments; £9.7m adverse CIP achievement; £1.6m deficit support shortfall. **SBS System Implementation:** • Tight timeline for April 1st go live, with little room for delay. • Resource and data migration risks identified; contingency would require extending the current ledger at additional cost. **Sterilisation and Endoscopy Units:** • Both are at end-of-life and require significant investment. • Equipment delays impacting theatre productivity / start times. **Workforce Reduction Challenge:** • The draft plan requires a reduction of 400 WTE in year one, which is considered high risk and currently lacks a detailed, executable plan. **Draft 2026/7 Plan Financial Deficit:** • Plan submission includes an £8.3m deficit for 2026/27, with a £4.7m revenue expenditure gap and £3.6m loss of deficit support funding. • Uncertainty remains around contract income, efficiency delivery, and workforce transformation.	**Pathology Managed Service Contract:** • Approval sought and granted for a £1.024m contract extension to maintain service until the ME2 network benefit is realised (expected July 2026). • The contract remains within budget and the affordability framework. **Cardiology ECHO Insourcing:** • Verbal update; virtual approval to be sought post-TMT. • Supports DMO1 position and is forecasted within budget. **Theatre Efficiency & Productivity:** • Ongoing job planning to address late starts and finishes. • Focus on reducing reliance on anaesthetist insourcing by half by Q4, dependent on recruitment. **Contract Management Improvements:** • New system for contract award recommendations and improved tracking of contracts over £250k. • Housekeeping underway to ensure all qualifying contracts are brought to committee for approval. **Capital Programme:** • MRI, CDC and EPR projects are major capital commitments; hence capital allocation of £10.4m for 2026/27 is mostly pre-committed.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
Pathology Service: • Delivered under budget for the past two years. • Extension aligns with divisional affordability and strategic direction. **Medicine Division Financial Governance:** • Improved governance processes and reduced agency spend. • Forecasts are being met, with further interventions planned. **Theatre Utilisation:** • Theatre session utilisation nearing the 85% target. • Cancer backlog, especially lower GI, has been reduced from 45 to 15 cases. **Cash Position:** • £6.2m at month 8, better than the previous year, with improved creditor management. Closely monitored / forecast. **Coding Opportunities:** • Detailed review underway, with potential for increased income through improved clinical coding.	**Approval of Pathology Managed Service Contract Extension** (£1.024m) until ME2 network is operational. **Approval of £800k NHIS IT procurement** for primary care (PCs and monitors), fully funded and not impacting Trust capital allocation. **Approval of Treasury Management Policy amendments** as per internal audit requirements. **Agreement to submit a non-compliant financial plan** for 2026/27, with a clear route to compliance by 2027/28, and to highlight underlying risks in the submission.

Comments on effectiveness of the meeting
The meeting was well-attended; robust debate and challenge, particularly around credibility / achievability of financial plan. There was clear recognition of the significant work undertaken by the finance and operational teams. Constructive discussion on balancing ambition with realism, especially regarding workforce and efficiency targets. The committee demonstrated a strong focus on governance, risk, and assurance.
Items recommended for consideration by other Committees
Contract Management Process: Audit & Assurance Committee to review the new contract award recommendation system and findings from the contract audit. **Performance and Quality Integration:** Proposal to involve performance leads in Finance Committee and review terms of reference, with implications for Quality Committee. **Capital Programme and Workforce Transformation:** Board to consider the link between capital investment (e.g., digital and EPR projects) and workforce reduction plans.
Progress with Actions
Number of actions considered at the meeting - 12 Number of actions closed at the meeting – 10 Number of actions carried forward – 2 actions not due until 2026. Any concerns with progress of actions – No

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

Key Figures:

- *Pathology contract extension: £1.024m*
- *IT procurement for primary care: £800k*
- *Planned deficit for 2026/27: £8.3m*
- *Planned workforce/financial gap: 400 WTE*
- *Capital allocation for 2026/27: £10.4m*
- *Cash at month 8: £6.2m*
- *Theatre efficiency target: 85% utilisation*
- *Cancer backlog (lower GI): reduced from 45 to 15 cases*

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NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Committee Chair's Highlight Report to Board of Directors

