MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 7th August 2025**
Time: **09:00 – 12:30**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** Register of Interest | Sherwood Forest Hospitals *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Staff Story – The People Promise** Debbie Kearsley, Deputy Chief People Officer, and Leanne Featherstone, People Promise Manager	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 5th June 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	**Acting Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	09:45	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity and Neonatal Update** Report of the Director of Midwifery ○ **Safety Champions update** ○ **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 9.1
10.	10:00	**Strategic Objective 6 – Work collaboratively with partners in the community** • **Fit for the Future – The 10-year Plan** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 10.1
	BREAK (10 mins)			
	Operational			
11.	10:25	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 11

	Time	Item	Status	Paper
12.	11:10	**Draft Winter Plan** Report of the Chief Operating Officer (presented by Mark Bolton, Associate Director of Operational Performance)	Approval	Enclosure 12
	Governance			
13.	11:30	**Well Led Action Plan Review** Report of the Director of Corporate Affairs	Assurance	Enclosure 13
14.	11:45	**Use of the Trust Seal** Report of the Director of Corporate Affairs	Assurance	Enclosure 14
15.	11:45	**Fit and Proper Person compliance – Update** Report of the Director of Corporate Affairs	Assurance	Enclosure 15
16.	11:50	**Data Security Protection Toolkit Submission** Report of the Director of Corporate Affairs / Senior Information Risk Owner (SIRO)	Assurance	Enclosure 16
17.	11:55	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • People Committee Report of the Committee Chair (last meeting) • Partnerships & 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 17.1 Enclosure 17.2 Enclosure 17.3 Enclosure 17.4 Enclosure 17.5 Enclosure 17.6
18.	12:15	**Spotlight on – The Parkinson's group at Mansfield Community Hospital (MCH)**	Assurance	Presentation
19.	12:20	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
20.	12:25	**Any Other Business**		
21.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **2nd October 2025, Boardroom, King's Mill Hospital**		
22.		**Chair Declares the Meeting Closed**		
23.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

Board of Directors Information Library Documents

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

Enc 9.1	• **Perinatal Safe Staffing Report**
Enc 9.2	• **Nursing Monthly Safe Staffing**
Enc 17.1	• **Audit and Assurance Committee – previous minutes**
~~**Enc 17.2**~~	• ~~**Finance Committee – previous minutes**~~ **July Finance Committee stood down**
Enc 17.3	• **Quality Committee – previous minutes**
Enc 17.4	• **People Committee – previous minutes**
Enc 17.5	• **Partnerships and Communities Committee – previous minutes**
Enc 17.6	• **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 5th June 2025, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Chair	GW
	Steve Banks	Non-Executive Director	SB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Lisa Maclean	Non-Executive Director	LM
	Richard Cotton	Non-Executive Director	RC
	Barbara Brady	Non-Executive Director	BB
	Manjeet Gill	Non-Executive Director	MG
	David Selwyn	Acting Chief Executive	DS
	Richard Mills	Chief Financial Officer	RM
	Simon Roe	Acting Medical Director	SR
	Rob Simcox	Director of People	RS
	Phil Bolton	Chief Nurse	PB
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Chris Dann	Acting Chief Operating Officer	CD
In Attendance:	Richard Kemp	Divisional Director of Nursing	RK
	Paula Shore	Director of Midwifery	PS
	Claire Hinchley	Director of Strategy and Partnerships	CH
	Mark Bolton	Associate Director of Operational Performance	MB
	Sue Bradshaw	Minutes	
	Olivia Hammond	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Rich Brown	Head of Communications	
	Laura Monaghan	Notts TV	
	Chris Wilson	Operational Performance Manager	
	Simon Illingworth	Newly appointed Chief Operating Officer (starting July 2025)	
	1 member of the public		
Apologies:	Jonathan Van Tam	Associate Non-Executive Director	JVT

Item No.	Item	Action	Date
25/120	**WELCOME**		
1 min	The meeting being quorate, GW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
25/121	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
25/122	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Jonathan Van Tam, Associate Non-Executive Director.		
25/123	**PATIENT STORY – SUPPORTING PATIENT FLOW: FIT2SIT**		
12 mins	RK joined the meeting. RK introduced the Patient Story, which highlighted the Fit2Sit area, which supports patient flow through ED. It was noted funding to establish this area was received via the Trust Charity's 'Dragon's Den' initiative and was the result of staff putting forward an idea for improving patient flow. GW welcomed the opportunity to see how the Fit2Sit area works and noted the improvement this has made to patient experience. GW acknowledged the work of the Trust Charity and the funding provided to make this area possible. RC noted the improved patient experience and queried how the impact of the Fit2Sit area can be shown as an output measure. PB advised there are a lot of metrics in the Integrated Performance Report (IPR) and the Fit2Sit area is not the only influencing factor. RK advised the Trust is maintaining strong ambulance handover times, despite increasing conveyance, and waiting times in ED are good. Patient and staff experience is also important, noting staff feel their voice is heard as this was a staff suggestion. RK left the meeting.		
25/124	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 3rd April 2025, the Board of Directors APPROVED the minutes as a true and accurate record.		

25/125	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/183.2, 24/377.1 and 25/088 were complete and could be removed from the action tracker.		
25/126	**CHAIR'S REPORT**		
10 mins	GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Chair's perspective, highlighting Executive Team recruitment, newly elected governors, work of the Trust Charity and volunteers, and meetings with partners and stakeholders. The Board of Directors were ASSURED by the report. **Council of Governors Highlight Report** GW presented the report, highlighting concerns expressed by governors in relation to the election process and a concern raised in relation to the cancellation of appointments for lesion removal at Newark Hospital. DS advised the governor who raised the concerns about the cancellation of lesion removal appointments has subsequently contacted him and advised it was a haematology clinic which had been cancelled. DS advised this cancellation was due to a locum consultant leaving the Trust at very short notice. The Board of Directors were ASSURED by the report.		
25/127	**ACTING CHIEF EXECUTIVE'S REPORT**		
11 mins	DS presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Acting Chief Executive's perspective, highlighting operational activity, capital developments, mobile research unit, new cancer information centre in Newark, launch of new public facing website, meetings with key partners and Staff Excellence Awards. The Board of Directors were ASSURED by the report.		
25/128	**MAKING TOMORROW BETTER – STRATEGY DELIVERY UPDATE**		
13 mins	CH joined the meeting. CH presented the report, advising the Strategy was developed as a framework, rather than a specific roadmap. CH highlighted the progress made against each strategic objective, measures of success and outcomes and plans for Years 2-5. SB noted one of the outcome measures is for the Trust to be rated as Outstanding by the Care Quality Commission (CQC) but queried if everything outlined in the Strategy was achieved, would that translate into Outstanding, as rated by the CQC.		

	DS advised a national report is awaited which will provide information in relation to regulation in the future. If the Strategy was being written today, this measure may be rewritten to include reference to the NHS performance framework and for the direction of travel to be focussed on improving performance. MG queried what CH felt was the one thing which would accelerate delivery of the Strategy. CH advised the NHS 10 Year plan should provide the anchor to enable the Trust to identify what needs to be done over the next 10 years, ensuring the needs of the local population are met. As the strategy is a framework, this allows for flexibility. MG felt it would be useful to have more visibility on the neighbourhood, community and prevention agenda. CH advised this is the direction of travel. The Trust has recently hosted a 'Lunch and Learn' session for colleagues which was attended by Place based and primary care teams, with the aim to start developing an understanding of these issues. This did highlight some gaps in knowledge which are being addressed. The Board of Directors were ASSURED by the report. CH left the meeting.		
25/129	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
14 mins	PS joined the meeting **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting Safety Champion walkaround, Perinatal Services Forum, launch of new Perinatal Services webpage, NHS Resolution (NHSR) Year 7 requirements, stillbirth review, neonatal staffing position and re-launch of Neonatal Transitional Care Service. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance Model*** PB presented the report, highlighting third and fourth degree tears, stillbirth rate and reduction in suspension of acute service. BB noted the number of third and fourth degree tears and sought assurance in relation to the actions being taken to address this. PS advised there has been an improved position in April 2025. The regional Local Maternity and Neonatal System (LMNS) has discussed this issue with other systems and a significant increase in the number of interventions, both across the Trust and regionally, has been identified. If the number of interventions was not included in the figures, the position would improve. From a qualitative perspective, the women are receiving relevant information and follow up care. A new consultant midwife has been appointed and a key focus for them will be on prevention, but also identifying how the report can be improved to show the information in a clearer way.		

	BB advised she would welcome a deep dive into this at Quality Committee later in the year. PS advised the team are looking at redesigning the dashboard to provide more information. SR advised the risk of a tear is always higher with an instrumental delivery and felt the refresh of the dashboard provides an opportunity to move to Statistical Process Control (SPC) charts. **Action** • **Deep dive into third and fourth degree tears to be presented to Quality Committee later in the year, once work completed by consultant midwife.** The Board of Directors were ASSURED by the report. PS left the meeting.	**PB / PS**	**TBC**
25/130	**STRATEGIC OBJECTIVE 3 - IMPROVE HEALTH AND WELLBEING WITHIN OUR COMMUNITIES**		
13 mins	**Health Inequalities Annual Statement** SR presented the report, advising there is a prescribed format which has to be used for this report. SR highlighted the local health inequalities data, Trust approach in relation to the health inequalities agenda, work undertaken to develop a health inequalities index and actions taken to address health inequalities in relation to the four prescribed areas of elective care, urgent and emergency care, smoking and oral health. MG asked SR what he would like to stress as next steps. SR advised the data intelligence is key, highlighting the development of the health inequalities index. In addition, SR highlighted the work being undertaken in relation to Making Every Contact Count. DS felt there is a need to understand the core cause of obesity, etc. SB queried what is the Trust's ability to make significant improvements in relation to health inequalities. SR acknowledged this will be a challenge, noting the pressures faced by the organisation. The Trust has identified key areas to progress. BB advised there is strong evidence in relation to Making Every Contact Count and, therefore, it is important to embed this. There are some actions which can be taken in relation to improve efficiencies within the Trust which, while not cash releasing, will enable the organisation to be more effective, noting the work in relation to did not attends (DNAs) in outpatients. The Board of Directors were ASSURED by the report.		

25/131	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
7 mins	**2025/2026 Operational Plan** RM presented the report, advising the Operational Plan was submitted on 27th March 2025, in line with NHS England (NHSE) requirements. The plan covers operational performance, activity, workforce and finance and aligns to the national priorities. RM highlighted the key improvements the Trust is aiming to achieve. Progress will be tracked through the relevant sub committees and the Integrated Performance Report IPR). MG noted the challenges the Trust faces in terms of budgets and queried if the Trust was open to 'invest to save' approaches. RM advised this varies on a case by case basis, noting if it is a small 'invest to save' case, with a relatively quick return on that investment, then these are likely to be taken forward. However, this is more challenging for large scale investments or capital investments. The Board of Directors were ASSURED by the report.		
20 mins	**Financial Efficiency Plan** RM presented the report, highlighting the profiling of the Plan, areas which are non-negotiable, approach being taken and status as at 26th May 2025. MG sought assurance all the opportunities identified are deliverable. RM advised this is the expectation. However, this will be looked at on a scheme-by-scheme basis, acknowledging there may be some duplication. GW noted the need to get the identified opportunities into delivery mode by the end of Quarter 2 (Q2). RM acknowledged this will be challenging. NM felt the delivery of savings is relentless and queried if the structure is correct for the required savings to be delivered. RM advised the Financial Efficiency Delivery (FED) Team has been established to be fully focussed on delivering savings. This is a multidisciplinary team. In addition, there is executive ownership of the six key programmes identified. RC noted the two potential major risks of the threat of industrial action and pay rates over and above what the Trust was asked to budget for and queried if £45m savings is sufficient. RM advised it is not yet known how these risks will materialise and how they will be valued. There is a need to consider other options, which will be the more difficult decisions. GW advised once the identified opportunities are delivering, there is a need to consider "what next". There is a need to understand the potential impact on the organisation of any actions taken. The Board of Directors were ASSURED by the report.		

3 mins	**Capital Expenditure Plan** RM presented the report, highlighting funding sources, planning process, planning risks and governance. The Board of Directors APPROVED the 2025/2026 Capital Expenditure Plan		
25/132	**INTEGRATED PERFORMANCE REPORT (IPR)**		
30 mins	**QUALITY CARE** PB highlighted patient experience, falls, hospital acquired pressure ulcers and patient safety incident investigations. SR highlighted Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indictor (SHMI). **PEOPLE AND CULTURE** RS highlighted appraisals, bank and agency usage, staff wellbeing, reduction in sickness absence, vacancy rate and flu vaccination rate. BB noted the reduction in agency usage over the past year, but noted there is more work to do in terms of agency usage over price cap. RS advised approximately 80% of agency usage is medical related and there is a need to be mindful of rates. This is reviewed on a weekly basis and rates are challenged, where appropriate. SB advised a report was presented to the recent meeting of the People Committee and provided assurance in relation to the actions being taken to reduce bank and agency usage. **TIMELY CARE** In terms of the emergency pathway, CD highlighted ED 4-hour wait performance, introduction of Clinical Decisions Unit and bed modelling work. In terms of elective care, CD highlighted a reduction in the number of 52-week waiters, 65-week waiters, the impact of Ear, Nose and Throat (ENT) waits on the overall 65-week wait performance and diagnostics. In terms of the cancer pathway, CD highlighted 62-day performance. BB referenced the benchmarking data in relation to Same Day Emergency Care (SDEC), noting the Trust is ranked 98 of 178, and queried if this is correct as she felt the Trust performed well in relation to SDEC. CD advised he would need to check the detail and report back. **Action** • **Update to be provided to the Board of Directors regarding benchmarking data for SDEC.**	**CD**	**07/08/25**

	BEST VALUE CARE RM outlined the Trust's financial position at the end of Month 1, highlighting efficiency delivery, reduction in agency spend, cash position and deficit support funding. The Board of Directors CONSIDERED the report.		
25/133	**INTEGRATED PERFORMANCE REPORT (IPR) ANNUAL REVIEW**		
20 mins	MB joined the meeting. MB presented the report, advising that following a discussion at the recent meeting of the Quality Committee, the decision has been taken to remove HSMR from the IPR. MB highlighted changes in national guidance, indicators to be added, removed or changed, rationale for any changes, sample scorecard, rollout of benchmarking data and introduction of data quality indicators. PB advised work is underway to develop a quality dashboard. BB advised there was good discussion at the recent meeting of the Quality Committee about the changes to the IPR. As the decision to remove HSMR from the IPR was taken after the publication of the reports for the Board of Directors, BB felt it would be useful to share further information on the rationale for this decision with the Board of Directors. SR advised there are various mortality metrics available. The Trust had raised concerns with the provider of HSMR in relation to the reasons for the figures being high for the Trust. The position has improved with the introduction of the revised HSMR+ metric. There is a need to focus on a broad range of metrics, and include data from Learning from Deaths, coronial inquests, etc. and move away from the headline metric. HSMR is not included in the draft national performance framework as this only references Summary Hospital-level Mortality Indicator (SHMI). A number of organisations have taken HSMR out of their reporting metrics. Therefore, in the interests of consistency at a local and national level, the Trust should look at SHMI only. BB provided assurance the Quality Committee will not lose focus on looking at deaths, but will take a more rounded approach. ARB queried if this change will mean the Board of Directors lose sight of any areas. SR advised a quality dashboard is being developed which will lead to a wider set of metrics being considered by the Quality Committee. Any concerns this flags up will be highlighted to the Board of Directors. MG queried if there is a different way of presenting the IPR, noting the scorecard on the first page shows a number of indicators which are off track. Noting this is a public document, some people may just look at the scorecard and not the context, benchmarking, etc. SR advised other organisations have moved to a 'making data count' approach and it would be useful to discuss this further at a Board of Directors workshop.		

	Action • **Consideration of a 'making data count' approach to the IPR to be a topic for a future Board of Directors workshop.** SB noted some of the measures are averages, which does not necessarily highlight areas for concern, and felt further assurance on the detail should be provided to the sub committees. SB noted there are some areas where the target is better than or equal to plan and queried if all areas can be benchmarked or if there is a better way to present the information. MB advised graphs are included in the report, which are SPC charts for the majority of indicators. However, they are not fully aligned to 'making data count'. These charts will be extended to March 2026, with the plan line to the end of the year included. This will show current performance, compared to the point the Trust needs to get to by year end. The chart will show the historical data, to show trends over time, and the forward plan. GW advised there is a need to carefully communicate the reasons for removing HSMR from the IPR to the governors, noting they have previously raised concerns about HSMR levels. The Board of Directors APPROVED the amendments to the IPR.	**SR**	**TBC**
25/134	**POST-WINTER PLAN DE-BRIEF**		
22 mins	MB presented the report, highlighting bed modelling, scheme evaluations, unpalatable actions and lessons learned. MB advised planning for Winter 2025/2026 is well underway, with mitigations in development at Trust and system level. BB referenced the changes at a system level and expressed concern in relation to the required system level mitigations being in place for Winter 2025/2026. SR acknowledged this is a concern. However, there are some positive actions underway, for example, the relationships built via the Primary / Secondary Care Interface Group and the frailty agenda is moving forward at a system level. DS noted while the bed modelling was good, there was a significant bed gap. DS felt there is a need to consider the Full Capacity Protocol, noting this should be a short, sharp action to create an immediate response. However, there were times this was in place for a number of days. DS noted the reduction in length of stay and queried if the reasons for this are known and if this is embedded across all areas of the organisation. MB advised the change in length of stay was mainly within the over 65 year old cohort, particularly their rehabilitation, noting this links back to the reduction in the number of patients medically safe for transfer shown in the IPR. MG queried if MB had any reflections on Winter planning over the past 2-3 years. MB advised some improvements for 2024/2025 include weekend trauma theatre operating list, Children's Assessment Unit scheme and the acute frailty unit. One of the opportunities to look at things differently in the future is day case.		

	RC queried how sensitive the modelling is to seasonal indications, for example, norovirus and flu, and if this could be abated through vaccinations. MB advised a lot of the seasonal pressures, which create a peak, are due to Winter illnesses. The Australian and southern hemisphere flu data is used to give an indication as to what Winter in the UK will 'look like'. The peak over Winter is driven by seasonality but does not make any assumptions in relation to vaccination rates. SB expressed the view demand will continue to grow and queried when conversations will need to start to look at what will be required in 5-10 years' time. MB advised the Trust is constantly and actively looking how finance can be brought into the organisation. DS advised the organisation's and public's mindset has to move from treating ill health to preventing ill health. The Board of Directors were ASSURED by the report. MB left the meeting.		
25/135	**BOARD ASSURANCE FRAMEWORK (BAF)**		
2 mins	DS presented the report advising all the principal risks (PR) have been discussed by the relevant sub committees. In addition, the BAF in its entirety is subject to quarterly review by the Risk Committee. The changes, and amendments which have been made, are highlighted in the report. It was noted five risks, namely PR1 (Significant deterioration in standards of safety and care), PR2 (Demand that overwhelms capacity), PR3 (Critical shortage of workforce capacity and capability), PR4 (Failure to achieve the Trust's financial strategy) and PR7 (Major disruptive incident) remain as significant risks and are also above their tolerable risk ratings. The Board of Directors REVIEWED and APPROVED the Board Assurance Framework.		
25/136	**TRUST SEAL**		
1 min	**Annual Summary Report 2024/2025** SBS presented the report, advising the Trust Seal has been used five times in the past year, with the details being previously presented to the Board of Directors. The Board of Directors were ASSURED by the report. **Application of the Trust Seal** SBS presented the report which confirms the Trust Official Seal has been affixed to the following documents, in accordance with Standing Order 10 and the Scheme of Delegation: • Seal number 120 was affixed to a document on 15th April 2025 for Kier Infrastructure and Overseas Ltd. The document related to the MRI unit at King's Mill Hospital.		

	The Board of Directors NOTED the use of Trust Seal number 120		
25/137	**PROVIDER LICENCE SELF-CERTIFICATION DECLARATION**		
1 min	SBS presented the report and advised this is an annual self-certification. This has previously been discussed by the Executive Team. There is no longer a requirement to submit the declaration to NHSE but it does need to be published on the Trust's website. The Board of Directors NOTED the declarations required by Continuity of Service Condition 7 of the NHS provider licence had been previously approved at the Private meeting held on 1st May 2025.		
25/138	**COMMITTEE EFFECTIVENESS REVIEWS**		
2 mins	SBS presented the report advising all committees review their Terms of Reference (TOR) and work plans each year and undertake an effectiveness review. It was noted one action was identified for the Finance Committee and two actions were identified for the Charitable Funds Committee as a result of the committee effectiveness review. The Board of Directors were ASSURED by the report.		
25/139	**ASSURANCE FROM SUB COMMITTEES**		
17 mins	**Audit and Assurance Committee** ARB presented the report, highlighting approval of the draft annual accounts for submission in line with the national timetable and agreement to continue to adopt the going concern basis in preparing the accounts. The Audit and Assurance Committee Annual Report was noted. The Board of Directors were ASSURED by the report. **Finance Committee** ARB presented the report, highlighting the Electronic Patient Record (EPR) full business case approval process and progress made, Capital Plan and the Cash Management Plan. The Board of Directors were ASSURED by the report. **Quality Committee** BB presented the report, highlighting the move to monthly meetings, data quality and capacity and resources available to allow for processing of data into meaningful intelligence and Quality Impact Assessments (QIAs). The Board of Directors were ASSURED by the report.		