Subject:	Finance Committee ("FC") Meeting	**Date:**	27th January 2026
Prepared By:	Marie McAllister, Corporate PA		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Cotton, Finance Committee Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee (Core) meeting of 27th January 2026.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Financials: M9 (£2.65m) deficit (Plan (£0.31m) deficit). M9 YTD (£10.92m) deficit (Plan (£0.12m) deficit: major negative variances Industrial action (£1.0m), adverse CIP (£10.3m), deficit funding withdrawal (£2.4m), MARS payments (£0.8m). Cash c. £1.0m – M10 expected higher. **Ledger Implementation – National Delay and Local Risk:** Key testing "gateway" did not achieve required threshold, leading to an increased risk to the 1 April 2026 go-live, which is unlikely to be achievable. Programme SRO to meet with supplier on implications, mitigations and revised timescales. **Risk to Procurement Efficiencies:** Ledger delay may undermine planned procurement automation benefits and related workforce efficiencies; concern regarding potential refilling of procurement vacancies. **Non-Compliant Financial Plan:** Early planning shows a c.£34m pre-efficiency gap for 2026/27 with significant uncertainty on income, workforce and efficiency delivery. **FY Forecast Outturn Risk:** Expected 2025/26 deficit c. £15m (including £4.9m Deficit Support Funding); committee stressed need for challenging yet realistic full year forecast. **GIRFT Findings vs Financial Trajectory:** GIRFT review indicates acute bed/staffing gaps that conflict with required cost reductions.	**Ledger Implementation**: Schedule meeting to confirm revised go-live windows (1 July or 1 October 2026 to avoid y/e audit / peak leave/training) and provide a full risk/timeline assessment. Paper due to February FC. Procurement paper requested for February setting out benefits delivered to date, effect of delay, and proposal to hold selected vacancies. **ControlUp renewal approved;** NHIS to track savings from reduced service-desk demand and licence optimisation. **Channel 3 EPR contract approved;** monthly KPI-based performance management to be led by CDIO. **Cardiology Echo insourcing** paper to undergo approval at Extraordinary Finance Committee on Friday 30th January. **Medicine Division** implementing strengthened flow, board-round oversight, and pay-control processes. **Hybrid mail contract** work initiated, with further work to reduce postal volumes. **PFI settlement deed nearing completion:** preparatory work underway for 2027 soft FM market test. **2026/27 FC Workplan:** being refined to incorporate wider performance management role of Committee. **Strengthen forward procurement contract governance** including 12-month pipeline visibility for >£250k contracts.

Medicine Division Capacity and Flow Pressures: Despite improvement to a £4.9m deficit, pressures remain around demand, sickness, industrial action and follow-up ratios. **System-Level Financial Risk:** Nottinghamshire ICS remains one of the more challenged in the DLN cluster, heightening contract and funding risks.	
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• NHIS reporting small underspend and forecasting break-even; aged debt fully under control with no debt >90 days. FEP forecast of £584k (target £575k); £217k already delivered. • ControlUp delivering measurable benefits through reduced call volumes, £37k licence savings and £70k recurrent staffing savings. • Medicine Division's deficit reduced from ~£9m forecast to £4.9m with improved governance, reduced agency/bank spend and stronger DLT oversight. • Corporate expenditure remains within expected parameters, cost control generally strong. • PFI programme governance strengthened through new internal roles and structured preparation for market testing. • Good Internal Audit report on financial ledger and reporting.	• Supported a cautious approach to ledger go-live and risks of being an early national adopter. • Approved contract renewal for NHIS technical tools for 3 years. • Approved 12-month, £495k contract for EPR programme support, with KPI-linked performance management. • Approved Trust participation in joint hybrid mail ICS contract. • Agreed principles for forecasting and planning: realistic 2025/26 deficit and a non-compliant but transparent 2026/27 plan with defined transformational schemes. • FC Governance health check: all items fully met. • Terms of Reference amended to include Performance Management role extension / CMO FC Committee membership.
Comments on effectiveness of the meeting	
Meeting was well attended with robust and constructive challenge. Strong scrutiny of forecast realism, consultancy use, and transformation vs incremental savings. Members recognised improvements in Medicine Division and NHIS performance. Emphasis placed on clear internal messaging regarding overspend and the need for structural financial recovery.	