	People Committee SB presented the report, highlighting the potential impact of financial challenges and industrial action on staff and patient care and ability to deliver the leadership development programme. NM suggested that if the leadership development programme has to be paired back due to other pressures, there may be a need to prioritise delivery to colleagues who will have the biggest impact. RS advised the revised approach to talent is being launched imminently. This will provide the opportunity, via talent conversations, to identify colleagues who can make an impact. PB advised the challenge will have the biggest impact on clinical teams as these are the areas where headroom is monitored and these may be the people who need to be targeted for development. RS advised the Committee has approved the People Strategy, following feedback from the Board of Directors. The Board of Directors were ASSURED by the report. **Partnerships and Communities Committee** BB presented the report, highlighting the ongoing concern regarding visibility and evidence of QIAs undertaken within the system and the changing landscape in relation to partnerships as a result of national guidance. The Partnerships and Communities Committee Annual Report was noted. The Board of Directors were ASSURED by the report. **Charitable Funds Committee** ARB presented the report, highlighting the launch of the Charity lottery, approval of a grant of £30k for the purchase of Dermatone equipment, review of the investment policy and end of life rooms. The Charitable Funds Committee Annual Report was noted. The Board of Directors were ASSURED by the report		
25/140	**SPOTLIGHT ON – SHOWCASING THE ESSENTIAL WORK OF THE ORTHOTICS TEAM**		
7 mins	A short video was played highlighting the work of the Orthotics Team.		
25/141	**COMMUNICATIONS TO WIDER ORGANISATION**		
3 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Patient story – Fit2Sit • Spotlight on video – Orthotics Team • Dragon's Den initiative		

	• Strategy progress • Current financial and operational performance • Annual planning commitments • Capital investments • Reflections on Winter 2024/2025 and planning for 2025/2026 • Work of the Trust charity, including launch of the lottery • Thanks to the Trust's volunteers		
25/142	**ANY OTHER BUSINESS**		
1 min	No other business was raised.		
25/143	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 7th August 2025 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:45.		
25/144	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Chair** **Date**		

25/145	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	GW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
25/146	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
25/054	06/03/2025	Nursing workforce numbers and spend to be a topic for a Finance Committee workshop at the end of Q1.	Public Board of Directors	Finance Committee	07/08/2025	R Mills		**Update 21/03/2025** Added to agenda for Finance Committee workshop on 29/07/2025 **Update 07/08/2025** A review of nursing workforce numbers and associated pay costs has been completed and a paper was submitted for the July meeting of the Finance Committee. Due to the cancellation of the July meeting, this paper will be further discussed at the August meeting of the Finance Committee. **Complete**	Green
25/094	03/04/2025	Reason for the increase in the number of cases related to worker safety and wellbeing being reported via Freedom to Speak Up to be investigated and reported to the People Committee.	Public Board of Directors	People Committee	07/08/2025	S Brook Shanahan	K Bosworth	**Update required**	Amber
25/129	05/06/2025	Deep dive into third and fourth degree tears to be presented to Quality Committee later in the year, once work completed by consultant midwife	Public Board of Directors	Quality Committee	TBC	P Bolton	P Shore		Grey
25/132	05/06/2025	Update to be provided to the Board of Directors regarding benchmarking data for SDEC.	Public Board of Directors	None	07/08/2025	C Dann		**Update 30/06/2025** Information provided to Board members via e-mail on 30th June 2025 **Complete**	Green
25/133	05/06/2025	Consideration of a 'making data count' approach to the IPR to be a topic for a future Board of Directors workshop	Public Board of Directors	None	TBC	S Roe			Grey

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:**	31 July 2025
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Graham Ward, Chair		
Presented By:	Graham Ward, Chair		

Purpose

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

AGM = Annual General Meeting
AMM = Annual Members Meeting
COO = Chief Operating Officer
CT = Computed Tomography
DL = Deputy Lieutenant
ICB = Integrated Care Board
ICP = Integrated Care Partnership
OBE = Officer of the Order of the British Empire
NED = Non-Executive Director
NHS = National Health Service
NUH = Nottingham University Hospitals
QEH = Queen Elizabeth Hospital
SID = Senior Independent Director

Executive Summary

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

Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and Norfolk & Waveney University Hospitals Group Interim Vice-Chair appointment

I am sharing this update to formally notify the Trust's Board of Directors that I have been appointed the Interim Vice-Chair of The Queen Elizabeth Hospital (QEH) King's Lynn NHS Foundation Trust and the Norfolk and Waveney University Hospitals Group.

As the Board here will know, I have been a Non-Executive Director at QEH since August 2019, Acting Chair in 2022, and have served as Deputy Chair there since January 2024. I will continue to undertake the role of Interim Vice-Chair at QEH alongside my duties as Chair here at Sherwood.

The Board of Directors is asked to note this update and all necessary declarations of interest here at Sherwood have now been completed.

Executive Team appointments

Chief Executive Officer recruitment update

Sherwood Forest Hospitals will soon welcome a new Chief Executive to the Trust, following a competitive recruitment process that concluded during July.

Jon Melbourne has been appointed to the role, subject to essential pre-employment checks being completed.

Jon is currently the Deputy Chief Executive and Chief Operating Officer at University Hospitals of Leicester NHS Trust, where he has worked since January 2022.

His appointment follows a highly-competitive recruitment campaign that attracted a number of high-quality candidates from across the country.

Jon Melbourne

The new Chief Executive will play a key role in helping to lead the Trust which was named the East Midlands' best NHS organisation of its kind to work for in each of the past seven years' NHS National Staff Surveys.

Everyone at Sherwood who has met Jon during this recruitment campaign has been inspired by his personable approach, his willingness to listen to and work with our colleagues and our partners, and the commitment he shares to improving lives across the communities we serve.

Despite having so much to be proud of as a Trust, we are always aspiring to improve – an ambition that I know Jon shares.

Jon brings extensive experience in operational, financial and strategic leadership to the role.

His previous experience includes a number of senior roles across the country's NHS, with Jon having also worked at University College London Hospitals NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, and Imperial College Healthcare NHS Trust.

Jon joined University Hospitals of Leicester when waiting lists at the Trust were among the worst in the country following the pandemic.

Under his leadership, the Trust achieved the largest reduction of long waiters in England and delivered sustained improvements to ambulance handover times.

During his time at the Trust, Jon also oversaw complex cross-site reconfigurations, major improvements to operational productivity, and the implementation of a new Patient Administration System earlier this year.

In announcing this appointment, I would also like to pay tribute to the Trust's Acting Chief Executive, Dr David Selwyn.

Dave has served as our Acting Chief Executive since May 2024, where he has continued to lead the Trust following the passing of former Chief Executive, Paul Robinson, earlier this year.

We all know how difficult the past year has been for everyone at Sherwood and I would like to place on record my thanks to Dave for his exemplary leadership during this difficult time in the Trust's history

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

Dave will continue to serve as the Trust's Acting Chief Executive until Jon takes-up his new post over the coming months, once essential pre-employment checks have been completed.

New Chief Operating Officer takes-up his new role

In July, the Trust welcomed its new Chief Operating Officer (COO), Simon Illingworth, into post.

Simon officially joined the Trust on Monday 14 July from The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, where he had been serving as its Chief Operating Officer since August 2023.

He takes over from his predecessor, Rachel Eddie, who left the Trust in July.

I welcome Simon into his role and extend my thanks once again to Rachel Eddie for her time in the role, as well as to the Trust's Deputy Chief Operating Officer, Chris Dann, who acted into the 'COO' role in anticipation of Simon taking up his new role.

Simon Illingworth

New Trust Vice Chair confirmed

I am pleased to confirm that one of the Trust's Non Executive Directors, Steve Banks, was confirmed as the Trust's new Vice Chair by the Trust's Council of Governors at its meeting on 11 June 2025.

Steve has been with Sherwood as a Non-Executive Director (NED) since December 2021. He takes over the Vice Chair role from his fellow 'NED', Barbara Brady.

I would like to congratulate Steve on this new role, as well as give my thanks to Barbara who has been a rock for me during my time as both a Non-Executive Director and Chair, where she has offered invaluable support during her time as both a Non-Executive Director and as the Trust's Senior Independent Director (SID).

I am delighted that Barbara will be continuing to support the Board by continuing in her role as the Trust's Senior Independent Director. I look forward to continuing to work with them both over the coming months.

Board of Directors

David Selwyn
Acting Chief Executive

Graham Ward
Chair

Phil Bolton
Executive Chief Nurse

Sally Brook Shanahan
Director of Corporate Affairs

Simon Illingworth
Chief Operating Officer

Steve Banks
Vice Chair & Non-Executive Director

Barbara Brady
Non-Executive Director

Richard Cotton
Non-Executive Director

Manjeet Gill
Non-Executive Director

Richard Mills
Chief Financial Officer

Dr Simon Roe
Chief Medical Officer

Robert Simcox
Chief People Officer

Lisa Maclean
Non-Executive Director

Neil McDonald
Non-Executive Director

Andrew Rose-Britton
Non-Executive Director

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

Council of Governors

Mansfield, Ashfield and surrounding wards

Liz Barrett OBE
Lead Governor

Tracy Burton

Neal Cooper

John Dove

Nabeel Khan

Pam Kirby

Julie Kirkby

Iain Peel

Jane Stubbings

Newark, Sherwood and surrounding wards

Ann Gray

Peter Gregory

Shane O'Neill

Position vacant

Rest of England

Dean Wilson

Staff governors

Samantha Musson

Mitchel Speed

Justin Wyatt

Appointed governors

Nikki Slack
West Notts College

Cllr Linda Dales
Newark and Sherwood District Council

Cllr Angie Jackson
Mansfield District Council

Kevin Stewart
Appointed Governor - Volunteers

Cllr David Walters
Ashfield District Council

Position vacant
Nottinghamshire County Council

Issued: July 2025

Trust to host 2025/26 Annual General Meeting

The Trust will host its Annual General Meeting (AGM) and Annual Members Meeting (AMM) to provide an in-depth review of the Trust's performance over the last financial year.

The meeting will also share how the Trust is planning to meet the challenges we are expecting to face in the remainder of 2025/26 and beyond.

The public meeting is due to take place on Tuesday 16 September 2025 from 5.30pm in Lecture Theatre 2 at the King's Mill Conference Centre at King's Mill Hospital. The meeting is expected to last around one hour.

Aligned to the meeting will be a showcase that will share a number of key developments from across the Trust with attendees.

Trust colleagues, partners and members of the public will also be invited to submit their questions to the Trust's Board for them to answer during the meeting. All questions must be submitted in advance of the meeting by emailing sfh-tr.communications@nhs.net.

Recognising the difference made by our Trust Charity and Trust volunteers

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

A summary of their key achievements and updates during that time are provided below:

Celebrating the contributions of our Trust volunteers

In June and July alone, 380 Trust volunteers generously gave over 9,000 hours of their time to help make great patient care happen across the 26 services they have supported during the month.

To show our appreciation for our longest-serving volunteers, we have been proud to recognise their long service at the Trust through a number of recent presentations.

Recipients of those presentations include Doreen who has volunteered at Newark Hospital for an amazing 25 years, where you will find her working on the main reception.

She is pictured right being presented with her award by the Trust's Acting Chief Executive, Dave Selwyn, and our Associate Corporate Director of Nursing, Yvonne Simpson.

Meanwhile, Merv works as a café storeman at King's Mill Hospital and loves being able to support the hospital. He was awarded his 15-year certificate by Community Involvement Coordinator Joy Wilson.

We thank them both – and all our volunteers – for the difference they make to supporting us to provide great patient care across our hospitals.

Hospitals charity launches lottery with top prize of £25,000

Supporters of King's Mill, Newark and Mansfield Community Hospitals can give back to the Trust by signing up to a weekly lottery with a cash prize of £25,000.

The Sherwood Forest Hospitals Charity has launched *Your Charity Lottery* which enables people to make payments of £5 per month to the charity and be entered into a weekly lottery draw, which started in July.

The introduction of the lottery gives people the chance to support the charity on an ongoing basis, for the small monthly amount.

By playing the weekly lottery, supporters can help the Trust to improve the lives of patients, their families, visitors and staff, and be in with a chance of winning a cash prize of up to £25,000.

Hundreds of tickets for the lottery have been sold and its first draw has taken place. We look forward to sharing more details about our first winners with you all soon.

Abseil announced to raise money for Sherwood Forest Hospitals Charity

On Friday 3 and Saturday 4 October, the Sherwood Forest Hospitals Charity is hosting an abseil event at King's Mill Hospital to raise money to help fund more schemes which will improve the lives of our patients, staff and visitors across our hospitals.

The charity has teamed up with *Big Bang Experiences* to give you the chance to take a leap of faith and abseil down six storeys of King's Mill Hospital.

The Trust has already received hundreds of expressions of interest to take part in the event, with more thrill-seekers encouraged to come forward to secure their place as soon as possible.

Anyone interested in registering to take part in the event can email kenneth.godber@nhs.net.

Pop Choir fundraiser raises £4,000 for Trust Charity

The Major Oak Pop Choir hosted a charity evening at the Civic Centre on Sunday 6 July, raising funds for The Sherwood Forest Hospitals Charity.

The event was organised by Sherwood Forest Hospitals governor Peter Gregory and his wife, Helen, with the support of other governors (pictured above) and the hospital charity.

The Major Oak Pop choir provided the entertainment for the evening, which was compered by Mansfield 103.2 Managing Director, Tony Delahunty. A big thank you to both parties for donating their time.

The event raised nearly £4,000 from a combination of ticket sales, raffle prizes, donations to the collection tin on the night, a donation from Experian and proceeds from a handmade quilt sale. The funds will be utilised by cancer services at the Trust.

Thank you to all those who supported, and all those who made the night possible, including businesses and individuals who donated amazing raffle prizes.

Other notable contributions made by the Sherwood Forest Hospitals Charity over recent months include:

- Children receiving treatment for diabetes at the Trust have been learning how to manage their condition thanks to a donation from the Sherwood Forest Hospitals Charity. The funds have allowed the diabetes team to run a group cooking session where participants learned how to prepare two healthy recipes – bean and cheese quesadillas on wholewheat wraps with salsa, and chicken Chow Mein.

- Clinicians at Newark Hospital will be able to improve the excellent CT Colon service, thanks to a kind donation of £7,000 from the Friends of Newark Hospital. Pictured right.

  The donation has enabled the CT (Computed Tomography) department at Newark Hospital to purchase an upgraded insufflator machine which works by safely delivering carbon dioxide into the body to inflate the large intestine and allows clinicians better access to view the area when a patient is receiving a CT scan.

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

Other notable engagements:

- I attended an event run by NHS Providers along with the Trust's Executive Chief Nurse. The event included discussions on the 10-year Health Plan for England and the role that trusts will have to play within that, as well as highlighting ongoing developments from the NHS App and its ongoing development.

- I attended the Council of Governors Membership and Engagement Forum on Tuesday 1 July to update Trust governors on a number of ongoing items, including the Trust's financial position and the Trust's recruitment of a new substantive Chief Executive Officer. This has complemented by regular ongoing conversations with the Trust's lead governor, Liz Barrett OBE DL.

- I have undertaken my latest '15 Steps' visit to Ward 22 at King's Mill Hospital, where I visited with Mitchel Speed, one of the Trust's new staff governors, to the ward where he first worked.

- I visited Newark Hospital for a tour of the site and to learn of the latest developments there.

- I held the latest of our quarterly meetings with representatives from Nottingham and Nottinghamshire Healthwatch.

- I took part in my latest monthly catch-up meeting with the Regional Director of NHS England (Midlands), Dale Bywater.

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

- Nottingham and Nottinghamshire chairs and elected members monthly meeting, which is led by the Nottingham and Nottinghamshire Integrated Care Board (ICB).

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	31 July 2025
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Dr David Selwyn, Acting Chief Executive		
Presented By:	Dr David Selwyn, Acting Chief Executive		

Purpose

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

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
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PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

None

Acronyms

A&E = Accident and Emergency
BAF = Board Assurance Framework
BFI = Baby Friendly Initiative
CRM = Customer Relationship Management
DM01 = Diagnostic Waiting Times and Activity
ED = Emergency Department
EPR = Electronic Patient Record
GPs = General Practitioners
ICB = Integrated Care Board
MARS = Mutually Agreed Resignation Scheme
NHS = National Health Service
NICU = Neonatal Intensive Care Unit
PTL = Patient Tracking List
RTT = Referral to Treatment
SFH = Sherwood Forest Hospitals
UNICEF = United Nations Children's Fund

Executive Summary

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

Government announces 10 Year Health Plan for England

The Government's 10 Year Health Plan for England was announced at the beginning of July.

Through the 'three shifts' – from hospital to community, from analogue to digital, and from treatment to prevention – set out in the plan, the government is aiming to support the NHS to personalise care, give more power to patients, and ensure that the best of the NHS is available to all.

Key commitments under the plan include expanding the use of the NHS App to become complete digital front door to NHS, where patients can book appointments, manage medicines, view data and access a Single Patient Record that will be in place from 2028.

Patients will also be able to self-refer on the app to mental health talking therapies, musculoskeletal services, podiatry, and audiology – freeing-up GPs and new Neighbourhood Health Services to reduce national waiting times for these services, as well as keeping our own Urgent and Emergency Care services free for those who need them.

You can read the full plan on the Government's website, where you can also find a shorter 'executive summary' of the plan.

Since its publication, the Trust has been reviewing the detail of the newly-published plan to understand what it means for the Trust's own five-year *Improving Lives* strategy and the work we do here at Sherwood.

A vital chapter of the 10 Year Health Plan for England is due to be published in the autumn which will detail how the plan will be implemented. At this point, the specific requirements on Sherwood will become clearer.

We will, of course, continue to update the Board on this as more detail becomes available.

Operational updates

Updates from national industrial action

July saw the return of national industrial action, as a result of the national dispute between the doctors' trade union, the British Medical Association, and HM Government. Resident doctors (previously called junior doctors) chose to take industrial action as part of their ongoing dispute with the government over pay and conditions.

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

Industrial action was always going to have an impact on our elective activity and backlogs but with forward planning we were able to mitigate this as much as possible, with minimal numbers of patients seeing their non-urgent elective procedures and outpatient procedures rearranged as we focused our efforts on providing urgent and emergency care. 639 outpatient appointments, 16 inpatient procedures and 53 daycase procedures were postponed and are in the process of being rescheduled. Over the five days, 84.17% of our resident doctors supported the strike action.

We remain grateful to all our Trust colleagues who worked to ensure that patients could continue to access the care they needed during this latest period of industrial action.

We remain grateful to all our Trust colleagues who worked to ensure that patients could continue to access the care they needed during this latest period of industrial action.

Overview of operational performance

During the summer months, our services have also been dealing with the unique challenges that periods of intense heat bring with them. This has included the Trust operating while several amber heat health warnings have been in place.

These weather conditions present unique challenges to our colleagues and we have been working with partners to share advice on how to stay well and look out for their elderly friends, family and neighbours during each period of warm weather to help reduce the chances of them needing hospital care during the warmer weather.

When considering operational performance, despite continued high levels of Emergency Department attendances, our headline A&E four-hour performance metric has been above 75% since March 2025 and has exceeded plan throughout the first quarter of 2025/26. This is our best quarter one performance since 2022/23.

Our ambulance handover position and Emergency Department (ED) 12-hour length of stay performance have also improved in recent months, benchmarking well nationally.

In terms of planned care, our 52-week wait backlog is steadily reducing and we are close to delivering our 2025/26 year-end operational planning requirement of no more than 1% of our total PTL (Patient Treatment List) waiting over 52 weeks.

Our 18-week referral to treatment (RTT) performance is stable at around 64% and is at the highest sustained levels observed since summer 2023. Our diagnostic DM01 performance has deteriorated in 2025/26 quarter one, falling below our plan.

A deterioration in our Echocardiography position following the release of insourcing capacity is the predominant driver of this recent performance trend which we are addressing. Despite the decrease in performance, we remain above the national average by circa 10% and benchmark favourably.

Our cancer performance for the 28-day faster diagnostic standard and the 62-day treatment standard both remain favourable to plan. Cancer 31-day treatment performance (first treatment) has varied in recent months and is presently worse than the national standard (which is also our plan). For 31-day and 62-day treatment standards, we benchmark in the lower quartiles nationally. Positive signs have been observed in the 62-day pathway, with the 62-day patient backlog reducing in recent weeks. Recovery plans are in place.

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

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

Update on Trust's position in NHS Oversight Framework 2024/25: Quarter 4 Segmentation

Amanda Sullivan, Chief Executive of the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), formally wrote to the Trust on 3 July 2025 to confirm the Trust's Quarter 4 2024/25 segmentation position and set out the process and timescales for the 2024/25 Quarter 1 segmentation assessment.

It was agreed that for Quarter 4 2024/25, Sherwood Forest NHS Foundation Trust should remain in segment 2 of the existing NHS Oversight Framework. This rating is based on the quantitative and qualitative assessments of the five national themes and one local priority contained within the NHS Oversight Framework.

The Trust is unclear when its new segmentation position for Quarter 1 2025/26 will be published, as the release date has been pushed back by NHS England. The initial segmentation will now be based on Q1 financial actuals as opposed to 'plan' financial position. Initial feedback has suggested that operational and quality metrics are pointing towards a segment 2 position but as a result of our 2025/6 dependence of deficit support, and the gateway impact of this in the calculation process, we are likely to be allocated segment 3.

Other Trust updates

Mutually Agreed Resignation Scheme launched in response to financial pressures

Over recent months, we have talked extensively about the financial challenges we are facing across our NHS and we know that Sherwood is no different in needing to live within its means, as we have committed to saving £45.8million before the end of March 2026.

In July, we followed a number of other local NHS trusts in launching a Mutually Agreed Resignation Scheme (MARS) to support us in making the significant financial savings we need to make as a trust.

Mutually Agreed Resignation Schemes enable colleagues who meet certain criteria to apply to volunteer to leave the Trust in return for a severance payment of up to 12 months' basic salary. That figure is capped and will depend on the individual's length of service. The scheme has only been opened to colleagues working in non-patient-facing roles and those who meet a number of strict criteria.

Under the scheme, we welcomed applications for a short window between Tuesday 1 July and Monday 28 July. A panel of senior leaders is reviewing those applications before applicants are informed of the outcome of their application.

Decisions on whether to accept applications will only be made where a resignation does not compromise patient safety, the quality of care we provide or the Trust's ability to deliver essential services.

Importantly, a Mutually Agreed Resignation Scheme does not involve voluntary or compulsory redundancies, as Sherwood Forest Hospitals is making every effort to deliver the financial savings it needs to make without the need for voluntary and compulsory redundancies.

We will update the Trust's Board of Directors at a future meeting on the outcomes of that process.

Maternity department reaccredited with UNICEF's Stage 3 Baby Friendly Initiative status

Our Maternity Department has passed its recent re-accreditation for Stage 3 Baby Friendly Initiative by the United Nations Children's Fund (UNICEF). Stage 3 is the highest level of accreditation available before applying for the Gold Sustainability Award.

UNICEF stated that the staff at Sherwood Forest Hospitals are commended for their hard work since last year's reassessment in continuing to support the women, parents and carers they work with.

It was clear to the assessment team that in many areas, pregnant women, parents and new families receive a high standard of care.

This re-accreditation recognises that the team have, for the 11th year running, shown their commitment to following Baby Friendly standards. These standards promote breast/chest feeding and the use of breastmilk based on extensive evidence to support parents and babies with their feeding journey.

Achieving re-accreditation highlights the Trusts commitment to excellent evidence-based care for parents and babies with one parent saying they received "outstanding care antenatally and during birth" and mentioned the Trust's Lime Green Infant Feeding Team saying that their support "has been amazing."

The hard work and determination from the team to gain this reaccreditation cannot be underestimated. We are extremely pleased to have been able to do this for our parents and babies.

We are proud of the collective ongoing work by our teams in community and the hospital to reach this stage of accreditation, which has been only been made possible thanks multi-disciplinary working as one across our Women's and Children's Division.

This 'one team' approach is vital in enabling us to offer progressive parent-centred infant feeding support at SFH, and for us to work towards the BFI Gold Award. A huge thank you and well done to all involved!

Trust announces partnership with Nervecentre's EPR to drive digital transformation

Steps to digitise patient records across our sites have taken a step forward recently, as the Trust announced its preferred supplier to make that ambition a reality.

As a Trust, we have selected Nervecentre as the preferred supplier to implement our Electronic Patient Record (EPR) – or, as I like to describe it, our whole hospital cultural change programme.

The announcement was made following a robust selection process supported by NHS England.

An Electronic Patient Record (EPR) is a digital record that stores detailed patient information all in one place, including medical history, test results, treatment plans, and other relevant data. It will provide a single, connected record to streamline decision-making, improve data quality, and help improve patient outcomes.