Items recommended for consideration by other Committees
Board / FRC: Ledger delay implications; recovery trajectory; system level contract/funding risk. **Audit and Assurance:** Contract pipeline governance; Financial Ledger and Reporting Internal Audit Report; Soft FM market-testing assurance. **Quality and People:** GIRFT workforce and quality implications; community hospital medical cover. **Digital / EPR Board:** NHIS technical tool benefits monitoring; EPR Programme Support performance oversight.
Progress with Actions
Number of actions considered at the meeting – 9 Number of actions closed at the meeting – 7 Number of actions carried forward – 2 actions not due until February 2026. Any concerns with progress of actions – No

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

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Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	**Monday 26th January 2026**
Prepared By:	Esther Smith, PA to Deputy Chief Nurse & Director of Nursing Quality & Governance		
Approved By:	Lisa Maclean, Non-Executive Director/Committee Chair		
Presented By:	Lisa Maclean, Non-Executive Director		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Emergency Department crowding & 12 hour waits: Overcrowding is now linked to Patient Safety Incident Investigations (PSII's) of which three have recently been launched. Heavy reliance on over 110 additional medical beds opened in response to the internal critical incident to manage extreme pressures. This is not yet reflected in the Trusts financial run rate. Increase in "no criteria to reside" bed days since July 2025. Delays attributed to transport issues, TTO delays, housing and social and community care pathways. Mental Health Patients in ED with insufficient system support- up to 8 mental health patients in ED at times awaiting beds for significant periods of time. IPC- C-diff performance & antimicrobial stewardship risks- high antibiotic volume recorded (259 courses across 58 patients) Two antenatal still births in November and December 2025. No new actions following external review.	Awaiting the outcome of the GIRFT review requested looking into system and flow improvements. This is to inform a strengthened UEC recovery plan. Identified work streams included the frailty pathway, and acute medicine performance. Actions underway include improving pre-conveyance clinical conversations for care home residents, addressing delays for medically fit patients, and improving discharge pathway functioning with social care. Completion of the C-Diff deep dive, including review of antibiotic usage specifically Tazocin and Cefuroxime prescribing patterns. Educational programmes for prescribers is also underway, while integrating C-Diff deep dove actions into the NHSE IPC action plan. Safeguarding – actions underway following 360 assurance audit include strengthening the mental health escalation pathways, especially for patients waiting in ED. A Task & Finish Group has been established to commence VTE Assessment Improvement Actions.

	Review of Patient Safety across the Health and Care Landscape in England (Penny Dash Report)- gap analysis identified actions to include development of a sharper internal early warning system, design of improved dashboards, strengthening oversight of high-risk services and embedding progress reporting into the patient safety committee and up to Quality Committee for assurance.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Positive assurance taken from the Safeguarding Annual Report and Quarterly update. Positive assurance taken from the NMAHP Strategy update for Objective 2. Q3 updates are due at an upcoming Committee in response to actions underway. Positive assurance taken from the Quality Impact Assessment Stage 2 update. Positive assurance taken from the update regarding the Clinical Services Strategy. Positive assurance taken from the Patient Safety Committee highlight report.	- APPROVED PR1 of the BAF with no changes suggested to the current risk scores. - APPROVED PR2 of the BAF with no changes suggested to the current risk scores. - APPROVED PR5 of the BAF with no changes suggested to the current risk scores. - The Committee APPROVED the IPR reports for Timely and Quality Care following discussion. - The Committee were informed of the decision to permanently close Newark Hospitals body storage facility due to security concerns. A paper has been approved and will be presented to the Board of Directors.
Comments on effectiveness of the meeting	
Members reflected that the meeting was effective, well-chaired and supported by high-quality papers. Despite significant operational pressures, contributors provided clear, thoughtful reports.	
Items recommended for consideration by other Committees	
None	

Progress with Actions

Number of actions considered at the meeting – 1
Number of actions closed at the meeting – 0
Number of actions carried forward - 0
Any concerns with progress of actions – No
If Yes, please describe –

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Audit and Assurance Committee Chair's Highlight Report to Board of Directors

Subject:	Audit and Assurance Committee Chair's Highlight Report	**Date:**	5th February 2026
Prepared By:	Sally Brook Shanahan		
Approved By:	Manjeet Gill, Committee Chair		
Presented By:	Manjeet Gill, Committee Chair		
Purpose:			
To provide the Board with a clear, concise summary of key issues, assurances, risks, decisions, and actions arising from the Audit & Assurance Committee meeting held on 5th December 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Fire safety – assurance and capacity: The Committee noted repeated references to fire safety actions (including dependencies on PFI/Skanska drawings and resource pressures) and **escalated a Chair-led deep-dive** (with the Director of Finance (DoF), Corporate Secretariat and Fire Safety Lead) to triangulate risks (e.g., alarms, cladding, training) and confirm mitigation/trajectory; output to return after January (post-holiday period). **Action:** meeting to be arranged; latest Risk Committee fire update to be shared with Committee members. **Escalated for action.** **Single large procurement control incident (Cardiology devices)**: An individual ordered cardiac devices via a local system without the expected prior controls, creating excess stock (£0.5m). **Action:** Medicine Division to report through ET in December, then to the Committee in January with root cause, control remediation and stock utilisation plan. **Escalated for action.** **Pharmacy write-offs trend**: Increasing trajectory reported in recent months (to c. £25k in October); **action** commissioned for detailed assurance in January to determine if trend is a blip or sustained and to confirm control improvements. **Escalated for action.**	The Committee commissioned/endorsed the following actions and workstreams: **Fire safety**: AAC Chair–DoF–Fire Lead deep-dive to take place; circulation of the latest Risk Committee fire update; subsequent Committee update after January. **Cardiology devices incident**: Executive Team review in December; **January Committee** paper with controls remediation and stock plan; relevant divisional leaders to attend. **Pharmacy write-offs**: **January Committee** assurance paper (drivers, controls, forecast). **Failure to Prevent Fraud**: 360 Assurance to provide a paper setting out organisational responsibilities and the Trust's response; alignment to evolving risk log. **Risk reporting (Cyber)**: Revised, concise categorisation format for cyber risks to avoid dilution within broader reporting; example format to be shared with the Chair. **Declarations of interest**: Divisional performance reviews to include DoI compliance; **assurance update in January** on year-end trajectory and **further divisional assurance by March**.

Failure to Prevent Fraud (Economic Crime Act) readiness and cyber threats: Positive progress on awareness and risk mapping, but the Committee requested a **specific Trust response paper** (controls/mitigations, roles, risk log) for a future meeting. **Escalated for action.** **Declarations of interest (DoI) compliance**: Continued **non-compliance of <20 staff (Band 7+)**; divisional triumvirates to provide assurance on achieving near-zero non-compliance by year-end (update to the January meeting; fuller divisional assurance thereafter). **Escalated for action.** **ICS planning/commissioning intentions – alignment risk**: Noted uncertainty as Trusts now submit individual 3-year plans with evolving system commissioning intentions; alignment across ICB/cluster required between December and February submissions. **Noted for Board awareness.**	**SBS Ledger migration**: Monthly project board in place; project risk to be added to the risk register (escalates through Risk Committee if score >12). Consider internal audit coverage during/after transition (26/27 IA plan). **Scheme of Delegation (Scheme of Delegation) & contract governance**: Development of a Contract Award Recommendation (CAR) form (covering e.g. extensions, indexation/VAT, documentation retention) and a timetable to standardise approvals by March 2026; changes to be routed via Finance Committee/Execs and brought back for Board approval.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Internal Audit (IA) progress: Absence Management – **Significant Assurance** (1 medium; 5 low actions). Cash Management – **Significant Assurance** with a single low-risk action (also noted at Finance Committee). Workforce Planning ToRs agreed; Risk Management review data now provided; DSP Toolkit planning underway. First-time implementation rate maintained at **78%**. **Counter Fraud**: Mid-year position broadly on track against NHSCFA standards; successful Fraud Awareness Week participation; active monitoring of seasonal payment-diversion phishing; Confirmation of the issue of Trust comms reminders. **External Audit**: Planning and risk assessment phase started; on track to report to Committee in January. **Freedom to Speak Up (FTSU)**: New database implemented; process and time-scale guidance rolled out (from 1 Sept) to improve expectations and timeliness; a complex case was satisfactorily	**Internal Audit Plan – change approved**: Replacement of "Project/Business Case Management" with "Strengthening Financial Management / Grip & Control" review aligned to NHS England guidance and HFMA-style evidence testing. **Single Tender Waivers (STW)**: Several STWs noted/assured via benchmarking and market context with a wider emphasis on system-level collaboration, where feasible. **Scheme of Delegation/Contract governance**: The Committee supported progressing CAR form standardisation and SoD clarifications (extensions/VAT/indexation) through internal governance, for subsequent Audit Committee recommendation to Board. **BAF audit**: Committee noted 360 Assurances's **low-risk** recommendations; agreed for the BAF audit report to be referenced