The introduction of an EPR to the Trust will enhance operational efficiency, streamline workflows, and improve communication across our Trust and the wider healthcare system. This transformation will grant better access to patient information, empowering individuals to make more informed decisions and ultimately elevate the standard of patient care.

Our previous work with Nervecentre has already allowed us to successfully implement various innovative solutions, including e-observations, escalations, electronic prescribing, and medicines administration.

The Trust is now able to build on its long-standing relationship with Nervecentre, which has supported patient monitoring in several departments at Sherwood since 2017. This move supports key areas like patient safety, managing hospital capacity, digital prescribing, electronic observations, clinical photography, and out-of-hours care.

I am delighted that our stringent procurement process has selected Nervecentre as our digital partner and we are confident that this partnership will deliver lasting benefits for our patients, empowering and supporting our staff whilst significantly improving the quality of care across our hospitals.

The partnership will also allow exciting opportunities to foster greater collaboration across the NHS Trusts in the East Midlands, ensuring we make the best use of our shared resources, improve communication across our hospitals paving the way for a more integrated healthcare system to the benefit of all.

Paul Volkaerts, Nervecentre CEO says: "We are delighted that Sherwood Forest Hospitals have chosen Nervecentre as their EPR. Its full breadth functionality, world-class ease of use, and collaborative capabilities will encourage safe and efficient care for people living in Nottinghamshire. We look forward to continuing to work with the trust in this exciting time of healthcare digitisation."

The decision to select Nervecentre as our preferred supplier has been confirmed by the Nottingham and Nottinghamshire Integrated Care Board (ICB) and is now awaiting ratification by the Cabinet Office.

Whilst our full EPR is still two years or so away, it is vital that we take every opportunity to continue to drive forward innovations in improving our patient care and this is now entirely in line thew the NHS 10 year plan. Consequently, we will be launching our Urgent & Emergency Care Nervecentre module this autumn to seamlessly integrate our front door patients, with the rest of our hospital.

First cancer information and support centre of its kind opens in Newark

People who have been affected by cancer were among those who attended the official opening of a new Macmillan Cancer Information and Support Centre in Newark – the first of its kind in the country.

Sherwood Forest Hospitals NHS Foundation Trust is working in partnership with Macmillan Cancer Support to provide the service at the YMCA Community and Activity Village on Lord Hawke Way in Newark.

It is the first Macmillan Cancer Information and Support Centre based in a community setting rather than in a hospital and is already welcoming a range of people who are affected by cancer.

Service user Andrea Ellis cut the ribbon to declare the centre officially open on Tuesday 10 June 2025. She was joined by the Chief Executive of Macmillan Cancer Support, Gemma Peters, along with representatives from Sherwood Forest Hospitals and the YMCA.

The official opening is another milestone in our journey to improve access to high-quality cancer information and support for local people affected by cancer. Our aim is to support people's physical, social, emotional, financial and practical wellbeing under the one roof. We really hope that by visiting us, people's experience of cancer will be more positive.

The new service, which offers support to anyone affected by cancer, is designed to provide information and support close to home, in a friendly and welcoming community setting.

The centre – which is open Monday to Friday, 8.30am to 4pm – offers drop-in services and appointments for personalised support.

There is also a growing timetable of sessions and events such as walking groups, craft and chat groups, Look Good Feel Better sessions, as well as bespoke workshops around the impact of cancer and carer support groups.

You can contact the service via 01636 681681, extension 5936, or on 07553 726425, or email sfh-tr.cancer.info@nhs.net. Alternatively, you can call the Macmillan Support Line 7 days a week, 8am to 8pm on 0808 808 00 00 or visit the Macmillan website.

Winning students’ designs to bring NHS heroes' commemorative garden to life

The entrance to Nottinghamshire's first Community Diagnostic Centre in Mansfield will be transformed into an eye-catching commemorative garden, thanks to our partnership with local college students and the contractors working to build the new purpose-built facility.

The design, created by a group of talented students from West Nottinghamshire College, was selected as part of a collaborative competition which challenged students to create their own eye-catching designs for the entrance to the new multi-million pound development that will eventually deliver tens of thousands more health checks each year.

The competition was launched to provide students with real-world experience and the opportunity to contribute to a meaningful project that will offer a peaceful, reflective space for staff, patients, and visitors to remember loved ones and colleagues to enjoy.

Using elements of the winning designs, the garden will now be brought to life at the new Mansfield Community Diagnostic Centre, which is being built alongside Mansfield Community Hospital in Stockwell Gate.

The panel were so blown away by the quality of the designs presented that they were unable to choose between them, so it was decided to take elements of each design and incorporate them into one final plan.

Showing our appreciation to our Armed Forces community

On Armed Forces Day on Saturday 28 June, we proudly celebrated the end of Armed Forces Week with an event to show our support for the men and women who make up the Armed Forces community – from currently serving personnel to service families, veterans, and cadets.

As a Trust, we are proud to have many reservists, service leavers, veterans, and members of the Armed Forces community contributing their skills and experience across a wide range of roles at SFH.

Throughout the week, some of our amazing veterans have been marking the occasion with information stands, sharing stories about military life and their career journeys.

The celebration followed our announcement that Sherwood was shortlisted for the Health and Wellbeing award, jointly with Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust at this year's Boots and Beret Awards.

The awards, run by Nottinghamshire County Council, honour the dedication, commitment and support for our Armed Forces community in Nottinghamshire. We will find out the outcome of that shortlisting following the ceremony on Thursday 11 September.

Trust’s new website enters top 30 NHS websites in the country for accessibility

Recently, the Trust’s website relaunched with a modern, clean, consistent new look that makes the site easier to use and navigate, and ensures everyone, including people with disabilities and impairments, is able to access and understand our website content.

We are proud to share that the Trust’s website has climbed to 30th place in the country for digital accessibility – a significant leap from the Trust’s lowest rating of rating of 230th place in October 2023.

We are now reporting our highest-ever levels of compliance (94.4%) with the EU web accessibility standards that we are legally required to comply with, and we are also reporting 90% compliance with the higher, more aspirational 'AAA' standards that reflect accessibility best practice.

Technical compliance with those standards is one thing, but the real benefit is that the Trust is now delivering an improved website and better experience for the tens of thousands accessing our trust website each month.

The work does not stop here, as we continue to make improvements and developments to the Trust’s website as part of our ongoing commitment to continue aspiring and improving to improve the lives of 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 at the Public Meeting of the Trust’s Board of Directors in October.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	3 July 2025
Prepared By:	Sarah Ayre, Head of Midwifery, and Rachael Giles, Deputy Divisional Director of Nursing, Women's and Children's Division		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women's and Children's, Philip Bolton, Executive Chief Nurse		

Purpose

The purpose of this paper is to assure the Trust Board on the safety, quality, and ongoing improvements within our maternity and neonatal services at Sherwood Forest Hospitals NHS Foundation Trust.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where items have been presented before

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

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Assurance Committee (PAC)
- Local Maternity and Neonatal System (LMNS)
- Professional Midwifery Advocate (PMA)
- Induction of Labour (IOL)

- Pregnancy Day Care (PDC)
- Neonatal Intensive Care Unit (NICU)
- Maternity Support Workers/Maternity Care Assistants (MSW/MCA)
- Head of Midwifery (HoM)
- Deputy Director of Nursing (DDoN)
- Perinatal Services Oversight Group (PSOG)
- Non-Executive Director (NED)
- Saving Babies' Lives Version Three: A care bundle for reducing perinatal mortality (SBLCBV3)
- Transitional Care (TC)
- Royal College of Midwives (RCM)
- Terms of Reference (ToR)

Executive Summary

This report provides an overview of the activity and assurance work carried out in month across the maternity and neonatal services at Sherwood Forest Hospitals NHS Foundation Trust. It reflects the continued commitment of the Maternity and Neonatal Safety Champions (MNSCs) to deliver safe, high-quality, and compassionate care in alignment with national priorities and local improvement plans. Overall, the report assures continued focus on safety, service user experience, workforce development, and cultural improvement across our perinatal services. Actions taken and planned continue to align with local and national strategies, with clear leadership and governance oversight via the Perinatal Assurance Committee and wider Divisional governance structures.

Perinatal Services Oversight June 2025

Maternity

1. Staff Engagement

1.1 Safety Champion Walkaround

As part of ongoing efforts to strengthen safety culture through regular frontline engagement, a walkaround was conducted on 10th June 2025, with participation from Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women's and Children's, Neil McDonald Non-Executive Director and Perinatal Services Safety Champion, alongside interim Divisional General Manager Adam Littler. Several areas of concern were reviewed, with discussion focused on identifying barriers to improvement and exploring practical solutions. In the Antenatal Clinic, Matron Lisa Foster provided updates on forthcoming staffing plans, the installation of TV screens, and replacement options for the scan photo cards. Following the insolvency of the previous card supplier, we are now exploring in-house production supported by the hospital charity, which would allow for Trust branding and the inclusion of key service information on the reverse.

They also reviewed the preferred approach for Triage reconfiguration. Phase one will involve a like-for-like relocation, with requirements for the move currently being identified. Phase two, developing an alternative entrance to the clinic area, will require further cross-divisional engagement but is progressing. Finally, we assessed the holding space located within the lift shaft between the Maternity and Neonatal units, which remains persistently cluttered. Adam Littler will follow up with the Estates team to establish a sustainable resolution to ensure this space remains safe and accessible throughout July, and a risk has been drafted by the Head of Midwifery 'Divisional risk to care during an emergency due to obstruction of emergency access route between Sherwood Birthing Unit and NICU', scoring a 12, to be discussed and finalised at Governance Meeting by the MDT on 14th July 2025.

1.2 Perinatal Services Forum
This forum was relaunched on 2nd April 2025, replacing the Maternity Forum. The June session was stood down due to operational pressures. The next forum is scheduled for 9th July 2028.

1.3 Perinatal Staff Council
This council was re-established in April 2025 with broader representation, including Transitional Care staff. The Council sends representatives to the Perinatal Services Forum and Perinatal Assurance Committee to enhance Ward to Board and Back communication. Efforts are ongoing to expand membership and align discussions with 2024 Staff Survey themes.

1.4 ICB Insight Visit – June 2025
On 5 June 2025, the Nottingham and Nottinghamshire Integrated Care Board (ICB) undertook an insight visit to Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) maternity services. The visit aimed to assess progress against the Maternity and Neonatal Three-Year Delivery Plan through clinical walkarounds and direct engagement with staff. The ICB team found that SFHFT is performing strongly across all key performance indicators and is not identified as a negative outlier in any domain. Furthermore, the Trust is recognised as a positive outlier in nine separate measures, reflecting consistently high standards in safety, quality, and outcomes. This level of performance provides a robust foundation for continuous improvement and broader system learning.

The visit highlighted a number of key strengths. Workforce and culture initiatives, such as the "10\@10" team huddles, cultural competency training, and the "PositiviTea Trolley," are contributing to enhanced staff cohesion, morale, and visible leadership. The introduction of 'Tree Teams' and a Staff Council supports shared leadership and responsive communication channels across the division. Service user engagement is well-embedded, with the Perinatal Service User Oversight Group—chaired by a Senior Advocate—ensuring co-production remains central to service development and improvement. Clinical improvements are evident, particularly in the implementation of the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), with over 80% of women assessed within 15 minutes of arrival. The Preterm Birth Service continues to develop positively under strong clinical leadership. Environmental enhancements, such as the installation of TV screens and the locally produced scan photo cards—enabled by charitable funding—have further improved the antenatal clinic experience for women and families.

There are, however, some areas that require continued focus. While Enhanced Continuity of Care is not currently in place, the Trust is actively mapping existing models to support future implementation. Triage remains on the maternity risk register, and although performance is strong, spatial constraints within the current estate limit the ability to establish a standalone unit. Alternative options are being explored. Staff confidence in triage, particularly in applying the BSOTS model, would benefit from improved rotation and structured training to maintain skill levels. Additionally, there is a recognised opportunity to pilot proactive preconception care in primary care settings to support the early identification and management of modifiable risk factors and improve early booking rates.

Overall, the insight visit provided a high level of assurance regarding SFHFT's ongoing commitment to delivering safe, high-quality, and person-centred maternity care. The Trust's positive culture, strong performance, and clear plans for service development place it in a strong position to maintain excellence and further its leadership role within the regional maternity and neonatal system.

2. Service User Feedback

2.1 Friends and Family Test – Envoy Data

Maternity Ward

30 Day Overview

Survey Status	No. of Discharges	% of Total
Survey Sent	248	96.12%
Message not scheduled due to error	9	3.49%
FFT open survey	7	2.71%
Excluded due to opt-out	1	0.39%

Postnatal Community

30 Day Overview

Survey Status	No. of Discharges	% of Total
Survey Sent	263	95.29%
FFT open survey	10	3.62%
Message not scheduled due to error	8	2.90%
Excluded due to opt-out	5	1.81%

Birth

30 Day Overview

Survey Status	No. of Discharges	% of Total
Survey Sent	263	95.64%
FFT open survey	27	9.82%
Message not scheduled due to error	8	2.91%
Excluded due to opt-out	4	1.45%

3. Quality Improvements

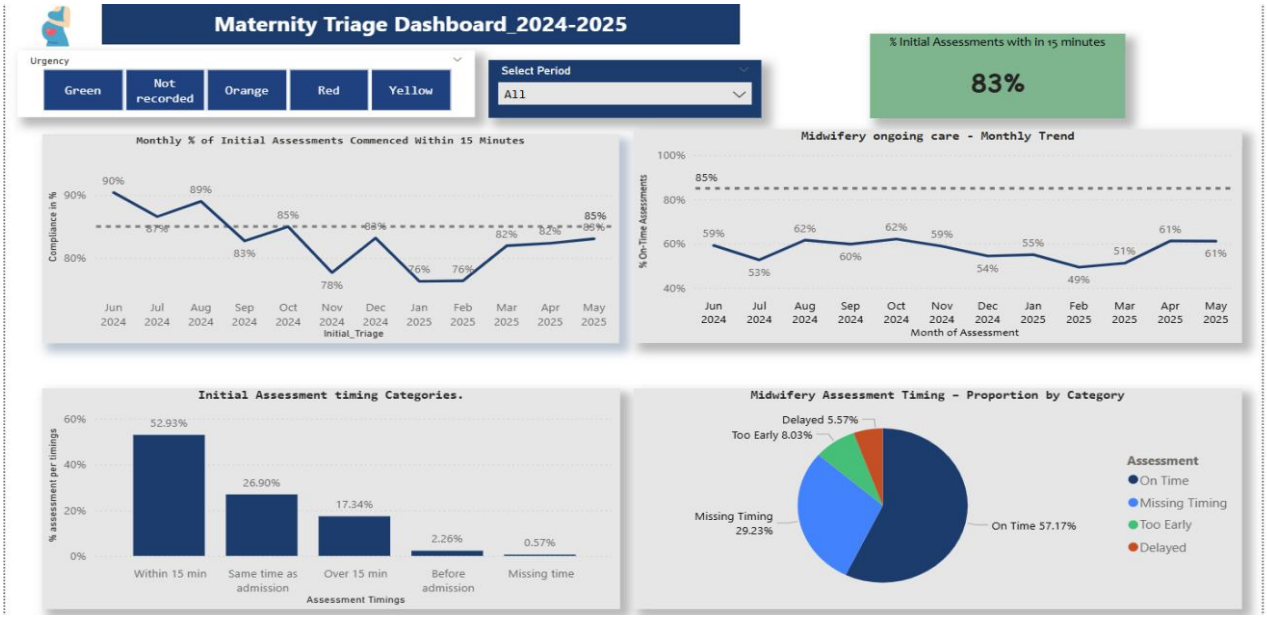
3.1 Perinatal Services Oversight Group (PSOG)

Lead Advocate Sarah Seddon will be collaborating with Head of Midwifery Sarah Ayre to refocus the MNSC Meeting that occurs in the months between PAC as part of our formal assurance reporting. This meeting will be renamed, attract a new ToR, and an agenda.

3.2 Triage Dashboard

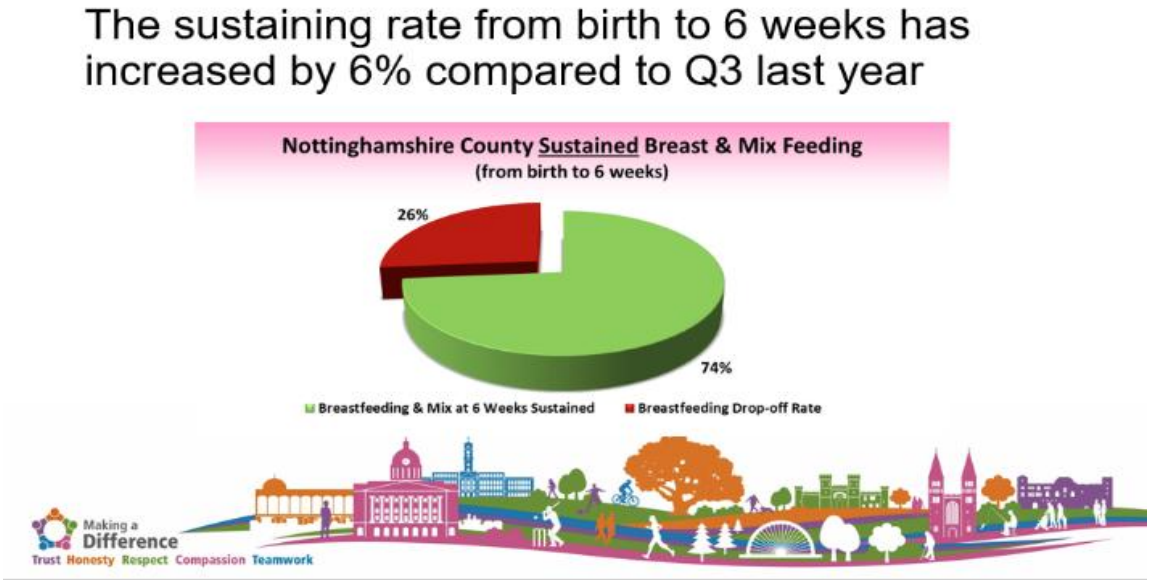
We will be introducing the new Triage Dashboard in August 2025, which has been developed by the Business Analyst team to support the continuous monitoring and improvement of safety and quality within Triage services. Designed to capture and present key performance metrics in a clear and accessible format, the dashboard enables real-time oversight of clinical activity, response times, and patient outcomes.

This tool will enhance data-driven decision-making, facilitate early identification of potential risks, and support targeted interventions to ensure high standards of care are maintained.



3.3 Infant Feeding

The team are currently preparing for 'Going for Gold' BFI accreditation. Network recently shared the impact of the LGT and the care we provide here at SFH as part of the wider community projects in Nottinghamshire.

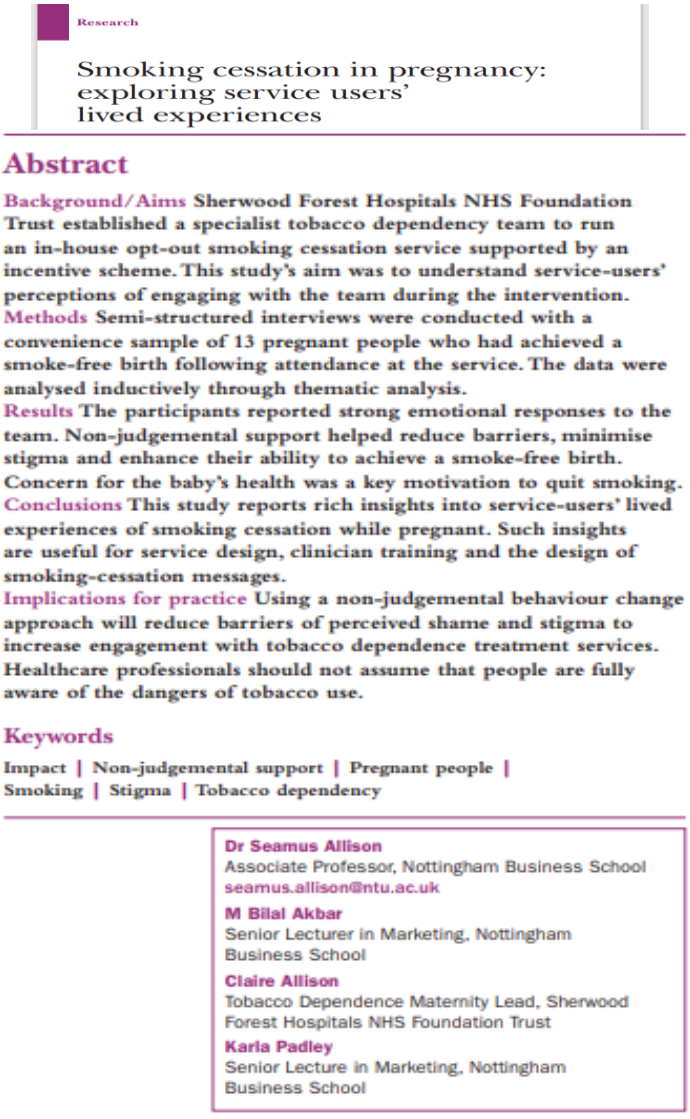


3.4 Pre-Term Birth Service

The proposal to permanently establish Preterm Birth Clinics across Sherwood Forest Hospitals (SFH) and Nottingham University Hospitals (NUH) received verbal approval from the ICB Commissioning Review Group in June 2025. Final approval is pending sign-off by the ICB Chief Executive. Upon confirmation of funding, the service will be embedded by securing the continuity of staff currently employed in seconded roles.

3.5 Smoking Cessation

This powerful and insightful piece of work, Smoking cessation in pregnancy: exploring service users' lived experiences, represents a significant contribution to maternity care at Sherwood Forest Hospitals (SFH). As the final project led by the dedicated and much-admired Claire before her retirement, it stands as a testament to her unwavering commitment to improving outcomes for women and families. The study captures the authentic voices of service users who successfully achieved smoke-free births through the Trust's in-house opt-out smoking cessation service, supported by a specialist tobacco dependency team and incentive scheme. The findings illuminate the transformative impact of non-judgemental, compassionate support in empowering pregnant women to quit smoking—enhancing maternal and neonatal health outcomes in the process. By reducing barriers such as shame and stigma, the approach fostered trust, motivation, and engagement, ultimately contributing to healthier pregnancies and long-term benefits for families across SFH. Claire's legacy is firmly embedded in this work, which not only informs future service development and staff training but also continues to shape a safer, more supportive maternity environment for generations to come.



Research

Smoking cessation in pregnancy: exploring service users' lived experiences

Abstract

Background/Aims Sherwood Forest Hospitals NHS Foundation Trust established a specialist tobacco dependency team to run an in-house opt-out smoking cessation service supported by an incentive scheme. This study's aim was to understand service-users' perceptions of engaging with the team during the intervention.
Methods Semi-structured interviews were conducted with a convenience sample of 13 pregnant people who had achieved a smoke-free birth following attendance at the service. The data were analysed inductively through thematic analysis.
Results The participants reported strong emotional responses to the team. Non-judgemental support helped reduce barriers, minimise stigma and enhance their ability to achieve a smoke-free birth. Concern for the baby's health was a key motivation to quit smoking.
Conclusions This study reports rich insights into service-users' lived experiences of smoking cessation while pregnant. Such insights are useful for service design, clinician training and the design of smoking-cessation messages.
Implications for practice Using a non-judgemental behaviour change approach will reduce barriers of perceived shame and stigma to increase engagement with tobacco dependence treatment services. Healthcare professionals should not assume that people are fully aware of the dangers of tobacco use.