resolved with cross-Trust support. Thematic split to be refined for People Committee triangulation (violence/aggression vs wellbeing). **Risk & BAF arrangements**: 360 Assurance annual BAF audit reconfirmed sound arrangements (two **low-risk** actions re: narrative clarity and policy update); 100% Board survey response achieved.	to the Board via reading room/Quadrant with specific focus on system-partner risk alignment.
Comments on effectiveness of the meeting	
The Committee provided robust and constructive challenge, secured clear actions with time-bound follow-up (e.g., fire safety, pharmacy write-offs, cardiology devices), and demonstrated good triangulation across committees (Finance, People, Quality, Risk) and external assurance providers (360, External Audit). The agenda supported a balance of assurance and improvement focus	
Items recommended for consideration by other Committees	
Partnerships & Communities Committee: To consider its role in addressing **system-wide risks** and BAF linkages with partners/ICB commissioning intentions. **People Committee**: 1. To deepen insight from FTSU by disaggregating “worker safety & wellbeing” themes (e.g., violence/aggression vs stress/burnout) and aligning with absence/workforce data; 2. To note national junior doctors’ priorities link to pay accuracy. **Risk Committee**: To note the planned risk entry for the **SBS Ledger migration** and ensure escalation/oversight routes.	
Progress with Actions	
Number of actions considered at the meeting – 19 Number of actions closed at the meeting – 13 (+3 not yet due) Number of actions carried forward – 3 Any concerns with progress of actions – No	

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

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Audit and Assurance Committee Chair's Highlight Report to Board of Directors

Subject:	Audit and Assurance Committee Chair's Highlight Report	**Date:**	5th February 2026
Prepared By:	Manjeet Gill, Committee Chair		
Approved By:	Manjeet Gill, Committee Chair		
Presented By:	Manjeet Gill, Committee Chair		
Purpose:			
To provide the Board with a clear, concise summary of key issues, assurances, risks, decisions, and actions arising from the Audit & Assurance Committee meeting held on 15th January 2026			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Fire Safety – overdue high-risk internal audit actions. Internal Audit highlighted two long-standing high-risk actions from a prior fire safety review. A focussed meeting with the responsible leads (Mark Jackson and Gary Tibbs) has been arranged to determine realistic completion dates and/or risk-based sign-off. **Escalated for ongoing oversight and timely resolution.** **Failure to Prevent Fraud** (Economic Crime & Corporate Transparency Act 2023) – Trust response. A risk assessment and action plan are in train; a public statement (Chief Executive sign-off) is being prepared for issue before year-end. Committee sought confirmation of alert responses and asked for an update back to AAC. (Assurance improving; no formal escalation requested.) **Learning from Deaths – Internal Audit** limited assurance. Findings related chiefly to policy completeness, governance clarity and timeliness of Structured Judgement Reviews (SJRs). Mitigations include strengthened tracking via Datix IQ and the appointment of five consultant investigators to support coronial and patient-safety investigations. (Assurance substantially improved on discussion; see "Positive Assurances".)	The Committee noted and/or commissioned the following work: **Failure to Prevent Fraud:** implement risk assessment actions; prepare and bring back the Chief Executive's public statement/assurance to AAC (targeted for early April cycle). Team to confirm completion of January NHS fraud alerts and notify the CFO if any responses remain outstanding. **Fire Safety actions:** Internal Audit to convene with Estates leads to determine realistic completion or alternative risk-mitigating sign-off for the remaining high-risk actions. Progress to be updated through the usual follow-up reporting. **Learning from Deaths**: strengthen SJR timeliness tracking; prioritise coronial cases; embed new consultant investigator capacity (five appointments) to support investigations and learning dissemination. **Efficiency Benchmarking**: reference the KPMG national benchmarking observations (risk profile, pay/non-pay mix, income generation opportunities) to the Finance Committee for deeper analysis and any further assurance work.

Non-clinical policies – backlog. Seventeen policies were reported overdue, with seven scheduled for approval in February and a plan to reduce to ~10 overdue by February. **Escalated for continued management attention until backlog is cleared.** **SBS Financial Ledger Migration.** Finance Committee continues to oversee risks; no specific control issues were escalated to AAC at this meeting. Procurement reporting dependencies for PO compliance post-migration were noted and are being worked through with SBS.	**Purchase Orders**: maintain "No PO, No Pay" control; continue work on SLA backlogs to reduce retrospective POs; ensure reporting continuity through the SBS migration.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Internal Audit Progress: three reports issued since last meeting—two **Significant Assurance** (Absence Management; Financial Ledger & Reporting), and one **Limited Assurance** (Learning from Deaths) which, after management's mitigation update, the Committee considered to provide **substantial assurance** overall on the direction of travel. First follow-up implementation rate improved to 80% (from 78%). **Counter-Fraud**: comprehensive action plan established for the new "failure to prevent fraud" offence; Trust on course to complete preparatory actions by year-end; fraud alerts process responsive. The Committee commended a successful £16k fraud investigation outcome. **External Audit**: Draft plan received. Significant risks retained over management override and expenditure recognition; revenue recognition rebuttal under review due to evolving NHS income arrangements. Property valuations remain a higher-assessed risk; Value for Money focus on financial sustainability and SBS migration. The auditors confirmed no delays to the year-end timetable. **Data Security & Protection Toolkit**: interim assessment at **Standards Met** under the revised rolling-evidence approach;	**Approved**: Losses and Special Payments report for 1 Nov–31 Dec 2025 (including classification clarifications and approach to salary overpayments). **Approved**: Committee Effectiveness Self-Assessment (external attendees affirmed it reflects an effective balance between scrutiny and efficiency). **Minutes**: Prior minutes approved subject to minor amendments; a previous item on final salary overpayments to conclude with "assured." **BAF**: BAF Process report received **for assurance**; further updates will flow from lead committees prior to Board consideration next month. (No explicit BAF score changes recorded at AAC.)

continuing to align governance and evidence to maintain compliance through final submission. **Risk Committee/Operational Controls**: learning from NUH on business continuity for ED go-live; strong water safety progress; EPRR compliance reported at 90–97% (c.90% improvement since 2026 baseline). **PO Compliance**: c.99% of invoices paid against valid POs by value and volume over the last six months. Some retrospective PO creation persists (especially where SLAs are awaited), with divisional remedial actions in hand. **Declarations of Interest**: significant improvement—non-compliant individuals reduced to 22 (two currently not in attendance—maternity/long-term sickness). Ongoing drive continues.	
Comments on effectiveness of the meeting	
The Committee operated effectively, focusing on material assurance issues and avoiding unnecessary detail. External auditors reflected positively on the Committee's balance of challenge and efficient use of time. The Chair emphasised the importance of recognising staff achievements alongside financial and governance scrutiny to support morale during sustained operational pressures.	
Items recommended for consideration by other Committees	
Finance Committee: deeper review of efficiency benchmarking insights (size of challenge vs. risk profile; high proportion of pay-related savings; scope for income generation), including any implications for deliverability and risk appetite. **People Committee (3 Feb)**: Freedom to Speak Up reporting—trial narrative separation of worker safety and wellbeing themes (statistics remain combined per National Guardian Office definitions). **Risk Committee**: confirm current assurance on mortuary security in light of national context and prior Trust review, and revise any material risks accordingly.	
Progress with Actions	
Number of actions considered at the meeting – 10 Number of actions closed at the meeting – 5 (+ 2 not yet due) Number of actions carried forward – 3 Any concerns with progress of actions – No	

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

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Partnership & Communities Committee Chair's Highlight Report to Board of Directors

Subject:	Chair's Report	**Date:**	13th January 2026
Prepared By:	Barbara Brady, Non-Executive Director		
Approved By:	Barbara Brady, Non-Executive Director		
Presented By:	Richard Cotton, Non-Executive Director		
Purpose:			
To provide an overview of the key items from the committee meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Changing partnership context because of local and national developments in the NHS and Local Government reorganisation. This will have a number of implications, including Place Based partnership work and ICB priorities, the details of this still being unclear.	Revision to draft Terms of Reference for Partnership Oversight Group
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Progress on delivery of the Trust's Partnership Delivery Plan Progress on the development of the Trusts Health Inequalities action plan	Board assurance Framework: No changes to risk ratings, updates agreed. Terms of Reference agreed for the Anchor Steering group Committee effectiveness self-assessment agreed

Comments on effectiveness of the meeting

The meeting was held at the time that a 'critical incident' was declared in the Trust. This had implications for quoracy as Execs were needed elsewhere, in turn this resulted in some agenda items being deferred until the next meeting.

Items recommended for consideration by other Committees

None

Progress with Actions
Number of actions considered at the meeting - 4 Number of actions closed at the meeting – 3 Number of actions carried forward - 1 Any concerns with progress of actions –No If Yes, please describe –

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

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Charitable Funds Committee Highlight Report to the Board of Directors

Subject:	Charitable Funds Committee update	Date:	20th January 2026
Prepared By:	Andrew Rose-Britton, Non-Executive Chair		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose:			
To provide an overview of the key discussion items from the Charitable Funds Committee held on 20th January 2026			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Capacity and resource levels needed to support and grow the charity.	Agreement to hold a further Abseil event in 2026. SFH participation in the London Marathon in 2026 to be publicised.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Operational group highlight report. Community Involvement headline report. Fund raising and project update. Finance update. Investment update. Report on the Lottery Fund. Improved performance of the Charity's Investment funds managed by Rathbones.	Recommendation from the CFC to the Board of Trustees that the CFC accounts are not consolidated into the SFH NHS Trust accounts. Review and strengthen guidance on use of the Charities funds. To convene an informal meeting to review the capacity and resource levels needed to support and grow the charity.