Keywords

Impact | Non-judgemental support | Pregnant people | Smoking | Stigma | Tobacco dependency

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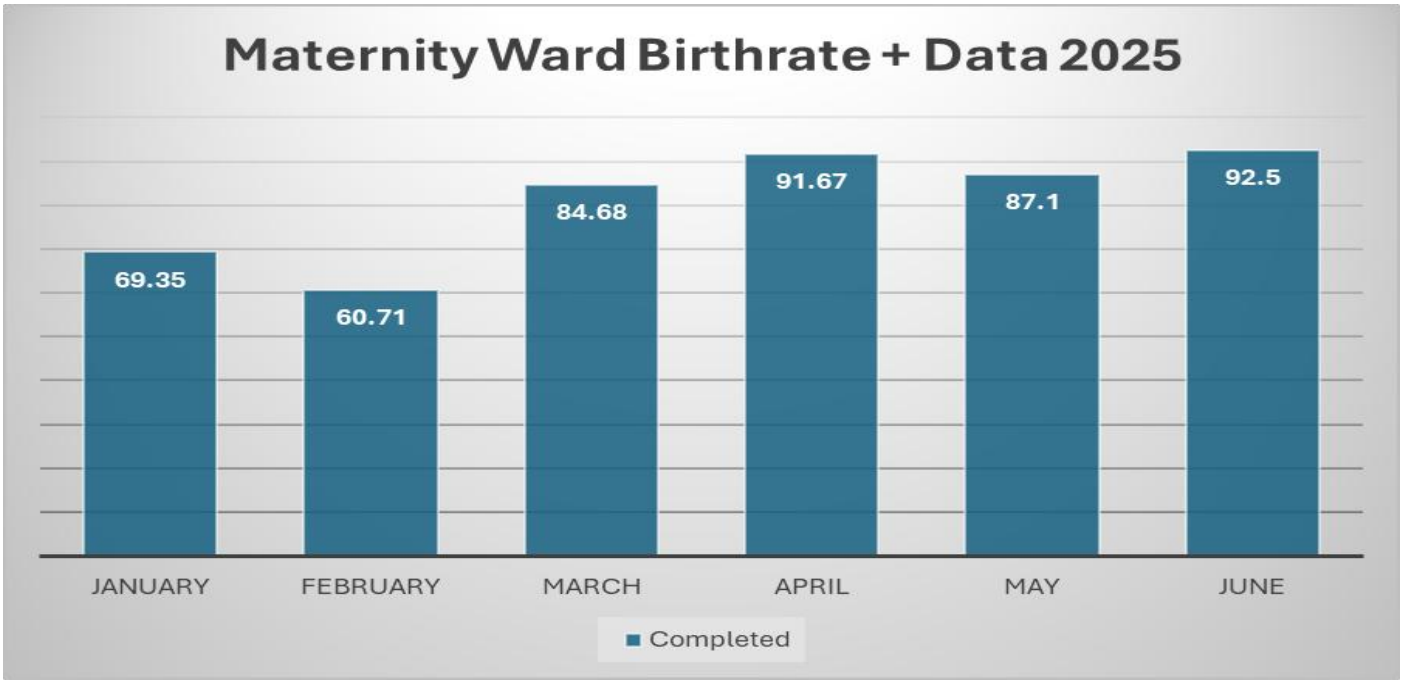
3.6 Birthrate Plus Acuity Tool – Maternity Ward

Improvements in ensuring all acuity reviews are completed across the Maternity Ward on time have shown an approximate 30% increase since the start of 2025.



Maternity Ward Data Jan-June 2025

The ward acuity tool has recently undergone a comprehensive review, testing, and update, and is scheduled for release in early 2026. The enhanced version is completed every six hours and calculates the care hours required for the subsequent six-hour period. In this updated tool, infants are categorised separately using a dedicated care needs matrix, while the care needs of the birthing person are assessed using either an antenatal or postnatal care matrix, as appropriate. The revision process followed an Expert Group methodology, with input and testing from several maternity units across the Midlands region. This included a large tertiary-level centre as well as smaller maternity units, ensuring a breadth of applicability. Qualitative data input functionality and summary reporting are expected to be available in the New Year.

4. Quad+3 Perinatal Services Culture Programme

4.1 Staff Survey

Through June and July 2025, the SLT are supporting Jacob Minihan, OD & Engagement Partner, with weekly face-to-face engagement sessions. These meetings will allow all our teams to contribute to the actions we agree to address the themes. Once the meetings have concluded, in August 2025, we will complete a report of actions already in place and next steps. This will be presented at PAC in September 2025. The new plan will be overseen and owned by the Quad+3, and the Staff Council will receive a monthly update on progress at their meeting from HoM SA.

4.2 Exemplar Accreditation 2026

Sherwood Forest Hospitals (SFH) Exemplar Accreditation Programme aims to provide a set of tools to enable a comprehensive assessment of the quality of care at ward, unit, department, and team levels. It does this by bringing all key measures together into one overarching framework so that all aspects of care can be evaluated and the quality of care can genuinely be measured: continuously learning, improving, and supporting the delivery of outstanding care to our patients (NHS England 2019).

5.National Programmes

5.1 Fit for the Future: 10 Year Health Plan for England

https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

The "Fit for the Future" 10-Year Health Plan sets out a bold and comprehensive vision for the transformation of the NHS, aimed at addressing rising service demand, suboptimal outcomes, workforce pressures, and public dissatisfaction. Central to this strategy are three major systemic shifts: transitioning care from hospitals to community-based settings through the creation of Neighbourhood Health Services; embedding digital technologies and data integration to support a fully digital NHS; and placing prevention and early intervention at the heart of care to reduce health inequalities and improve population outcomes.

This transformation will be underpinned by a reformed and devolved NHS structure, increased accountability, and a strategic focus on workforce investment, education reform, and the adoption of AI-enabled clinical support tools. The plan also introduces a new quality and transparency framework, with financial incentives aligned to patient outcomes rather than activity.

Maternity and neonatal services are specifically recognised as priority areas for reform. In response to persistent concerns about safety and variability in outcomes, the plan outlines a number of critical national interventions. These include an independent national investigation into maternity and neonatal care, and the establishment of a National Maternity and Neonatal Taskforce, chaired by the Secretary of State. This taskforce will co-produce a national action plan in collaboration with bereaved families, ensuring that the lived experiences of service users shape future policy and delivery.

Quality, transparency, and safety are core themes, with a renewed emphasis on data publication and accountability. Maternity services will be benchmarked through national league tables, and performance will be assessed using clinical outcomes and patient experience. Services consistently failing to meet quality standards, whether NHS or independent, may face decommissioning or contract termination.

The wider workforce strategy, although not exclusive to maternity, has important implications for midwifery. Key commitments include career development pathways, expansion of advanced practice roles, and increased access to nursing and midwifery apprenticeships, particularly in underserved areas. The introduction of AI and digital tools is expected to reduce administrative burdens and support clinical decision-making, thereby improving efficiency and freeing up time for direct patient care.

In line with the broader shift toward community and preventative models, maternity care will increasingly be delivered through integrated Neighbourhood Health Centres. This approach supports personalised care planning, streamlined digital self-referral, and enhanced access to perinatal mental health services, ensuring a more holistic and responsive maternity pathway.

In summary, the plan places maternity care at the centre of NHS reform, with clear priorities focused on improving safety, transparency, and trust; empowering the midwifery workforce; reconfiguring care models to emphasise prevention and community delivery; and ensuring that family experience and outcomes are central to service design and evaluation. This agenda aligns with the Trust’s own strategic goals and presents opportunities to lead, innovate, and further strengthen maternity services.

5.2 Maternity Outcomes Signal System (MOSS)
The Maternity Outcomes Signal System (MOSS), developed by the Maternity and Neonatal Outcomes Group, is an early warning tool designed to detect potential safety issues in maternity care that may lead to adverse outcomes. It supports timely intervention by flagging emerging risks and will be integrated into the Perinatal Quality Surveillance Model of the Maternity and Neonatal Programme to enhance care quality and safety (NHS England, 2023).

5.3 Thirwell Inquiry

https://thirlwall.public-inquiry.uk/

The Thirlwall Inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial and subsequent convictions of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. The Chair, Lady Justice Thirlwall, is expected to send out warning letters from September 2025 and the final report will be completed by the end of November. The report will then undergo copy editing and typesetting, ahead of publication in early 2026.

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

5.5 Three-Year Maternity and Neonatal Delivery Plan
We continue to collaborate with the LMNS on the 4 main themes and 12 objectives of the 3-year delivery plan. The collaborative LMNS mapping process against this plan is currently being overseen by the Head of Midwifery. Once the LMNS formally requests our evidence for meeting the 4 main themes, we will fix an agenda item at PAC to share our status and provide assurance against the plan.

5.6 NHSR
Specialty General Manager Samantha Barlow will lead the collation of our evidence once again, with safety action owners assigned as per below. As per the previous process, Samantha will report via PAC.
Safety Action 1 PMRT – Sarah Sarjant
Safety Action 2 MSDS – Lisa Butler
Safety Action 3 Transitional Care – Rachael Giles
Safety Action 4 Clinical Workforce – Samantha Barlow
Safety Action 5 Midwifery Workforce – Lisa Butler
Safety Action 6 Saving Babies Lives – Sarah Sarjant
Safety Action 7 Listening to service users – Sarah Ayre
Safety Action 8 Training – Lisa Butler
Safety Action 9 Board Assurance – Sarah Ayre
Safety Action 10 MNSI – Sarah Sarjant

5.7 Ockenden
The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan embedded within Maternity. The visit's findings supported the self-assessment completed by the Trust. The plan is to revisit the maternity self-assessment tool created by NHSE in May 2025, led by the Head of Midwifery, to be presented at PAC once completed. Our Regional team requested assurance against the Ockenden Letters, and we submitted our return by 12th June 2025.

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

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

6. Maternity Perinatal Quality Surveillance scorecard May 2025
6.1 Stillbirth Review 2024-2025
The Quality and Safety team has reviewed the 38 cases from February 24 to March 25, noting these cases have previously been through an internal governance process. We have added additional information columns to review the Saving Babies Lives indicators. There is a full review paper for PAC in July 2025.

6.2 Red Flags for June 2025
In June 2025, a total of 49 red flags were reported across maternity services, with the highest number recorded on 12 June (6 red flags), followed by 18 June (5 red flags). Many incidents related to delayed or reduced fetal movement assessments and one-to-one care in labour which remain the most consistently reported concerns. The red flags were predominantly attributed to staffing shortfalls and activity pressures, particularly impacting the ability to provide timely triage assessments and continuous support during labour. On several occasions, increased acuity and multiple simultaneous emergencies contributed to delays in care, including missed observations and postponement of induction of labour.

Notably, there were no harm incidents reported because of red flag events during the month. Escalation protocols were followed appropriately, and senior oversight was maintained throughout. The data continues to inform real-time staffing decisions and supports ongoing workforce planning, while also feeding into quality improvement initiatives to strengthen safe and responsive care delivery. Monitoring of red flag trends will continue, with particular attention to mitigating recurrent issues and ensuring resilience during periods of heightened demand.

8. Neonatal Services
8.1 Staffing update
The Trust is seeing a better position in staffing. All new starters band 5 and 6 have now all started and completed induction.
Sickness management has improved particularly long term sickness
There will be a MSW vacancy with 1 staff member leaving and an uplift to Nursing Associate. There are no other vacancies.

We have recruited into the NICU clinical educator role. This is an internal promotion for one of our band 5. The post is ODN funded for 12 months at 22.5 hrs with a focus on supporting the new and upcoming QIS students. The post holder will be line managed by the practice development lead on NICU and they will work together to ensure the support and direct education is provided on the unit.
The ODN have stated that they are trying to increase this funding for an additional year (2 years total) and we will review this nearer the time.

The ODN have offered funding also for additional spaces on QIS course. We have supported our staff to attend within the training budget we have (2 staff -twice a year =4 total per year) and we have bid for the additional funded places. The outcome is awaited.

NTC are now fully recruited too and all staff in post and past induction period. We should now see the full delivery of this service within the allocated budget.

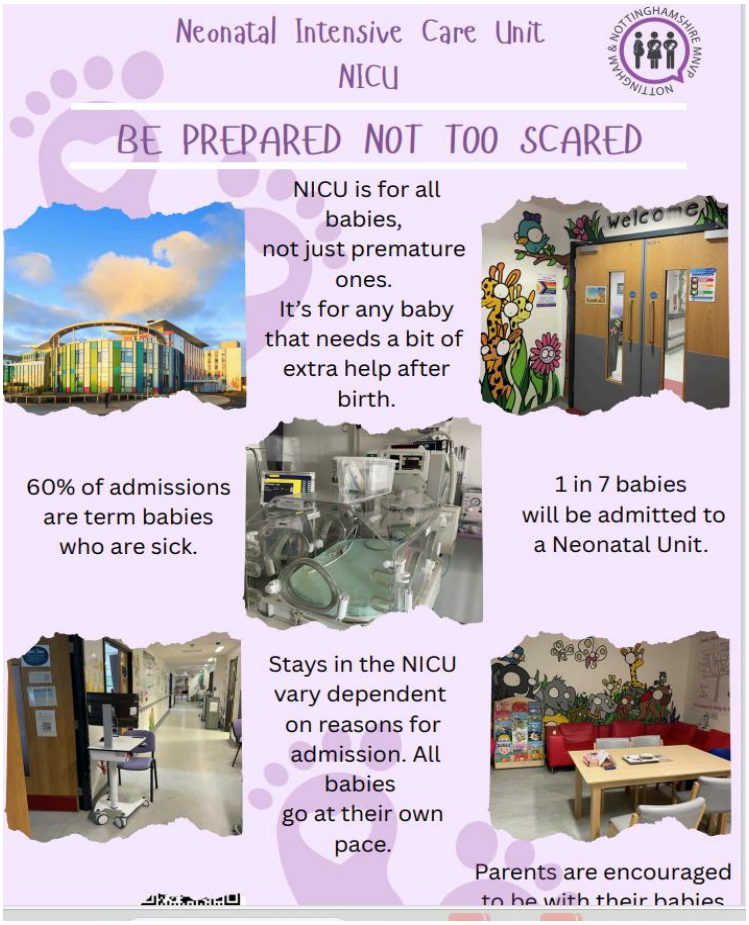
The NTC Ward leader has handed in their notice, and we are on Trac for replacement.

Delivering home based phototherapy to babies with physiological jaundice
The recommended treatment for babies with physiological jaundice is phototherapy (PT), which is traditionally delivered in hospital by overhead phototherapy units. Babies lie under lamps and are only taken out for brief periods of feeding. PT treatment is typically for around four days depending on severity, cause of jaundice and response to treatment. Readmission to hospital is disruptive to family life and can cause high levels of stress within families.

It has been identified that the Hospital at Home service had capacity to manage babies with physiological jaundice at home as part of its objective to reduce length of stay for patients in hospital and improve service user satisfaction.

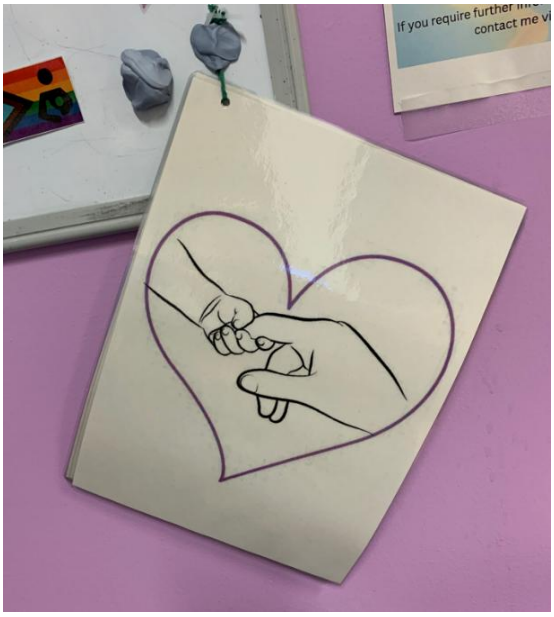
The Trust has started work with NUH for the use of home phototherapy for jaundice babies. This work is part of the Homecare team expansion and incorporated maternity ward, NTC, NICU and Ward 25.
Meetings are now in place to develop guidelines / SOP / training and start exploring how we can offer this service to families at SFH.

Antenatal poster.
A poster containing information relating to NICU has been developed by the MNVP. This poster is going through trust governance process currently for sign off.



Symbol for ladies on maternity – my baby is on NICU
The implementation of this symbol was a feedback action. It was developed as a way of informing staff such as domestics, catering etc that a baby is on NICU / NTC care.

The sign below is used on the allocation board and on door / above bed space to inform staff baby on a different department / requiring NTC support.



BLISS BABY CHARTER
The Baby Charter is seven simple statements that encapsulates the care, respect and support that the most vulnerable babies should receive. The Baby Charter has become a nationally recognised tool referenced in the NHS England Neonatal Critical Care Review, Neonatal Critical Care Transformation Review, the BAPM Quality Indicators, the RCPCH QI resource map, the National Neonatal Audit Programme and the BAPM FICare framework for practice as well as being endorsed by the Scottish Government and included in the all Wales Neonatal Standards.

The Bliss Baby Charter is a tool that helps examine the procedures, practices and environment of a neonatal unit. The Baby Charter encourages healthcare professionals to empower parents to be primary caregivers through joint decision-making and hands on care, as well as understanding families' needs and availability to provide truly individualised care. This facilitates a solid foundation for Family Integrated Care. Achieving Bliss Baby Charter accreditation is an esteemed marker of quality.

Benefits for baby and family
Improved long-term health outcomes, enhanced bonding, increased parental confidence, increased parental wellbeing, reduced stress, reduced hospital stays, increased breastfeeding rates, and makes positive memories.

Benefits for the unit
Consistency of practice, increased staff morale, tackling barriers to care, improves relations with parents, professional development opportunities, boosts recruitment, reduces readmissions, enhances unit culture

We have just been accredited the **SILVER AWARD** at Kings Mill Hospital

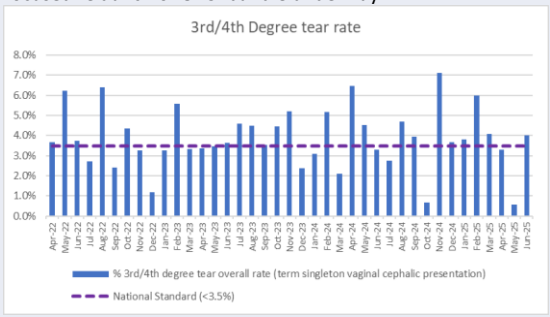
Perinatal Quality Surveillance Model for July 2025 (June 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

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

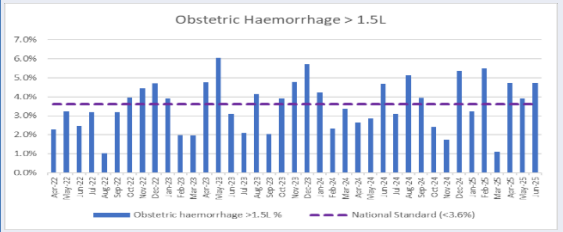
3rd/4th Degree Tear 4.0% (June 2025) 2.6% YTD

Focused relaunch of OASI bundle underway



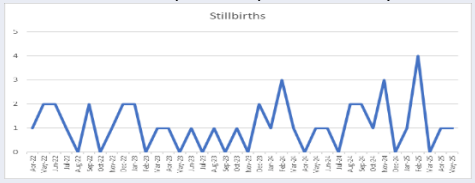
Postpartum Haemorrhage 3.9% (June 2025)

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



Stillbirth Rate 3.4% YTD (June 2025)

No stillbirths in June
Cluster review complete – report to PAC July 2025

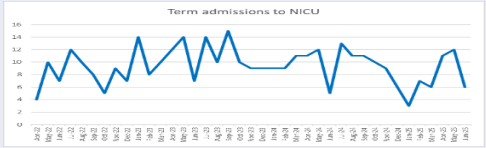


Patient Experience: 90.2% SBU (June 25)

SBU FFT Feedback was 90.2% positive for June. 275 births, 19% response rate. The theme for feedback in June was a lack of support for one family with feeding whilst on SBU.

Quality Improvements – TERM ADMISSIONS TO NICU

ATAIN – promotes understanding of the importance of keeping mother and baby together when safe to do so, MDT review of all term admissions to support learning.



Workforce (June 2025)

Maternity

3 new O&G consultants due to start in July, August, and November 2025

Midwifery B6 vacancy filled, B5 vacancy out to advert

Maternity Support Workers – B3 vacancy out to advert

Consultant Midwife interviews 1st August

New B7 Lead ANC/PDC commenced in June

Neonatal

Significant nursing challenges remain – clear oversight and a recruitment plan in place

B8a Matron C&YP interviews planned for mid-July

No Neonatal Consultant vacancy.

Staffing Red Flags (June 2025)

Red flags x1

Delay in patient receiving pain relief/time-critical activity

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

29 staffing incidents were reported through the Datix (May and June 2025)

5 – Staff redeployed

7 - increased acuity and activity, which impacted the staffing capacity

9 - unfilled shifts due to short-notice absence

6 - skill mix or training concerns

3 - Unit divert activated due to high acuity

All recorded as no harm, with the appropriate escalation taken at the time of reporting (where investigations had closed). All women/birthing individuals diverted have been followed up, no concerns reported.

Saving Babies Lives Care Bundle (SBLCB v3)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	91%	CNST Met

Perinatal Assurance

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

Incidents reported June: 133 (131 low harm, 2 moderate or above)

MDT reviews	Comments
Triggers x 14 Rapid Review x2	No themes identified

MOD HARM - DW224916 18.06.25
UNEXPECTED ADMISSION TO NICU

MOD HARM - DW224858 – 16.06.25
MISSED WEIGHT LOSS

1 CASE DISCUSSED AT PSIRG

Perinatal Quality Surveillance scorecard June 2025

Sherwood Forest Hospitals NHS Foundation Trust

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

Quality Metric	Standard	Running Total/ average	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			48%	48%	46%	48%	46%	44%	54%	51%	52%	51%	48%	49%	52%	49%	
3rd/4th degree tear overall rate	<3.5%	3.50%	4.50%	3.00%	2.80%	4.70%	3.90%	0.70%	7.10%	3.70%	3.80%	6.00%	4.10%	3.30%	0.60%	4.00%	
3rd/4th degree tear overall number		79	8	4	4	7	6	1	12	6	6	6	6	5	1	6	
Obstetric haemorrhage >1.5L number		127	9	11	9	15	12	7	5	16	9	14	3	13	12	13	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	2.90%	4.70%	3.10%	5.10%	3.90%	2.40%	1.70%	5.40%	3.20%	5.50%	1.10%	4.70%	3.90%	4.70%	
Term admissions to NICU	<6%	3.10%	4.00%	2.90%	4.70%	4.00%	3.90%	3.60%	3.30%	1.90%	1.10%	1.95%	2.32%	3.90%	4.10%	2.18%	
Stillbirth number		10	1	1	0	2	2	1	3	0	1	4	0	1	1	1	
Stillbirth rate	<4.4/1000			2.3			4.4			4.5			4.3			3.5	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:22	1:22	1:23	1:22.18	1.22.10	1.22.10	1.22.10	1.19.53	1:20.59	1:19.50	1:21.63	1:19.03	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:23	1:23	1:24	1:22.75	1:22.18	1.22.10	1.22.18	1.19.85	1:20.42	1:21.30	1:23.74	1:21.02	
Number of compliments (PET)		38	4	1			1	2	1	1	2	3	2	2	3	1	
Number of concerns (PET)		9	0	4			4	0	1	0	0	1	0	0	0	0	
Complaints		6	1	0			0	0	0	0	0	0	1	0	1	1	
FFT recommendation rate - COMMUNITY POSTNATAL	>93%														77.78%	100%	
FFT recommendation rate - MATERNITY WARD	>93%														86.60%	71.43%	
FFT recommendation rate - SBU	>93%														97%	90%	

External Reporting	Standard	Running Total/ average	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Maternity incidents no harm/low harm		1339	130	102	125	169	115	159	142	131	89	107	107	89	124	131	
Maternity incidents moderate harm & above		0	0	0	2	1	0	0	0	0	2	0	0	0	1	2	
MNSI/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	N	N	N	1	0	0	
Coroner Reg 28 made directly to the Trust		Y/N	0	1	1	0	0	0	0	0	0	0	0	0	0	0	
Progress in Achievement of MIS YEAR 7 - from May 2025	<4 <7 7 & above																

Findings of review of all perinatal deaths using the real time monitoring tool	Jun-25	No themes identified in month - Cluster Review paper to PAC, July 25, 38 cases reviewed 2024-2025
Findings of review all cases eligible for referral to MNSI	Jun-25	Factual accuracy review underway of recently received report
Service user voice feedback	Jun-25	PSOG commenced in June - Led by Sarah Seddon Lead Advocate - report to PAC
Staff feedback from Safety Champions and walk-abouts	Jun-25	Review of latest plans for Triage - highlighted in MNSC Report to PAC

Public Board - Cover Sheet

Subject:	NHS 10 year plan and alignment with SFH strategy Improving Lives	**Date:**	7th August 2025
Prepared By:	Claire Hinchley, Director of Strategy and Partnerships		
Approved By:	Dave Selwyn, Acting Chief Executive		
Presented By:	Claire Hinchley, Director of Strategy and Partnerships		

Purpose		
To provide a high-level summary of the NHS 10 year plan: Fit for the Future for consideration alongside SFH's Improving Lives Strategy	**Approval**	
	Assurance	
	Update	
	Consider	**X**

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**
Indicate which strategic objective(s) the report support					

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

Committees/groups where this item has been presented before

Trust Management Team Meeting 9th July 2025

Acronyms

AI – Artificial intelligence
CQC – Care Quality Commission
ICS – Integrated Care System
IHO – Integrated Health Organisation
NHS – National Health Service
SFH – Sherwood Forest Hospitals Trust

Executive Summary

On 3rd July 2025, the Government released the NHS 10 year plan: Fit for the Future. The priority in the plan is transforming care delivery to be more integrated, preventative, and digitally enabled, with a strong focus on improving population health and reducing health inequalities. We are reminded within the plan that it is a plan with a vision for 10 years time, not a 1 year operational or delivery plan.

The plan was created as both the public and staff recognise our current model of care is no longer fit for purpose and requires radical reform. Patients are seen too late when they should be diagnosed earlier, prevention and care in the community isn't prioritised against treatment in hospital. Children are sicker today than a decade ago and adults are falling into ill health earlier in life. Patients have little say and even less choice.

The plan centres around three radical shifts which together support one core purpose – to put power back into patients' hands. Throughout the plan, patients are equipped with more choice and a louder and meaningful voice in delivery of our services, with an emphasis on supporting the more disadvantaged

populations to speak up.

The three shifts are:

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

There is also a large emphasis on Neighbourhood health, and ensuring care is delivered as close to the person's home as possible. The plan specifically states that demand in Acute hospitals will fall as a result of digital and technological advancements, and growth of neighbourhood delivered services.

The three shifts and a neighbourhood health model are underpinned by 5 enabling reforms:

- New operating model
- New transparency of care
- Workforce transformation
- Innovation and technology
- Finance and productivity

The plan contains a mixture of incentives to encourage desired behaviours and mechanisms to ensure accountability and performance. Incentives include funding, support, workforce development, innovation enablement, collaboration incentives and recognition for the highest performers.

Accountability is recognised in the plan as performance monitoring, conditional funding, governance enforcement, regulatory actions and public accountability.

Whilst the plan imparts the importance of no longer working as a single NHS provider and moving at pace to delivery of integrated care, there are also many areas discussed which impact Acute trusts.

Sherwood Forest Hospitals Improving Lives Strategy

The Trust is in a good position to receive the plan and has already made progress against several of the delivery areas outlined in the 10 year plan. The Trust has a good foundation upon which to build further success as a local care provider for the local population, delivering excellent patient outcomes by dedicated colleagues whilst maintaining operational excellence.

The second and subsequent years of the Improving Lives strategy is about delivery of an Integrated model of healthcare delivery with partners, development of a commercial strategy and maximising the freedoms as a Foundation Trust.

Since the plan was published, NHS England has identified priority delivery areas and is asking for health and care systems to apply to be part of designing and delivering new ways of working, supported by national teams within the National Neighbourhood Health Implementation Programme (NNHIP).

SFH is coordinating an application with partners to put in a strong application to be part of the first round of support for the Mid and North Notts Place areas (Mansfield, Ashfield, Newark & Sherwood and Bassetlaw). The outcome of applications will be known in early September. Regardless of the outcome, SFH will need to ensure it is aligned to delivery of integrated neighbourhood teams.

Summary

The NHS 10 year plan is a large 168 page plan that is a challenge to summarise. Everybody is encouraged to read the plan and digest the detail within it.

Whilst we await release of the detail behind the plan, consideration should now be given to how to improve patient-reported outcomes as a direct result of quality and safe service delivery, how to achieve operational excellence and how to deliver a financial breakeven or surplus position. A relentless focus on integrated care with partners in a way that reduces the care gap and ensures patients are partners within this

transformation work is essential.

Delivery of a digitally enabled neighbourhood health model aligns well with the Trust's Improving Lives strategy, maximising the health outcomes for our local population.

Both the public and staff recognise our current model of care is no longer fit for purpose

Change will happen in 3 radical shifts

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

One core purpose:
To put power in patients' hands

We will need:

- New reforms to how the system is organised and how money flows around it
- New ways to actively empower patients
- New types of skills in the workforce
- New infrastructure in the community
- To embrace technology and build new partnerships with innovators

We will bring the NHS closer to patients

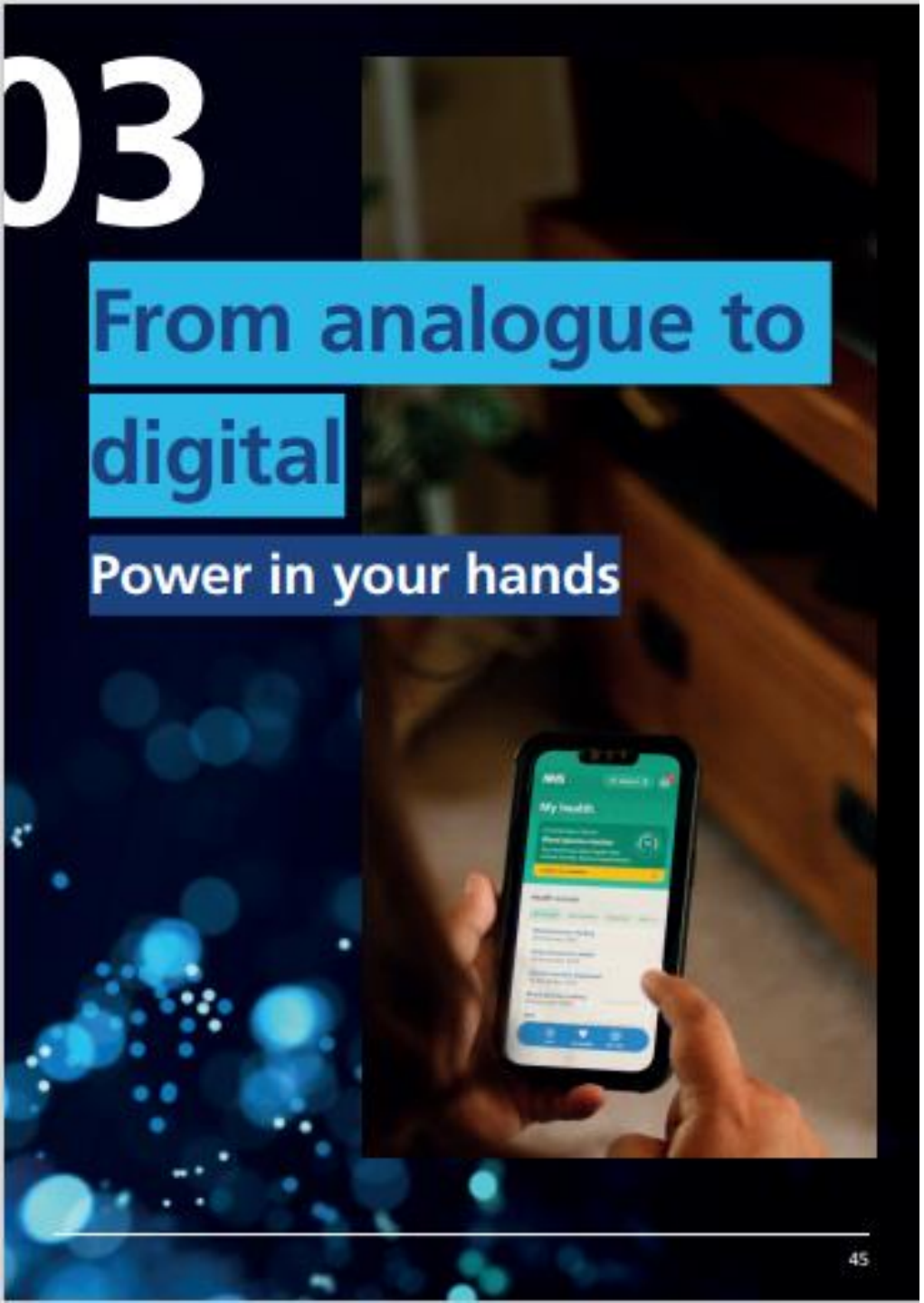
Establish a Neighbourhood health Centre (NHC) In every community

NHCs will be a one stop shop for patient care and the place from which multi-disciplinary teams operate

NHCs will be open at least 12 hours a day, 6 days a week providing access to coordinated services locally, removing the need to go to hospital for urgent care

NHCs will co-locate NHS, local authority and voluntary sector services, to help create an offer that meets population need holistically.

NHCs will bring historically hospital based services such as diagnostics, post operative care and rehab into the community and offer services like debt advice, employment support and smoking cessation or weight management services.



The NHS App will be the front door to the NHS – from bricks to clicks

‘Doctor in your pocket’, the NHS App will be the front door to the NHS, digital care by default, available digitally 24/7

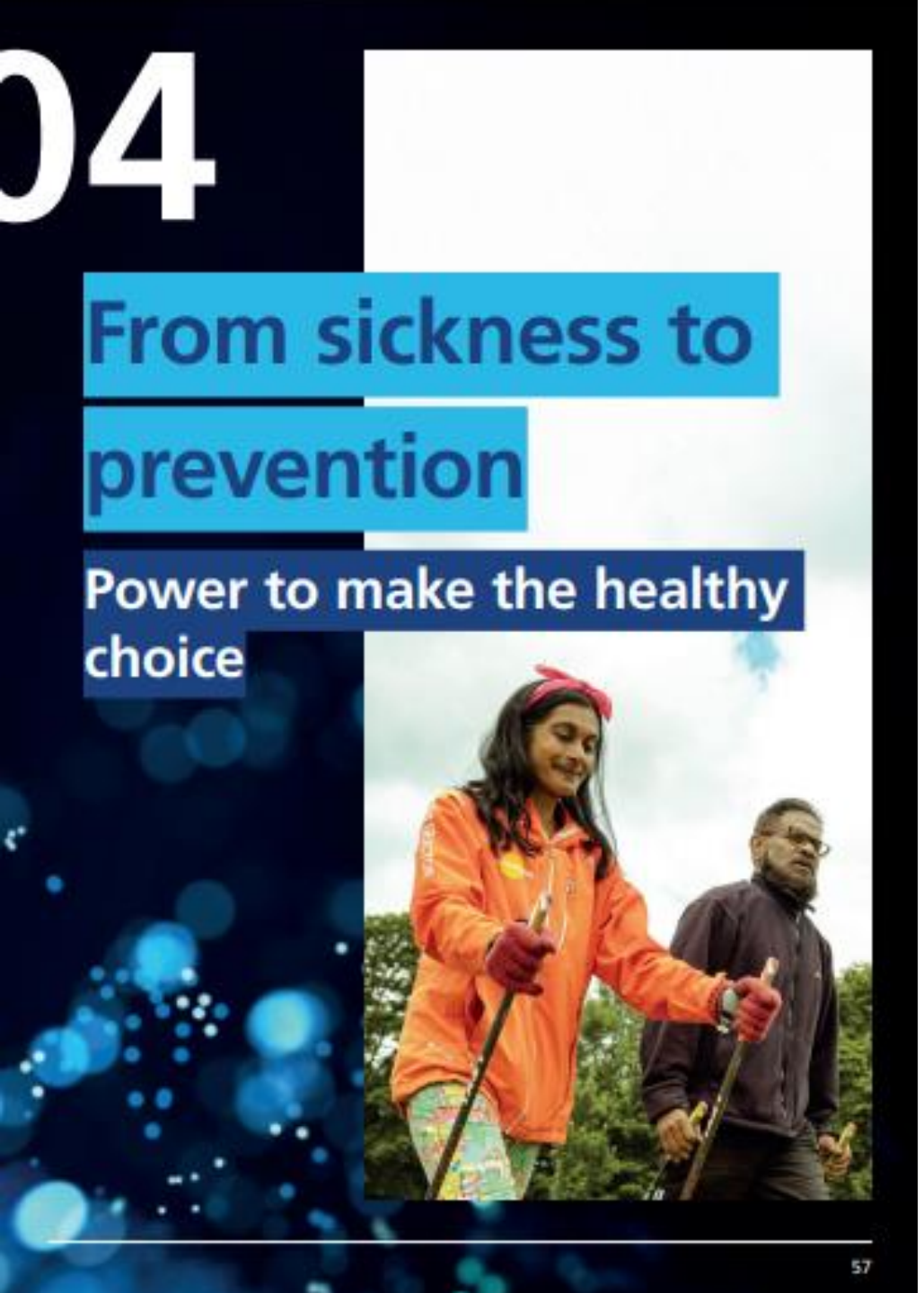
Inclusion will be designed into the NHS App by default, with tailored health information

Continue to recruit App Ambassadors

Single Patient Record (SPR)

- My NHS GP tool
- My Choices
- My Specialist
- My Consult
- My Care
- My Companion
- My Medicines tool
- My Vaccines
- My Health tool
- My Children
- My Carer

HealthStore



Our health is shaped by the places we live in

Over the course of this plan, the combination of genomics, predictive analytics and AI will usher in a new era for secondary prevention.

We will work with the Office for National Statistics and other experts to develop a new suite of delivery indicators, alongside a broader measure of the health of the nation.

Creating a smoke free generation for a smoke free UK

Health Coach

Ending the obesity epidemic

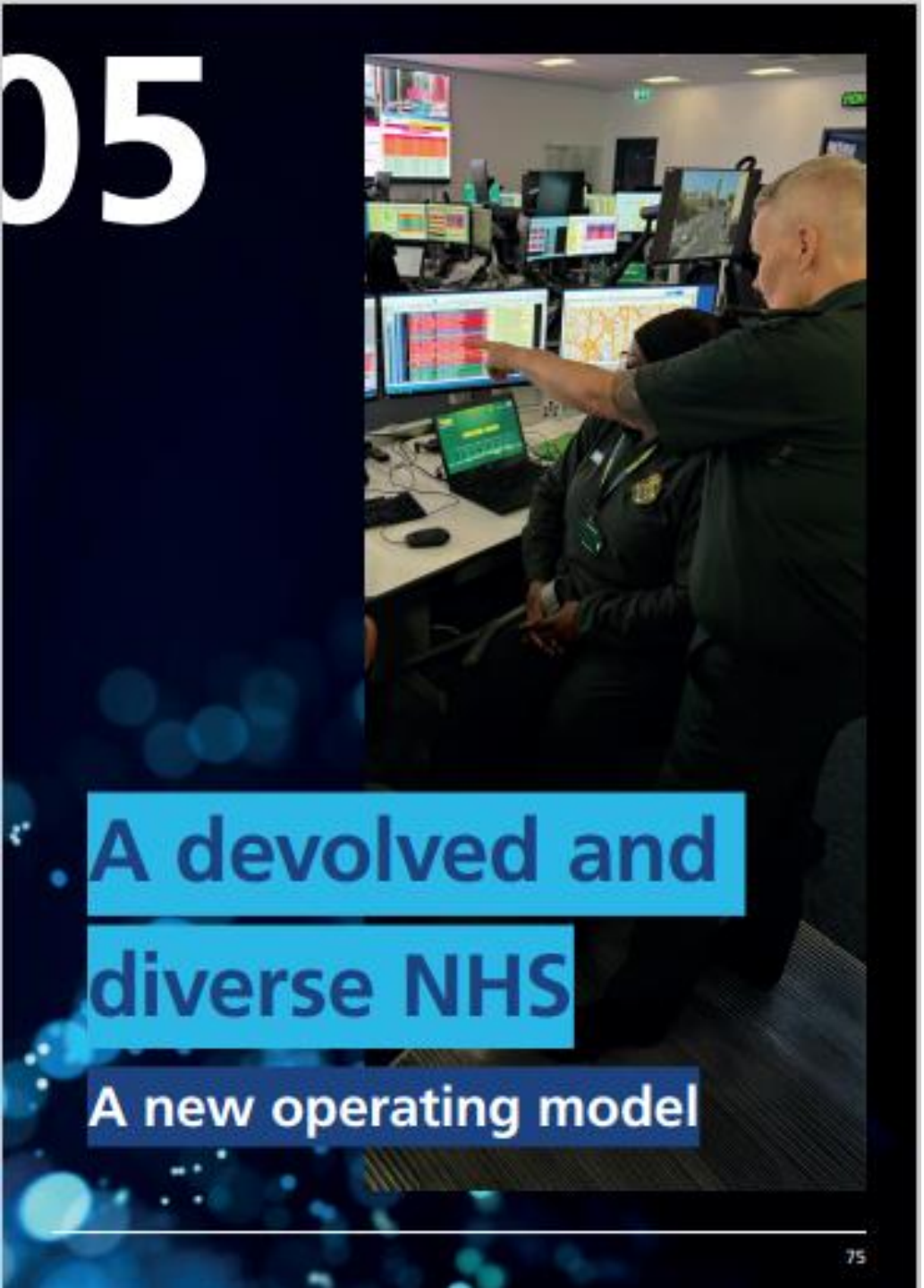
Tackling harmful alcohol consumption

Cleaning up our air

Employment and good work

Thriving young lives

From a sickness service to a prevention service



Patients need to be given genuine control

Create a new NHS operating model to deliver a more diverse and devolved health service

New system of earned autonomy, failure regime to bring poor performers up to standard, reward the best performers and give them new freedoms to innovate

Set higher standards for leaders, with pay tied to performance and good work rewarded

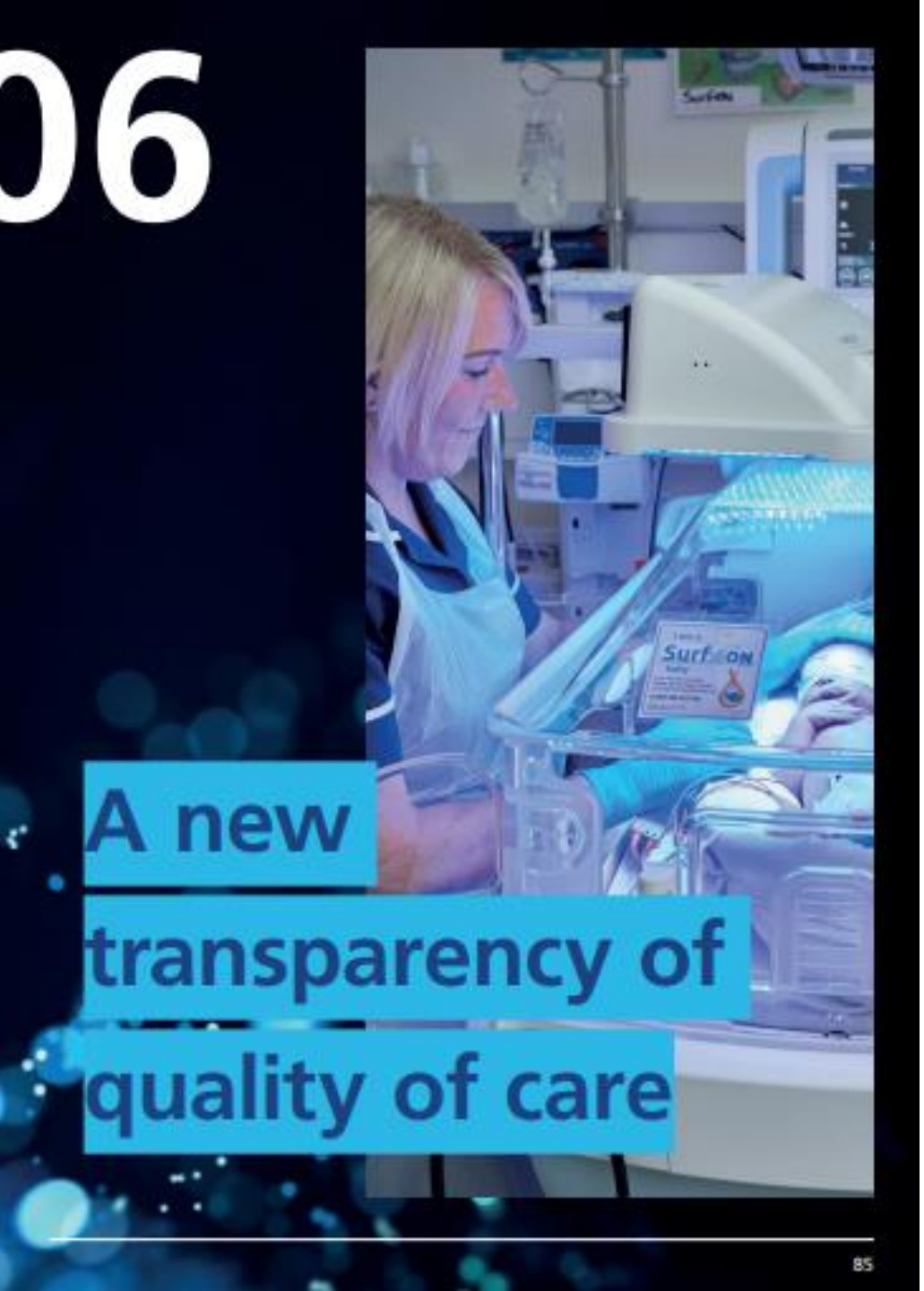
Multi-year budgets and financial incentives to enable investment in better outcomes

Transparency and choice will drive performance – clear metrics, ranked on performance, information provided to patients for them to make a choice

Reinventing the centre and ICBs as strategic commissioners

New Foundation Trust freedoms, including Integrated Health Organisation (IHO) status

Patient power



Make the NHS the most transparent healthcare system in the world

Put patient choice, voice and feedback at the heart of how we define and measure quality

Create and clarify accountability for high quality care - supported by new incentives to reward the leaders and staff who deliver it best

Streamline regulation, including a shift to a more intelligence-based regulatory approach

Everyone in the NHS is responsible for delivering high-quality care

Modern Service Frameworks, CVD, Mental health, Frailty, Dementia

Reward clinical teams that provide high quality care

New role for CQC

Given our reform plan, what workforce do we need?