Comments on effectiveness of the meeting
Good discussions made easier by excellent reporting of the issues.
Items recommended for consideration by other Committees
None

Progress with Actions
Number of actions considered at the meeting-4 Number of actions closed at meeting-1 Number carried over-0 Any concerns of actions-0

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

Board of Directors - Cover Sheet

Subject:	NHS Oversight Framework – Quarter 2	**Date:**	27/01/26
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Jon Melbourne, Chief Executive		
Presented By:	Jon Melbourne, Chief Executive		

Purpose

To provide an update to the Board of Directors on the NHS Oversight Framework publication for 2025/26 Quarter 2.	**Approval**	
	Assurance	
	Update	**X**
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X	**X**	**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	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Executive Team

Acronyms

- NOF – NHS Oversight Framework
- NHSE – NHS England
- ICB – Integrated Care Board
- SFH – Sherwood Forest Hospitals
- DSF – Deficit Support Funding
- IPR – Integrated Performance Report

Executive Summary

The NHS Oversight Framework (NOF - published on 26 June 2025) sets out how NHS England (NHSE) assess providers and ICBs, utilising a range of agreed metrics to promote improvement and identify quickly where organisations need support.

Quarter 2 NOF segmentations and rankings were published in December 2025.

The attached report provides an overview of the NOF process and SFH performance across the five domains. The majority of metrics are routinely reported to the Board through the Integrated Performance Report (IPR).

The overall Trust segment is 3 (Below Average and/or financial deficit), which is no change from the previous segment. This is influenced by the receipt of Deficit Support Funding (DSF).

The Trust rank is 56 of 134 acute providers, which is a deterioration from 48th in Quarter 1.

Reports on each of the five domains will be routinely presented to the relevant Board Sub-Committees for discussion, as and when NOF segmentations and rankings are updated.

Members are requested to consider the update.

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NHS Oversight Framework

This document describes the latest position on the

NHS Oversight Framework

Board of Directors February 2026

Context

- The NHS Oversight Framework (published on 26 June 2025) describes a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.
- The one-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.
- The framework is supported by a focused set of national priorities, including those set out in the Planning guidance for 2025/26, aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes.
- The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.
- At SFH, our Integrated Performance Report (IPR) is provided to the Board to support it in its role of holding Executive Directors to account for the Trust's performance. It should assist the Board in assessing the level of achievement against the Trust's objectives. The IPR is reviewed annually with the last review being at Jun-25 Trust Board. The 2025/26 IPR incorporated elements of the Oversight Framework that was in consultation at the time.

Segmentation Process and Scoring

Sherwood Forest Hospitals NHS Foundation Trust

The automated segmentation process follows 4 sequential steps:

1. Each metric is scored on a scale of 1 to 4 (some with discrete scores and some continuous) with 1 being the highest rating
2. All individual metric scores are consolidated, averaged and quartiled to give a single overall segment of 1, 2, 3 or 4
3. An adjustment ensures that any organisation with an underlying financial deficit cannot be allocated to a segment higher than 3
4. The segment is finalised. As part of this process the NHS England considers the organisation's capability and segment to identify the most challenged providers, placing them in segment 5

Each metric receives a score between 1 and 4 (with 1 being the highest performance rating), in line with the following schema:

- Where there is a defined operating standard or benchmark for a metric, any organisation reaching that level will be scored 1
- Where there is a defined floor (for example, an instruction to improve metric performance from a baseline), any organisation failing to meet that floor will be scored 4
- Organisations that do not meet the above conditions, or where those conditions do not exist for the metric, will be sequentially ordered in line with direction of the metric – that is, higher is better or lower is better. The highest and lowest scoring individual organisations will receive a 'bookend' score of 1.00 and 4.00 respectively (where no standard or floor exists), 2.00 and 4.00 (where a standard exists as the score of 1 will be reserved for those meeting the standard) or 1.00 and 3.00 (where a floor exists as 4 will be reserved for those not meeting the floor). Those in the middle will receive a score rounded to 2 decimal places based on their position within the range between these bookends as an even spread. This approach limits cliff edges to defined performance thresholds.