10 year workforce plan

Use digital technology and automation to free up clinical time to care

Embrace skill mix and deliver training to equip staff to work at the top of their capability

The NHS will become a modern employer, led by a new tranche of top-quality leaders

Expand roles in genomics and data science

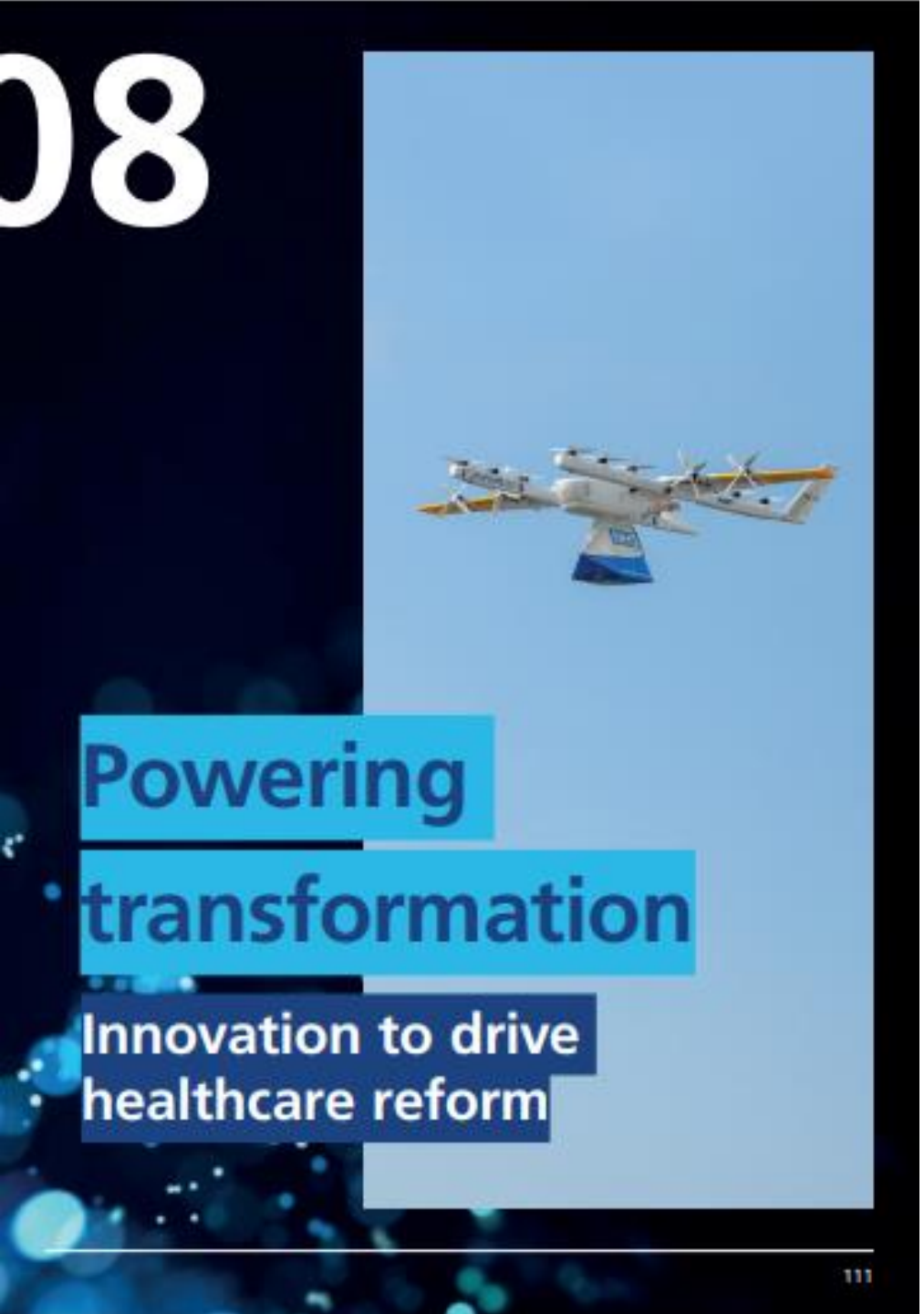
Digital first HR strategy

Review of education and medical training, including placements in neighbourhood teams

Capability frameworks for innovation, clinical research, clinical and patient entrepreneurs programme

Expand training and specialty posts

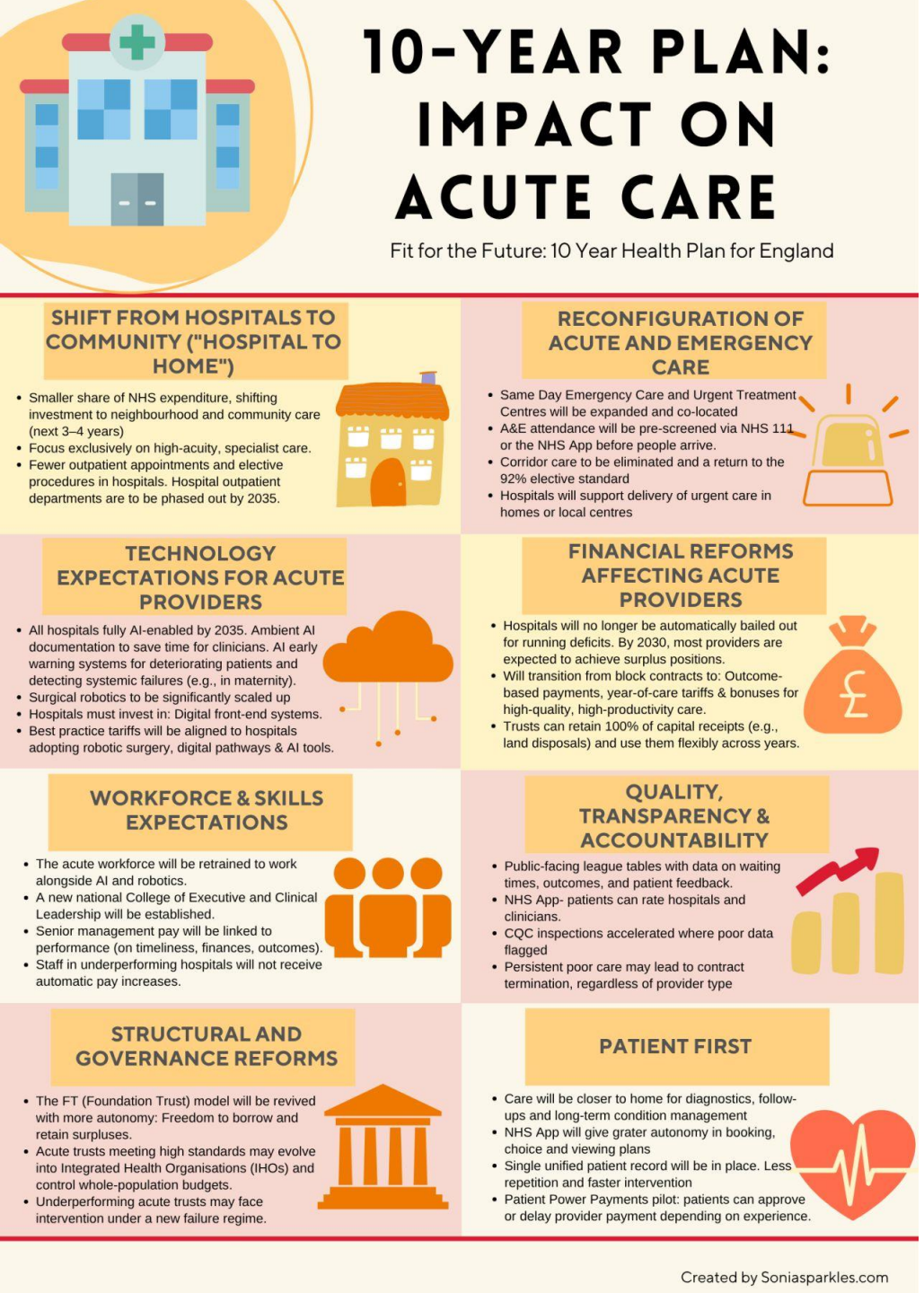
New leadership frameworks



We need to articulate the future we want to see, signal that with intent to industry, and show willingness to collaborate to achieve it

NHS at the forefront of data to deliver impact, AI to drive patient power and productivity, genomics and predictive analytics for pre-emptive personalised care, wearables to make care ‘real time’, robotics to support precision

Up to P125….



- Focus exclusively on high-acuity, specialist care
- Fewer outpatient appointments and elective procedures in hospitals
- Hospital outpatient departments are to be phased out by 2035
- Same Day Emergency Care and Urgent Treatment Centres will be expanded and co-located
- A&E attendance will be pre-screened via NHS 111 or the NHS App before people arrive
- Corridor care to be eliminated
- Return to the 92% elective standard
- Hospitals will support delivery of urgent care in homes or local centres
- Care will be closer to home for diagnostics, follow ups and long term condition management
- NHS App will give greater autonomy in booking, choice and viewing plans
- All hospitals fully AI enabled by 2035
- AI early warning system for deteriorating patients
- Surgical robotics to be significantly scaled up
- Best practice tariffs will be aligned to hospitals adopting robotic surgery, digital pathways and AI tools
- The acute workforce will be retrained to work alongside AI and robotics
- Staff in underperforming hospitals will not receive automatic pay increases, and Senior management pay will be linked to performance (timeliness, finances, outcomes)
- Patients can rate hospitals and clinicians on the NHS App
- Persistent poor care may lead to contract termination, regardless of provider type
- The FT model will be revived
- Acute Trusts meeting high standards may evolve into Integrated Health Organisations and control whole-population budgets

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Strategy
2024-2029

IMPROVING LIVES

IMPROVING LIVES

VISION:
Outstanding care, compassionate people, healthier communities.

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 estate
- Work collaboratively with partners in the community

Values

Scan the QR code for the full Trust Strategy and deliver plans.

C Communicating and working together

A Aspiring and improving

R Respectful, inclusive and caring

E Efficient and safe

Hospital to community

Bring the NHS to you In your community, including homes and high streets

Modernise hospitals
Long waits reduced and a renewed focus on world-class, life-saving care

A neighbourhood health centre
In every community, with multi-disciplinary teams working together, under one roof

Create teams that work around you
Different professions, social care and voluntary sector

A new era for general practice
End the 8am scramble and bring back the family doctor

Analogue to digital

for staff

Embrace AI to support clinicians - Using AI as part of treatment to improve clinical outcomes

Liberating staff from bureaucracy - Using AI to automate tasks. Building care plans and recording clinical information, which can save clinician time

for patients

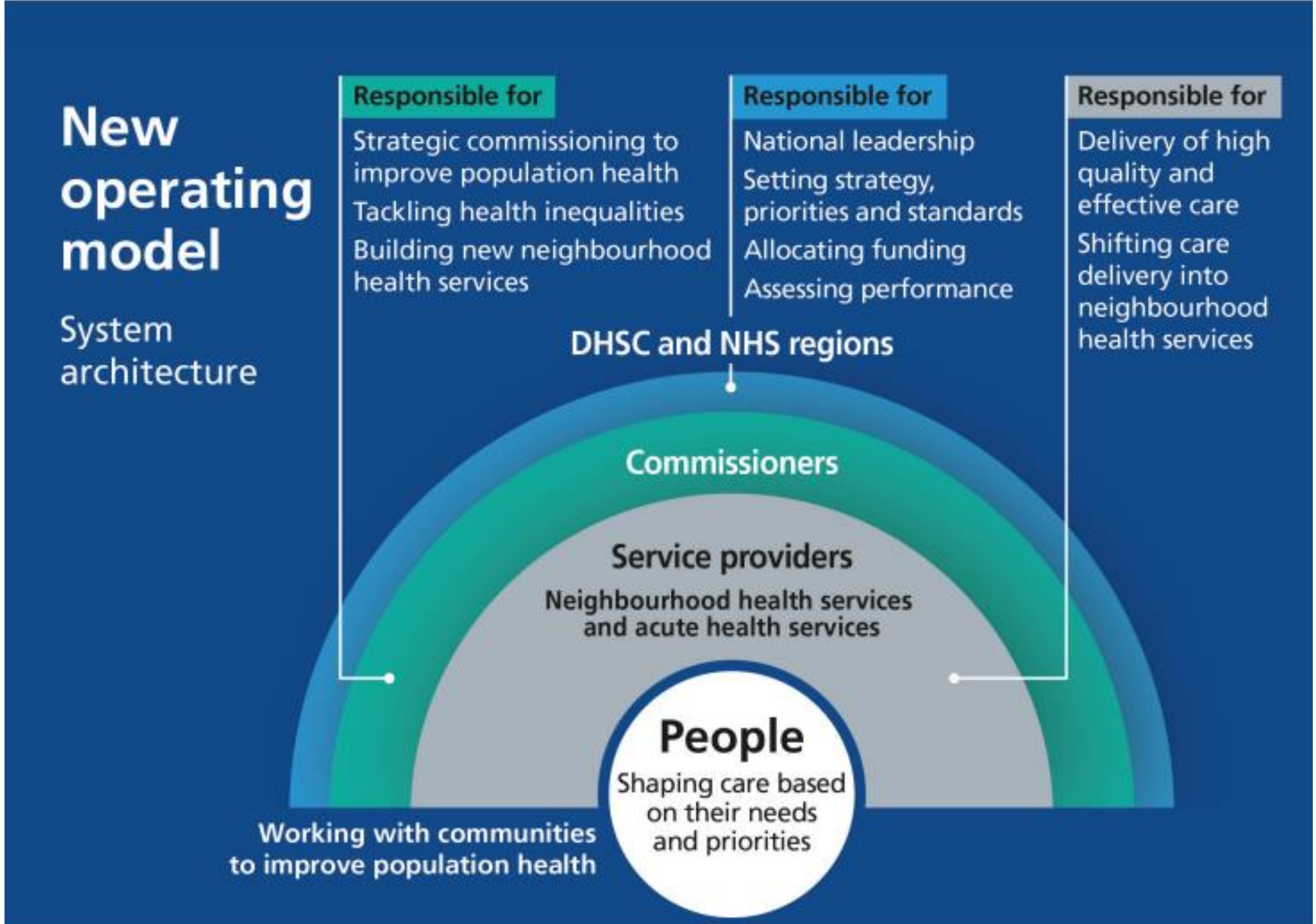
A Single Patient Record - Giving you control over your data, accessible by all healthcare professionals, with your consent

Manage your care digitally - Book and change appointments and discuss your care all through the NHS App

Your NHS companion - By 2035, you'll have a virtual assistant - a doctor in your pocket

New operating model

System architecture



Quality

A **lack of transparency** on quality of care makes it difficult for patients to make informed decisions.

Their voices are not heard and safety failures are too common.

1. **Better data** to support patients to make choices

2. **Patient voices** will be critical to improving care, with feedback routinely collected about public and staff experiences

3. **Clearer incentives and accountability** for leaders and staff to ensure they deliver the best care

4. **Investment in technology** to support and enable high quality care

Workforce

We will introduce **a new set of standards** to make the NHS a great place to work.

These standards will be co-produced with staff **through the Social Partnership Forum.**

New staff standards

Nutritious food and drink at work

Protection from violence, racism and sexual harassment at work

New standards of healthy work

Flexible working options

Employers will publish data on these standards **every quarter.**

Poor performance on staff outcomes will act as an 'early warning' signal for CQC.

Our 5 big bets

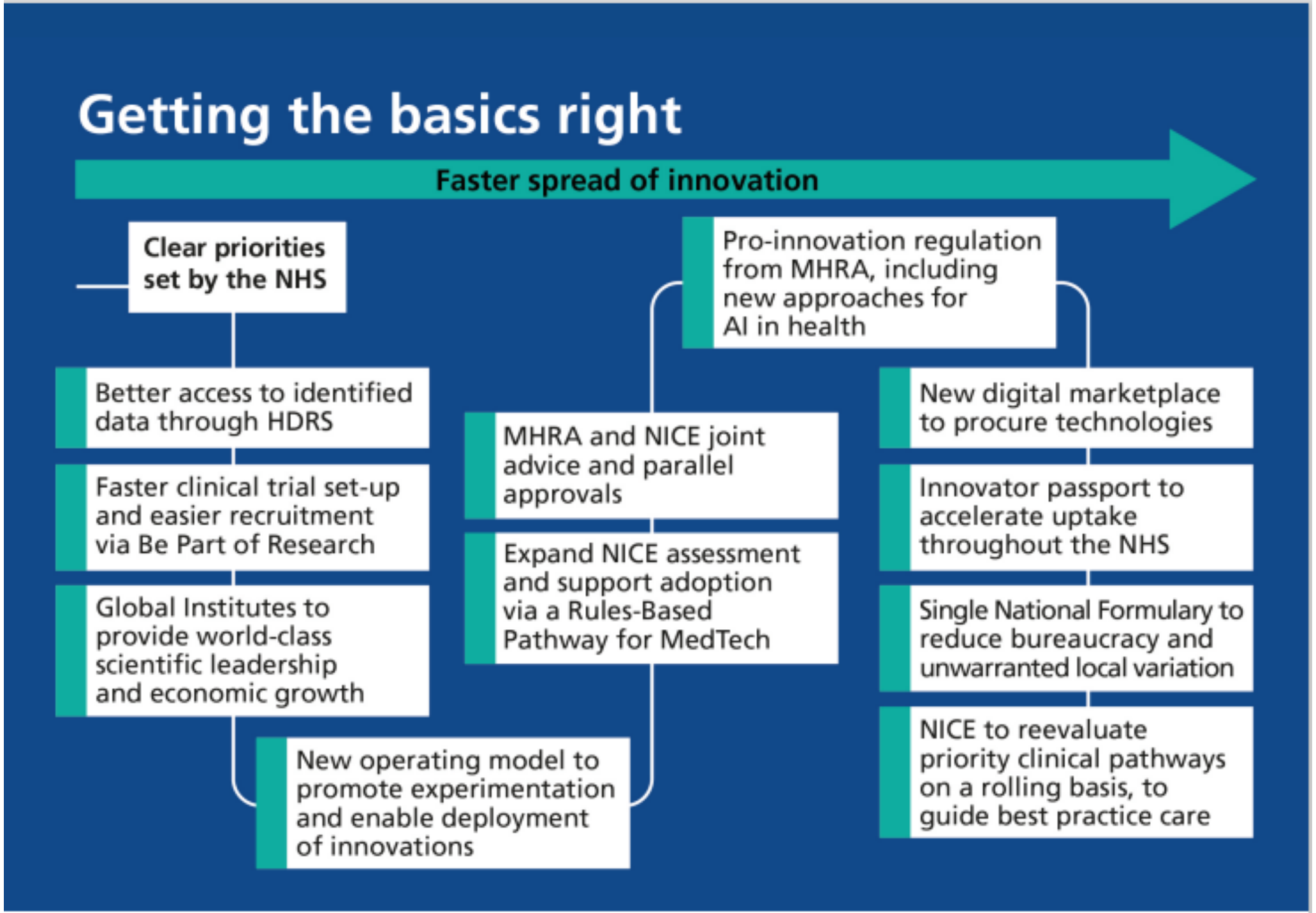
AI to drive productivity supporting patient choice and liberating staff

Wearables to make care 'real time' and become standard in preventative, chronic and post-acute treatment

Data to deliver impact, flowing seamlessly and securely to enable earlier diagnosis and better health research

Genomics and predictive analysis for pre-emptive, personalised care starting at birth

Robotics to support precision, transforming patient care from surgery to rehabilitation


Getting the basics right
Faster spread of innovation
Clear priorities set by the NHS
Better access to identified data through HDRS
Faster clinical trial set-up and easier recruitment via Be Part of Research
Global Institutes to provide world-class scientific leadership and economic growth
New operating model to promote experimentation and enable deployment of innovations
MHRA and NICE joint advice and parallel approvals
Expand NICE assessment and support adoption via a Rules-Based Pathway for MedTech
Pro-innovation regulation from MHRA, including new approaches for AI in health
New digital marketplace to procure technologies
Innovator passport to accelerate uptake throughout the NHS
Single National Formulary to reduce bureaucracy and unwarranted local variation
NICE to reevaluate priority clinical pathways on a rolling basis, to guide best practice care

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – To June 2025	**Date:**	7 August 2025
Prepared By:	Domain leads and Mark Bolton, Associate Director of Operational Performance		
Approved By:	Domains approved by lead Executive		
Presented By:	Domains to be presented by lead Executive		

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

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

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

Committees/groups where this item has been presented before

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

Acronyms

All acronyms are defined within the paper.

Executive Summary

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

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

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

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

Maintaining good performance against some of the key indicators contained in the report has been challenging for the Trust during 2025/26 to date partly due to patient demand pressures (particular in terms of Accident and Emergency [A&E] attendance demand which triggered as special cause variation in Mar-25 and Jun-25 due to high levels). The continued pressure means at times we have enacted escalation actions to support patient care; these actions place pressure on our people and the financial position of the Trust.

Areas of focus for improvement include: eliminating never events, reducing c difficile levels, improving VTE risk assessment compliance, reducing our vacancy rate and levels of sickness, reducing agency usage, reducing the number of medically safe patients, improving 18-week referral to treatment performance, recovering our diagnostic DM01 position, strengthening performance against our cancer standards, and reducing the financial risk within the organisation through the delivery of financial efficiency plans.

We have noted strong performance across several areas including: SHMI which remains as expected, complaints, staff turnover, mandatory and statutory training, bank usage, four and 12-hour emergency access, elective long waits, cancer 28-day faster diagnosis, and our year-to-date variance to our financial plan.

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

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Integrated Performance Report

Reporting Period: To June 2025

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Integrated Scorecard

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

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

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

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

Integrated Report

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

Category	At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.9	2.4	3.0	2.4	2.6	2.1	1.7	2.6	1.9		2.1				
		Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 2	✗ 1				
		MRSA reported in month	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0				
		Cdifficile reported in month	≤13 qtr	4	7	4	6	4	5	5	7	5	6	✗ 55	✗ 18				
		Number of gram-negative bloodstream infections reported in month	n/a	No Standard	5	8	0	5	1	5	6	3	6	0	15				
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.2	0.1	0.0	0.1	0.2	0.0	0.1	0.2	0.0	0.1	0.1				
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 6	✓ 0				
		Patient Safety Incident Investigations (PSII) & Duty of Candour	No Standard	No Standard	1	0	2	2	1	0	5	12	9	17	26				
		Percentage of inpatient Service Users undergoing risk assessment for VTE	n/a	≥95%	✗ 92.2%	✗ 91.9%	✗ 82.4%	✗ 80.9%	✗ 82.9%	✗ 86.6%	✗ 87.7%	✗ 86.6%	✗ 86.6%		✗ 87.0%				
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 0.8	✓ 0.8	✓ 0.4	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 0.9	✓ 1.4				
		Compliments received in month	No Standard	No Standard	204	160	147	140	152	184	155	115	141	1831	411				
	Effective	SHMI	As expected	As expected	✓ 106	✓ 106	✓ 106	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 107	✓ 105				
		Still birth rate	≤4.4	≤4.4	✓ 3.4	✗ 10.3	✓ 0.0	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 0.0	✓ 4.3	✓ 2.3				
		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%	-	-	✓ 7.1	-	-	✓ 7.1	-	-	-	✓ 6.9	-				
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✓ 8.0%	✗ 9.5%				
		Time to hire	n/a	≤53.1 days				✓ 49.0	✓ 34.0	✓ 27.0	✓ 23.0	✓ 21.0	✓ 29.0		✓ 24.3				
		Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.7%	✓ 0.5%				
		Appraisals	≥90%	≥90%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 89.0%	✗ 89.6%				
		Mandatory & statutory training	≥90%	≥90%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 91.5%	✓ 92.8%				
		Medical job plan compliance	n/a	≥95%				✗ 57.0%	✗ 86.1%	✗ 76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%		✗ 64.1%				
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.9%				
		Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	-	-	✗ 47.8%	-				
		Employee relations management	<17	<21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✗ 21	✗ 21				
	New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✗ 8.9%	✓ 6.2%				
		Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✓ 2.9%	✗ 3.5%	✗ 4.0%	✗ 3.0%				
		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%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 52.9%	✓ 37.9%				
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 91.4%	✗ 91.1%				
		Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 0.4%				
		ED 4-hour performance	≥76%	≥Plan	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 71.0%	✓ 77.7%				
		ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✗ 2.1%	✓ 1.7%	✓ 1.8%	✗ 3.4%	✓ 1.8%				
		Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	16	17	31	26	19	18	21	19	23	58				
		Adult G&A bed occupancy	≤92%	≤92%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 94.5%	✗ 95.1%				
		Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	3.1	3.2	3.0	2.7	3.1	✓ 3.3	✓ 3.0	✗ 3.8		✓ 3.4				
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 64	✗ 57				
	Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 11.1%	✓ 6.0%	✓ 11.0%				
		Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	62.9%	63.2%	63.8%	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	64.6%	✗ 63.9%				
		Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	2.2%	2.1%	1.7%	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	1.3%	✓ 1.2%				
	Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥95%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✓ 93.1%	✗ 88.9%				
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	-	✓ 78.3%	✓ 77.0%				
		Cancer 31-day treatment performance	≥Plan	≥96%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	-	✓ 91.9%	✗ 91.2%				
		Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	-	✗ 64.4%	✓ 64.4%				
Best Value Care	Financial Performance	Financial surplus / deficit	n/a	≥£0.00m							✗ -£0.90	✗ -£0.70	✗ -£0.20		✗ -£1.80				
		Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£0.17	✗ -£0.79	✗ -£0.10	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✓ £0.01	✓ £0.00				
	Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £4.70	✗ -£1.97	✗ -£0.20	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✓ £0.08	✗ -£2.83				
		Risk adjusted efficiency forecast to plan (%)	n/a	100%							✗ 46.5%	✗ 55.0%	✗ 56.6%		✗ 56.6%				
	Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£13.70	£2.63				
		Reported bank expenditure	No Standard	No Standard	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£30.55	£5.48				
	Rate of Productivity	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✓ 6.9%	✓ 5.4%	✓ 4.6%	✓ 3.3%	✓ 4.3%	-	-	-	-		-				
	Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%							✗ 24.7%	✗ 33.5%	✗ 62.6%		✗ 47.6%				
		BPPC - Value of bills paid within target	n/a	≥95%							✗ 69.2%	✗ 71.8%	✗ 69.3%		✗ 70.9%				
		Operating expenditure days	n/a	≥5							✓ 16	✓ 16	✓ 13		✓ 13				
	Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£1.41	£1.01	£1.92	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.40	✗ £0.44	✓ £33.58	✗ £1.88				
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)			547	557	544	515	543	582	552	562	577	547	564				
		Non-elective admissions			146	146	141	142	150	146	139	139	154	145	144				
	Electives	Average daily elective referrals			374	350	304	346	362	330	326	325	352	341	334				
		Outpatients - first appointment			349	347	294	327	339	323	318	309	313	347	313				
		Outpatients - follow up			889	851	748	875	907	855	849	810	779	852	813				
		Outpatients - procedures			278	258	236	287	278	254	257	253	241	265	250				
		Day case			126	126	110	127	126	116	114	116	123	122	118				
		Elective inpatient			16	15	12	12	13	13	13	14	13	14	14				
	Diagnostics	Diagnostics			506	514	462	496	518	490	476	464	477	479	472				

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Quality of Care

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Scorecard: Quality of Care

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Safe	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.9	2.4	3.0	2.4	2.6	2.1	1.7	2.6	1.9		2.1				
	Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 2	✗ 1				
	MRSA reported in month	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0				
	Cdifficile reported in month	≤13 qtr	4	7	4	6	4	5	5	✗ 7	✗ 5	✗ 6	✗ 55	✗ 18				
	Number of gram-negative bloodstream infections reported in month	n/a	No Standard	5	8	0	5	1	5	6	3	6		15				
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.2	0.1	0.0	0.1	0.2	0.0	0.1	0.2	0.0	0.1	0.1				
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 6	✓ 0				
	Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	1	0	2	2	1	0	5	12	9	17	26				
	Percentage of inpatient Service Users undergoing risk assessment for VTE	n/a	≥95%	92.2%	91.9%	82.4%	80.9%	82.9%	86.6%	✗ 87.7%	✗ 86.6%	✗ 86.6%		✗ 87.0%				
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 0.8	✓ 0.8	✓ 0.4	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 0.9	✓ 1.4				
	Compliments received in month	No Standard	No Standard	204	160	147	140	152	184	155	115	141	1831	411				
Effective	SHMI	As expected	As expected	✓ 106	✓ 106	✓ 106	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 107	✓ 105				
	Still birth rate	≤4.4	≤4.4	✓ 3.4	✗ 10.3	✓ 0.0	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 0.0	✓ 4.3	✓ 2.3				
	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				

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Domain Summary: Quality of Care

Overview	Lead: Executive Chief Nurse/Chief Medical Officer

During May-25 and Jun-25, our hospitals have continued to experience busy periods with a continued high volume of people accessing urgent care; the Trust has often been in escalation and using surge capacity. This unrelenting period of operational pressure impacts our ability to provide good, safe patient care.

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

- Clostridium difficile (CDiff): 65 cases
- Escherichia coli (E. coli): 80 cases
- Klebsiella: 15 cases
- Pseudomonas: 9 cases
- Methicillin-resistant Staphylococcus aureus (MRSA): 0 cases.

During 2025/26 quarter one:

- For Cdiff, we have had 18 Hospital-Onset Hospital-Associated (HOHA) and five Community-Onset Healthcare Associated (COHA) infections. We have observed an increase in our rates compared to the same period last year, seeing an outbreak on one ward with two further periods of increased incidence awaiting typing. When benchmarking against peer organisations, we are the 5th highest organisation out of 11.
- For MRSA bacteraemia, we have had one HOHA. When considering benchmarking against our peer organisations, we are one of six Trusts to have a bacteraemia.
- For Gram Negative bacteraemia, we are currently in a good position, and when benchmarking against our peers, we are in the three Trusts with the lowest numbers.

One Never Event was reported in May-25 relating to a patient within the Emergency Department (ED) who received a fascia iliaca block to the right hip. It was identified that the block had been administered to the incorrect patient in error. A patient safety incident investigation was commissioned, which remains in progress.

During Jun-25, one Patient Safety Incident Investigation (PSII) was commissioned by the Patient Safety Incident Response Group (PSIRG) following an in-depth discussion during which the Integrated Care Board (ICB) was present. During Jun-25, four PSIIs were signed off.

There are three off-track metrics during May-25 and Jun-25:

- Never Events.
- CDiff reported in month.
- Percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE).

Summary Hospital-level Mortality Indicator (SHMI) remains as expected and as agreed by Quality Committee, no indicator in focus page is presented.

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

Indicator in Focus: Never Events

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

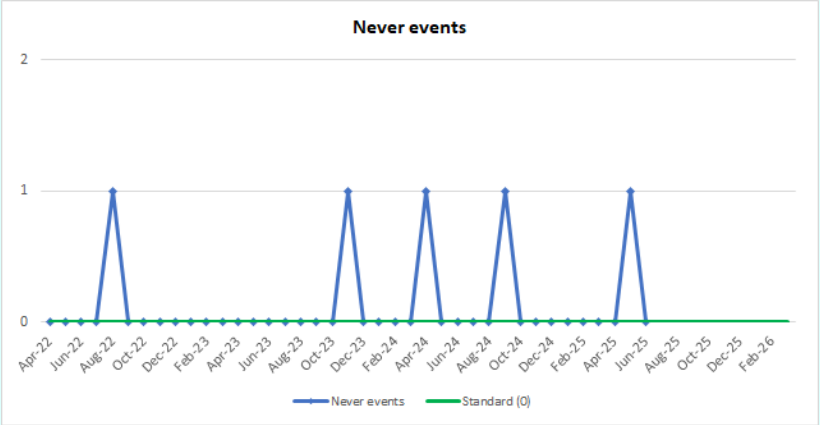
NHS England Definition of a never event is: “Never Events are serious incidents that are entirely preventable because of guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers”.

At the time of this report being produced the National NHS England Provisional Never Events data for 1 Apr to 31 May-25, available online indicates that there have been 62 Never Events reported nationally, of which 11 were wrong site blocks.

In May-25 SFH reported an incident relating to a patient within ED who received a fascia iliaca block to the right hip. It was identified that the block had been administered to the incorrect patient in error, and a patient safety incident investigation was commissioned which remains in progress.

There have been no Never Events reported since May-25 across SFH.

Data



Root causes	Actions and timescale	Impact
The incident has been reported on Strategic Executive Information System (STEIS) and declared a Never Event. A formal investigation is being undertaken by a Quality Governance Facilitator (QGF) within Governance Support Unit (GSU).	Patient safety alert reminding staff of the positive patient identification process and need to ask patients to state their details was approved at PSIRG and circulated trust wide.	Trust wide learning.
	Ongoing PSII investigation.	Ongoing.

Indicator in Focus: Infection Prevention and Control

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

The national trajectories for healthcare-associated infections have been published, with the following annual targets: CDiff – 65 cases, Ecoli – 80 cases, Klebsiella – 15 cases, Pseudomonas – 9 cases, and MRSA – 0 cases.

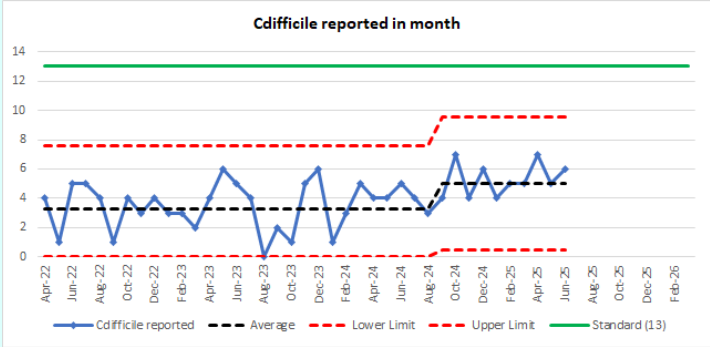
During 2025/26 quarter one, for CDiff we have had 18 HOHA and 5 COHA infections. We have observed an increase in our rates compared to the same period last year, seeing an outbreak on one ward with two further periods of increased incidence awaiting typing. When benchmarking against peer organisations, we are the 5th highest organisation out 11.

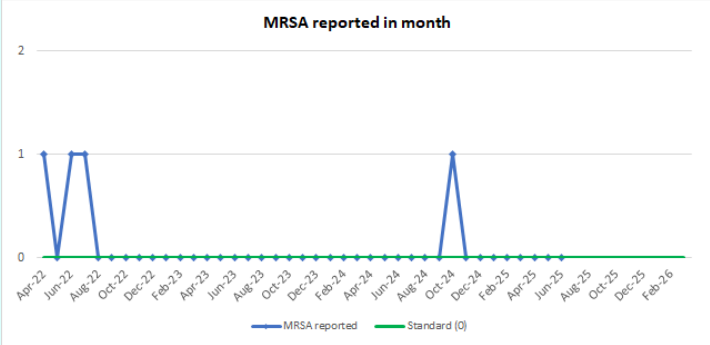
For MRSA bacteraemia we have had one HOHA. When considering benchmarking against our peer organisations, we are one of six Trusts to have a bacteraemia.

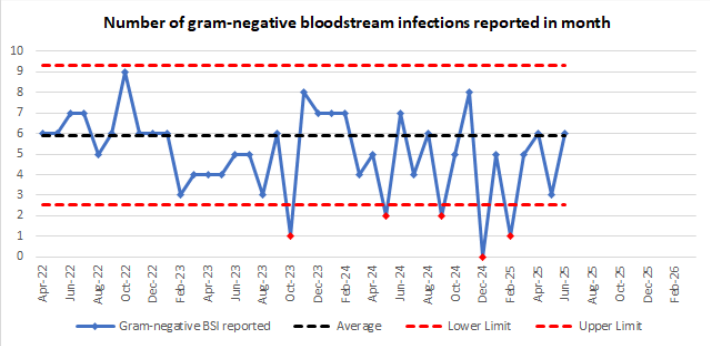
For Gram Negative bacteraemia we are currently in a good position, and when benchmarking against our peers we are in the three Trusts with the lowest numbers.

Root causes	Actions and timescale	Impact
CDiff - antibiotics	Review of antibiotic guidelines – reduce the use of Tazocin.	To reduce the number of Cdiff cases.
	Promote intravenous (IV) to oral switch and regular review of antibiotics.	To improve antimicrobial stewardship.
CDiff – cross transmission	Increased environmental, personal protective equipment (PPE) audits.	To improve patient environment.
	Update training on appropriate PPE usage .	To promote knowledge and improve practice.
	Training on appropriate hand decontamination methods.	To promote knowledge and improve practice.
MRSA – unknown source	MRSA questionnaire sent out to all clinical areas to assess for any knowledge gaps. To enable focused training to be provided.	Identify any education gaps to support focused training.
	Decolonisation update training – provided by company for all areas.	To improve compliance with use and reduce infection rates.

Data







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

Sherwood Forest Hospitals NHS Foundation Trust

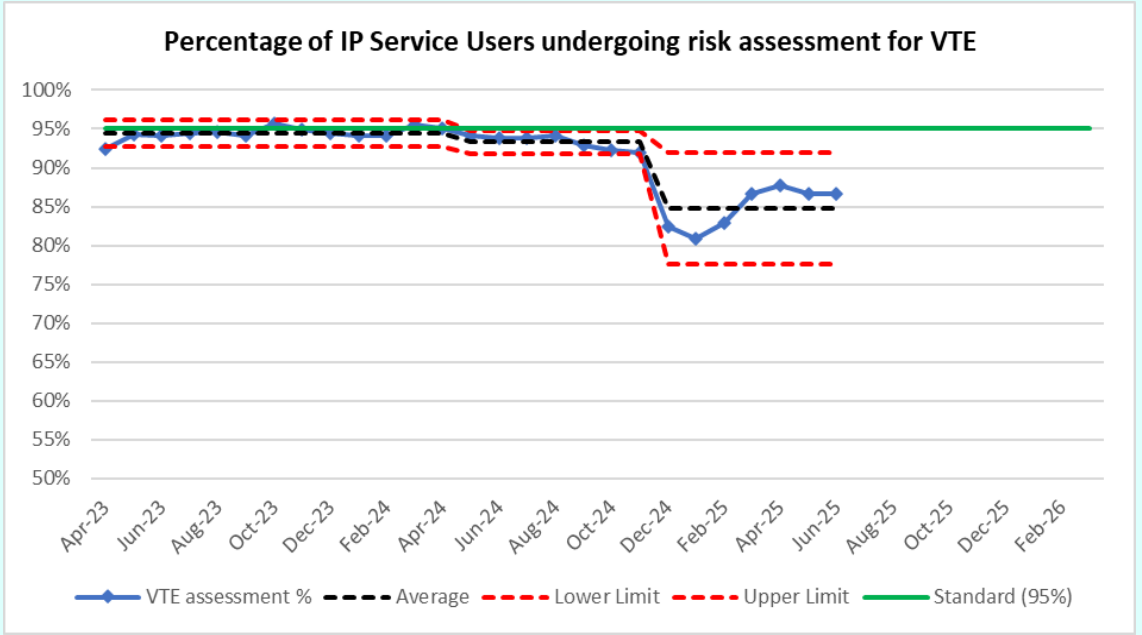
Overview and national position

Historically, we have delivered a consistent and relatively strong position until Nov-24. There was a small decline in May-24 as the risk assessment process transferred from a paper-based process to Nevercentre (computer system). In Nov-24 we saw a more significant decline driven by two main factors: (1) data quality and (2) clinicians by-passing the automatic prompt.

Since the decline in compliance with completing the VTE risk assessments, we are not aware of any increase in hospital thrombotic events. In cases where the VTE risk assessment was not complete within 14 hours, we are assured that prophylaxis is prescribed, as needed, in greater than 90% of cases.

Root causes	Actions and timescale	Impact
Data quality	Review wards regarded as inpatient to ensure that we are only capturing genuine inpatient areas by Sep-25.	Improve data quality.
Clinicians by-passing the automatic prompt	Divisions to develop recovery action plans with a likely focus on clinical guidance and education (including at medical induction). Divisions to provide an update at Sep-25 Divisional Performance Reviews.	Support performance recovery.
	Review potential system configuration changes to prevent clinicians by-passing completing the VTE risk assessment on admission, ensuring it is a mandatory part of the patient admission process.	

Data



Outstanding Care,
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People and Culture

Outstanding Care,
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Domain Summary: People and Culture

Overview	Lead: Chief People Officer

The Trust and Nottingham and Nottinghamshire Integrated Care System (ICS) have experienced a busy start to 2025/26. We have continued with the grip and control and financial challenge we ended 2024/25 and we have observed positive performance across several People and Culture metrics and a promising start to 2025/26 quarter one.

During 2025/26 quarter one, six out of twelve People and Culture indicators consistently met or exceeded the standard.

The appraisal compliance level has fluctuated and is reported at 89.6% for the quarter, prompting significant efforts to promote the benefits and ensure the quality of appraisals. Divisions and services, along with Divisional Performance Reviews (DPRs), have reviewed and challenged the position, resulting in a compliance level 0.4% below our standard (90%).

Turnover has remained strong, staying below the standard, with quarter one reporting at 0.5%. Our Mandatory and Statutory Training (MaST) compliance level has consistently surpassed targets across the quarter.

We have also seen continued improvement in our bank usage level, aligned with ongoing efforts to meet NHS planning expectations of a 15% reduction in bank usage. Agency usage is showing above the standard, however, the hours worked has remained at a static level and the noted increase is aligned to the late receipt of timesheets that has then resulted in a spike in paid agency usage. Work has been undertaken to address this. There has been zero use of ‘off framework’ agency and over price cap agency is below standard.

Sickness absence levels for quarter one are reported at 4.9%, higher than our standard of 4.2%, but still within the upper and lower statistical process control limits. Significant work is underway within the Trust, where we report and challenge the overall absence level and the management of cases. Local benchmarking shows that the Integrated Care Board (ICB) provider sickness absence level is reported at 5.6% (Jun-25). NHS England state that as of early 2025/26 the sickness absence rate in Acute Trusts is approximately 5.5%, which is higher than the NHS average 5.3%. NHS England recognise this 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.

Employee relations cases over the quarter have remained high and sits equivalent to the standard (21 cases). We are seeing elevated levels associated with grievances; however, these are being managed in line with processes.

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

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Scorecard: People and Culture

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Belonging in the NHS	Engagement score	≥6.8%	≥6.9%	-	-	✓ 7.1	-	-	✓ 7.1	-	-	-	✓ 6.9	-				
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✓ 8.0%	✗ 9.5%				
	Time to hire	n/a	≤53.1 days				49.0	34.0	27.0	✓ 23.0	✓ 21.0	✓ 29.0		✓ 24.3				
	Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.7%	✓ 0.5%				
	Appraisals	≥90%	≥90%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 89.0%	✗ 89.6%				
	Mandatory & statutory training	≥90%	≥90%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 91.5%	✓ 92.8%				
	Medical job plan compliance	n/a	≥95%				57.0%	86.1%	76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%		✗ 64.1%				
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.9%				
	Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	-	-	✗ 47.8%	-				
	Employee relations management	<17	<21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✗ 21	✗ 21				
New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✗ 8.9%	✓ 6.2%				
	Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 4.0%	✗ 3.0%				
	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%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 52.9%	✓ 37.9%				

Indicator in Focus: Vacancy Rate

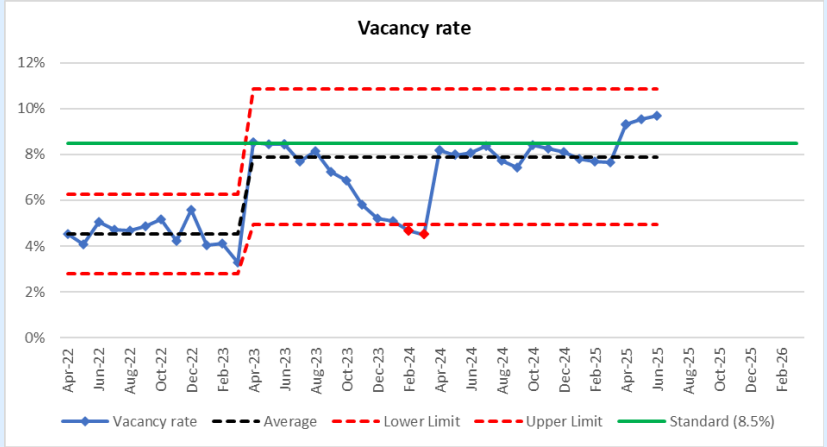
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

The 2025/26 quarter one vacancy position is reported at 9.5%, which is above our standard (8.5%) and has shown an increase over the 2024/25 period. The levels in quarter one fall between the statistical process control (SPC) mean and upper limit.

Nationally there has been a significant increase in vacancies; this is reflected across the Nottingham and Nottinghamshire ICS.