NHS Oversight Framework: Summary

Sherwood Forest Hospitals NHS Foundation Trust

NHS Oversight Framework - Acute trusts

Current data: **Q2 2025-26**
Published: **11 December 2025**

NHS England

About | **Overview** | League table | Metrics table | Trust map | Trust chart | Timeseries table | Timeseries chart | Statistics table | Metric metadata | Glossary

Select a trust

Sherwood Forest Hospitals NHS Foundation Trust (RK5)

View the glossary page

Average score

2.26

Higher by 0.13 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).

Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

3 - Below average and/or financial deficit

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

Some of the more challenged trusts may be referred to the Recovery Support Programme and therefore allocated to a fifth segment.

How has segment been calculated?

Trust rank

56 out of 134

Previous quarter's rank: 48 out of 134

Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with the lowest average score) to 134 (the segment four trust with the highest average score).

How has rank been calculated?

Deteriorated from 48th in Q1

Performance domains

Access to services	2 - Above average
Finance and productivity	4 - Low performing
Effectiveness and experience	3 - Below average
Patient safety	1 - High performing
People and workforce	2 - Above average

2 in Q1

1 in Q1

Average score by trust rank placement

View full league table

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Access to services

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Quarter	Segment	Access to services domain segment
Q2 2025/26	3 - Below average and/or financial deficit	2 - Above average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Elective care	Difference between planned and actual 18 week performance	Sep-25	-5.13	percentage points	-3.96 ↓	3.78	124 out of 131	-0.04	0
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q2 2025/26	69.80	%	-7.90 ↓	3.49	103 out of 123	75.70	78
Access to services	Mental health care	Annual change in the number of children and young people accessing NHS-funded MH services	Oct 24 - Sep 25 vs Oct 23 - Sep 24	0.37	percentage points	-1.39 ↓	3.04	13 out of 21	6.65	
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q2 2025/26	67.10	%	2.39 ↑	2.86	72 out of 118	69.28	75
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Sep-25	61.95	%	-2.15 ↓	2.29	57 out of 131	61.18	
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q2 2025/26	5.00	%	2.23 ↓	1.76	31 out of 119	8.61	
Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q2 2025/26	82.02	%	3.06 ↑	1.00	16 out of 118	76.04	80
Access to services	Elective care	Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Sep-25	0.88	%	-0.23 ↑	1.00	28 out of 131	2.07	1
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Sep-25	0.00	%	0.00 →	1.00	1 out of 79	0.54	

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Safety & People/Workforce

NHS Sherwood Forest Hospitals NHS Foundation Trust

Quarter	Segment	Patient safety domain segment
Q2 2025/26	3 - Below average and/or financial deficit	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Patient safety	Patient safety	Number of MRSA bacteraemia cases	Oct 24 - Sep 25	5.00	count	2.00 ↓	3.21	89 out of 134	3.00	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Oct 24 - Sep 25	0.96	rate	0.00 →	1.00	1 out of 134	1.18	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.81	out of 10	0.00 →	1.20	10 out of 134	6.42	
Patient safety	Patient safety	Proportion of C. difficile infections	Oct 24 - Sep 25	1.49	rate	0.11 ↓	3.66	115 out of 134	1.18	1

Quarter	Segment	People and workforce domain segment
Q2 2025/26	3 - Below average and/or financial deficit	2 - Above average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
People and workforce	Retention and culture	Sickness absence rate	Q1 2025/26	5.04	%	-0.27 ↑	2.74	91 out of 134	4.72	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.13	out of 10	0.00 →	1.50	23 out of 134	6.88	

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Effectiveness & experience and finance & productivity

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Quarter	Segment	Effectiveness and experience domain segment	Return to overview
Q2 2025/26	3 - Below average and/or financial deficit	3 - Below average	

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Sep-25	0.86	days	0.16 ↓	2.79	75 out of 125	0.78	
Effectiveness and experience	Patient experience	Summary Hospital-level Mortality Indicator	Jul 24 - Jun 25		score		2.00			
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		2.00			

Quarter	Segment	Finance and productivity domain segment	Return to overview
Q2 2025/26	3 - Below average and/or financial deficit	4 - Low performing	

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Finance and productivity	Finance	Planned surplus/deficit	2025/26	-1.82	%	0.00 →	3.00	72 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 6 2025	-1.08	%	-1.08 ↓	4.00	104 out of 134	0.00	
Finance and productivity	Finance	Combined finance	Q2 2025/26		score		4.00			
Finance and productivity	Productivity	Implied productivity level	Q1 2025/26 vs Q1 2024/25	5.00	%	2.02 ↑	1.61	28 out of 134	1.77	