Data



Root causes	Actions and timescale	Impact
Our vacancy level is calculated from a variance between establishments and in-posts. It is being artificially inflated due to stronger financial controls and grip and control associated with our internal vacancy control processes.	Aligned to financial control, we monitor vacancies on a weekly basis via our Vacancy Control Panels (VCP). Within our VCP processes we strongly scrutinise level 3 and 4 posts and only advertised based on a break glass process. We have re-set establishment levels and will continue to monitor our vacancy levels.	We actively manage vacancies on a weekly basis via the VCP process and have strong governance processes around this.

Indicator in Focus: Sickness Absence

Sherwood Forest Hospitals NHS Foundation Trust

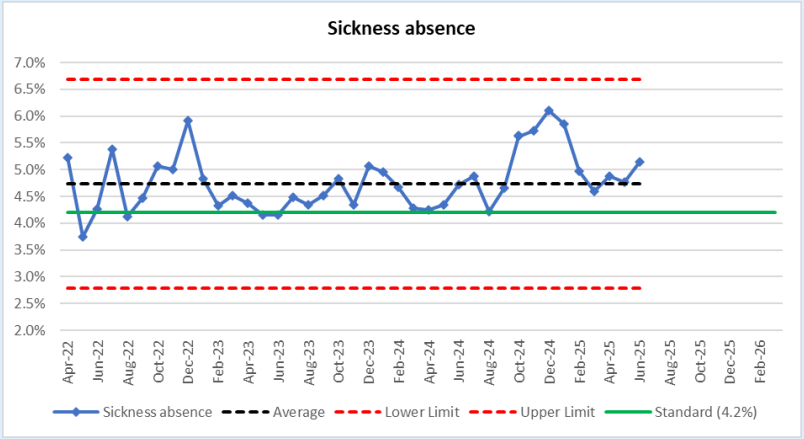
Overview and national position

The sickness position across 2025/26 quarter one is reported at 4.9%, this sits above our standard (4.2%), but within the upper and lower SPC control limits (indicating standard variation). Across short-term elements we are noting high levels of staff reporting absences related to Cold, Cough, Influenza and in Chest and Respiratory problems, and across long-term are related to Stress and Anxiety reasons.

We report and discuss the sickness absence position at a divisional and service line level monthly. Within the people directorate, we review absences over 28 days and provide a case review on each long-term absence; this is to provide assurance that the management of absences falls in line with our policy. We also review the root causes; these are mainly personal issues. We are seeing instances relating to NHS waits for treatments, sickness relating to processes directly and indirectly, personal issues such a family illness/bereavement, financial worries and safeguarding elements.

Local benchmarking shows that the ICB provider sickness absence level is reported at 5.5% (May-25). NHS England state that as of early 2025/26 the sickness absence rate in Acute Trusts is approximately 5.5%, which is higher than the NHS average 5.3%. NHS England recognise this 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.

Data



Root causes	Actions and timescale	Impact
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.	• Sickness absence support and guidance given through dedicated members of People Services team. New process with one-to-one support from the People Service teams with sickness absence management on a case-by-case basis and in line with policy re-focusing on fundamentals. • Fair and consistent processes to manage and support medical absences across all Divisions being implemented through discussion with Divisional Triumvirates and the Associate Director of People (Operations). • Medical sickness absence management reinforced at medical manager level and exploration of inclusion with new Medical Leaders programme. • Focus on prevention of absences and further support for colleagues in conjunction with Occupational Health and Wellbeing Team including targeted Wellbeing promotion. • Additional coaching and training being provided across Jul-25, Aug-25 and Sep-25, including attendance at team development days and meetings. • Sickness absence key performance indicators are monitored through People and Performance meetings, Service Line meetings and via DPRs. • The Deputy Chief People Officer is meeting monthly with the People Service team to review all sickness cases and provide guidance and support in terms of management.	We actively manage sickness cases through a person-centred approach and are aware of outside influences that are contributing to an elevated sickness level.

Indicator in Focus: Agency Usage

Sherwood Forest Hospitals NHS Foundation Trust

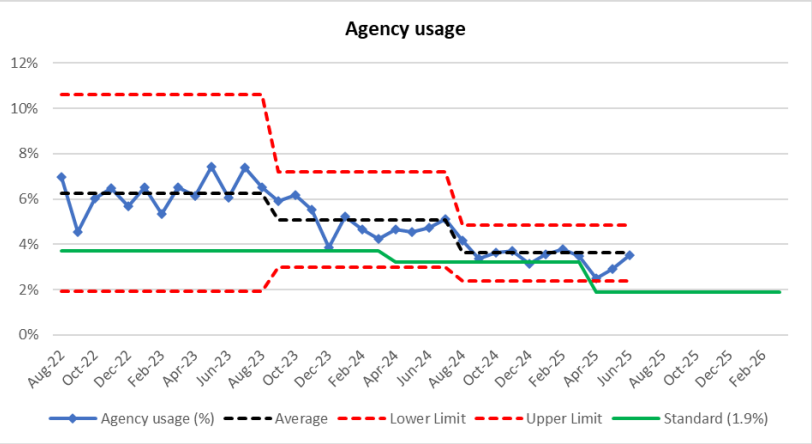
Overview and national position

The agency position across 2025/26 quarter one is reported at 3%, with the Jun-25 position at 3.5%. This sits above our standard (1.9%). Our current agency position for Jun-25 shows a zero usage of off-framework agencies and a strong performance within 'on framework, over price cap' position.

We have modelled this with plans over the 2025/26 period to sit around the NHS planning guidance and our targets have been amended to reflect this. Within month three we are showing a 29.7% reduction to Bank usage and 11.1% reduction to Agency usage from the 2024/25 month eight level.

The reduction to both these metrics are aligned to our workforce efficiency programmes and the work we are undertaking on the 'on framework, over price cap', as key reductions in over price cap support reductions to the overall agency target. We are also working towards the East Midlands Acute provider work on rate compliance by 2025/26 quarter three.

Data



Root causes	Actions and timescale	Impact
As the data informs us, our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services where there are national speciality shortages. There has been an increase to the agency position over the last two months that is largely due to the submission of late timesheets, which is distorting the position.	During 2025/26 we have continued the significant work to reduce reliance on agency usage and support the financial recovery challenge.	We have been actively filling medical roles and have had success in some key specialities.
	We continue to advertise and fill medical posts we have 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, on to 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 them with substantive roles.
	A strict authorisation process for approval of shifts for Thornbury has been implemented in Nursing. Detailed reports illustrating areas using all agency, with Thornbury highlighted, are produced for the Deputy Chief Nurse.	

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Timely Care

Outstanding Care,
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Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

During the reporting period (the last two months), we have maintained performance improvements in several Urgent and Emergency Care metrics. Our headline A&E 4-hour performance metric has been above 75% since Mar-25 and exceeded plan throughout the first quarter of 2025/26. This sustained four-month period of improved performance is the highest levels observed since 2022/23 quarter one. The recovery in 4-hour performance we have delivered in recent months is greater than many other Trusts across the country as evidence by the improvement in our benchmarked position nationally. Our ambulance handover position and Emergency Department (ED) 12-hour length of stay performance have also improved in recent months, benchmarking well nationally. This progress has been achieved and sustained despite A&E attendance levels reaching unprecedented high levels during the last four months. The improvement is testament to the great work that has been taking place at all points of the patient pathway to improve flow and reduce waiting times, thereby reducing the risk of delay-related harm and improving patient experience.

In terms of planned care, we have continued to reduce the number of long wait patients, although we have further work to do to treat all patients waiting over 65 weeks; this is a key priority for us with a focus on ENT. Our 52-week wait backlog is steadily reducing, and we are close to delivering our 2025/26 year-end operational planning requirement of no more than 1% of our total PTL waiting over 52 weeks. 18-week referral to treatment (RTT) performance is stable at circa 64% and is at the highest sustained levels observed since summer 2023. Although we are currently tracking below our operational planning requirement of delivering a 5% improvement on our Nov-24 position by the end of Mar-26, we continue to benchmark strongly on this metric, . We continue with strong performance providing patient initiated follow up delivering performance consistently better than the standard.

Our diagnostic DM01 performance has deteriorated in 2025/26 quarter one, falling below plan. A deterioration in our Echocardiography position following the release of insourcing capacity is the predominant driver of this recent performance trend. Despite the decrease in performance, we remain above the national average by circa 10% and benchmark favourably.

Our cancer performance for the 28-day faster diagnostic standard and the 62-day treatment standard remain favourable to plan. Cancer 31-day treatment performance (first treatment) has varied in recent months and is presently worse than the national standard (which is also our plan). For 31-day and 62-day treatment standards we benchmark in the lower quartiles nationally. Positive signs have been observed in the 62-day pathway, with the 62-day backlog reducing in recent weeks. Recovery plans are in place across several tumour sites and further details around the key root causes and actions are on the following pages.

The following pages provide further detail on performance against key Timely Care 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

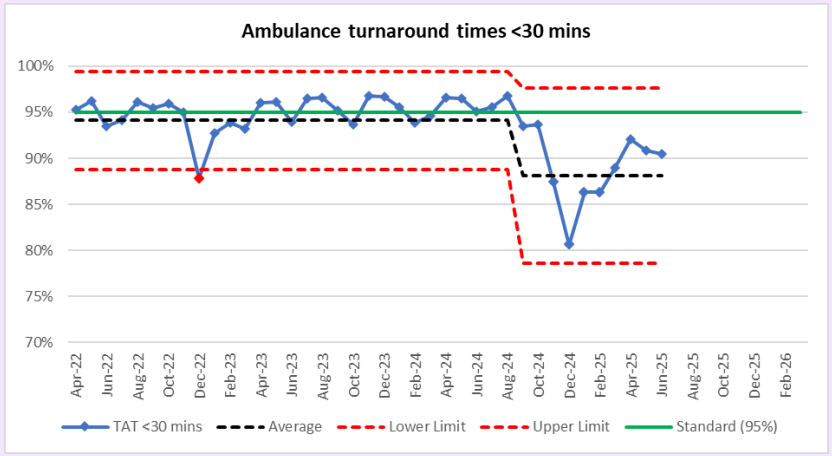
Green tick = target met/exceeded; Red cross = target not met

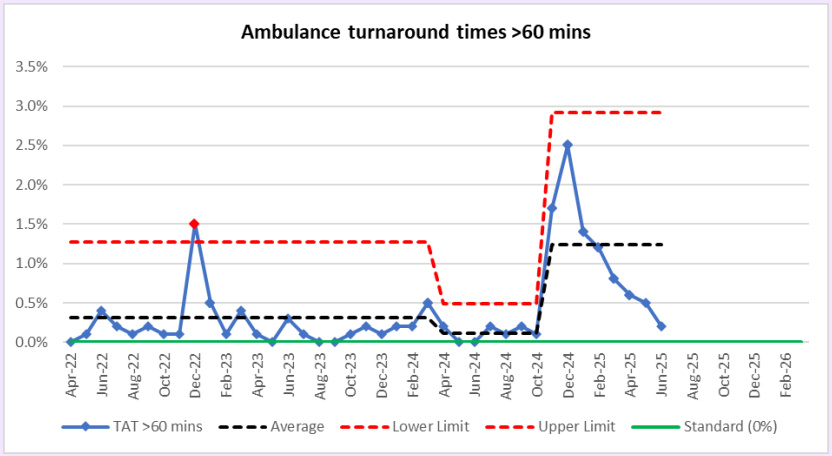
At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD	Latest Benchmark Position (Mar 25)	STAR Data Quality Assurance S	T	A	R
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 91.4%	✗ 91.1%	✓ 24 / 175				
	Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 0.4%	✓ 31 / 175				
	ED 4-hour performance	≥76%	≥Plan	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 71.0%	✓ 77.7%	✓ 51 / 141				
	ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✗ 3.4%	✓ 1.8%	✓ 24 / 175				
	Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	16	17	31	26	19	18	21	19	23	58					
	Adult G&A bed occupancy	≤92%	≤92%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 94.5%	✗ 95.1%	✓ 68 / 179				
	Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	3.1	3.2	3.0	2.7	3.1	✓ 3.3	✓ 3.0	✗ 3.8	3.1	✓ 3.4					
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 64	✗ 57					
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 11.1%	✓ 6.0%	✓ 11.0%	✓ 4 / 134				
	Percentage of incomplete Referral to Treatment (RTT) pathways complet	n/a	≥Plan	62.9%	63.2%	63.8%	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	64.6%	✗ 63.9%					
	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	2.2%	2.1%	1.7%	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	1.3%	✓ 1.2%					
Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥95%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✓ 93.1%	✗ 88.9%	✓ 45 / 136				
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	-	✓ 78.3%	✓ 77.0%	– 71 / 132				
	Cancer 31-day treatment performance	≥Plan	≥96%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	-	✓ 91.9%	✗ 91.2%	✗ 112 / 132				
	Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	-	✗ 64.4%	✓ 64.4%	✗ 102 / 132				

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

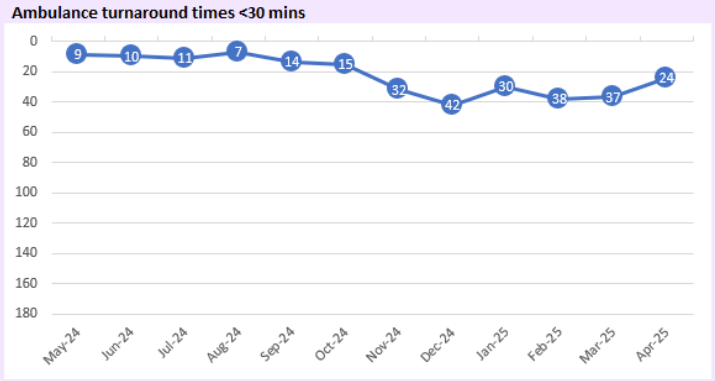
Sherwood Forest Hospitals NHS Foundation Trust

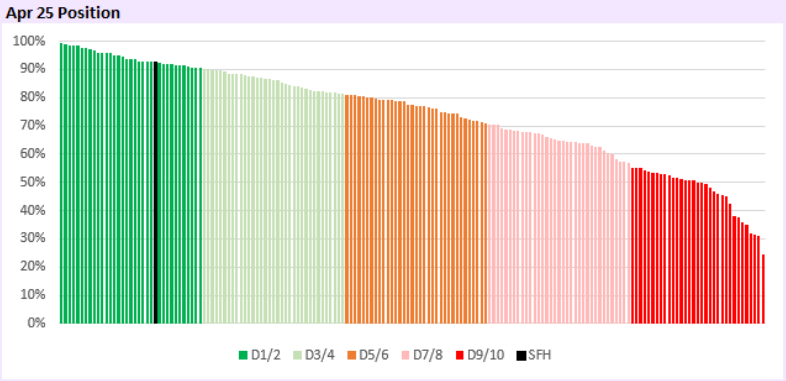
Local data

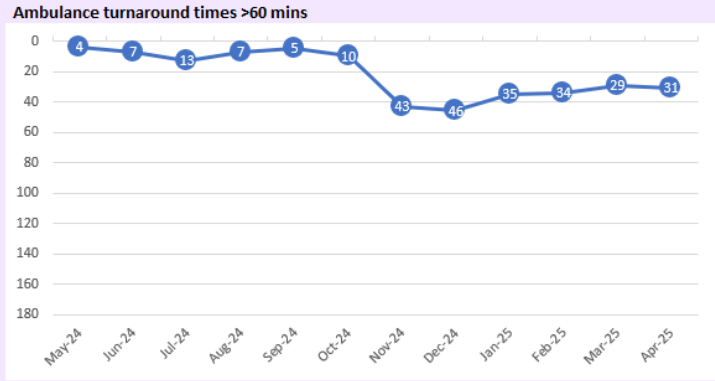


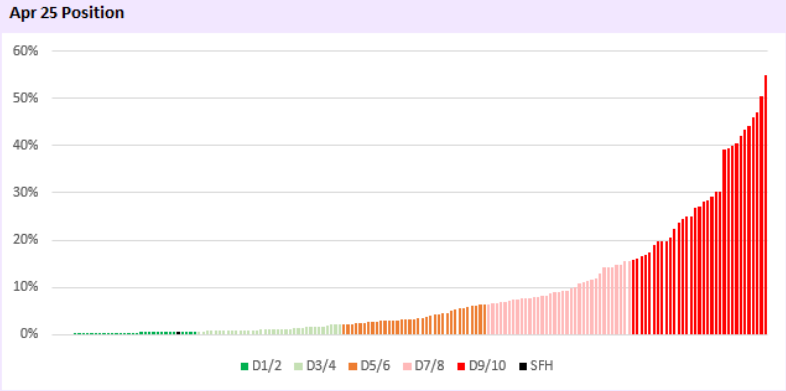


Benchmark position





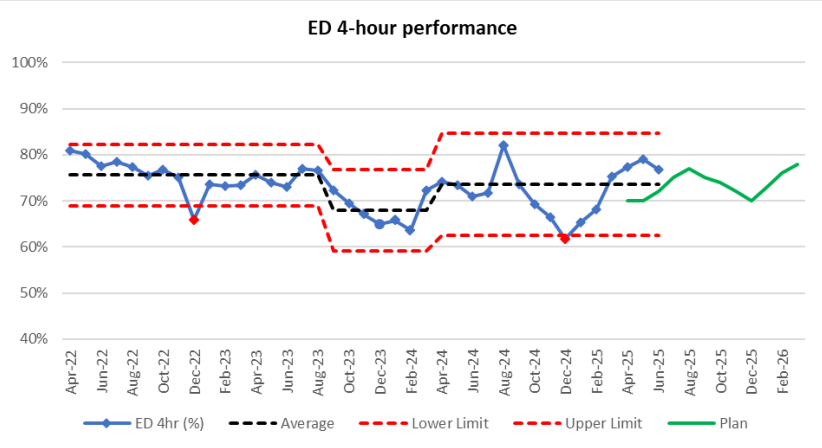


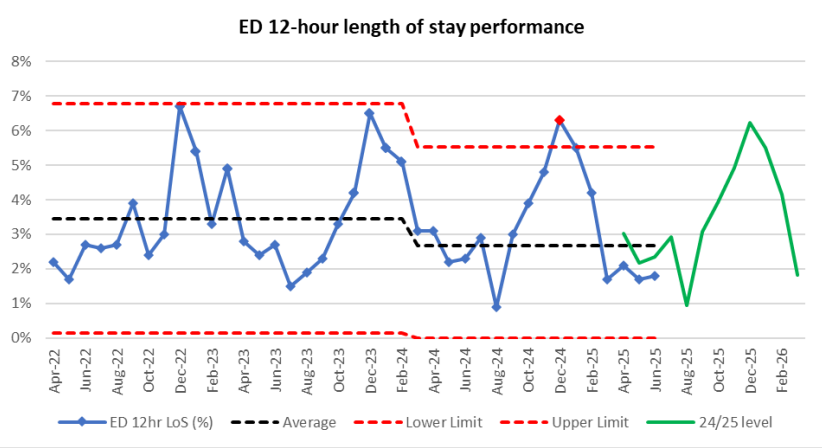


Indicators in Focus: Urgent Care – A&E (2/4)

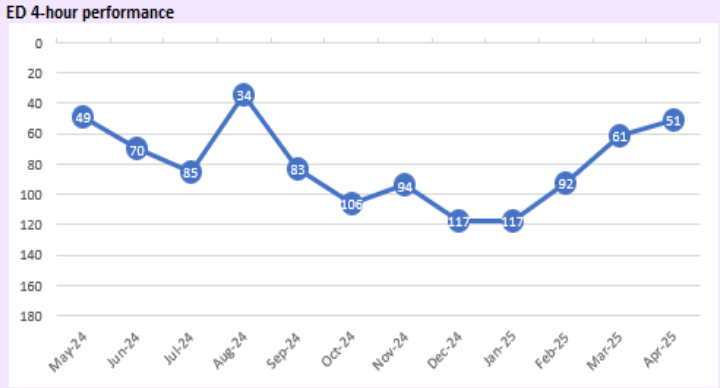
Sherwood Forest Hospitals NHS Foundation Trust

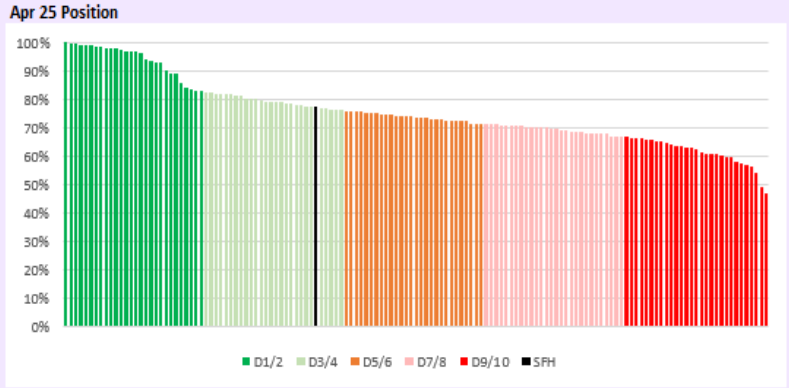
Local data

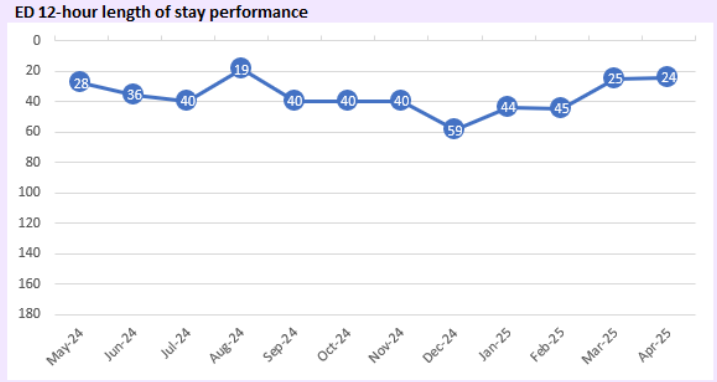


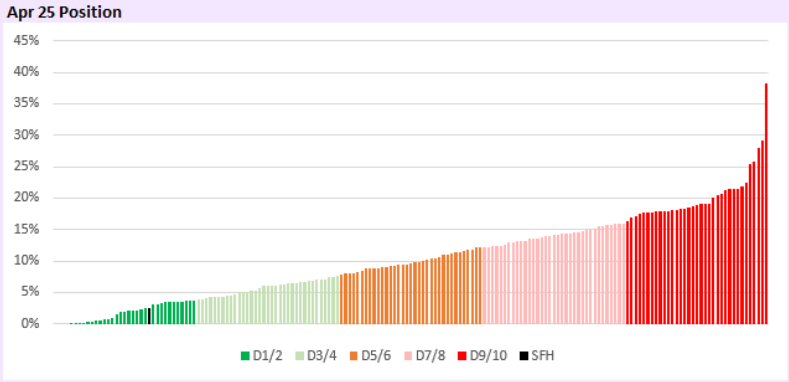


Benchmark position









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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

Ambulance 30-minute handover performance deteriorated during the Winter months; however, continued to benchmark in a strong position nationally. Performance improved in the Spring and in the last three months has stabilised, albeit at a lower level than in 2024. This is reflected in our benchmarking position, which is now in the top 20% of Trusts nationally; in 2024 we were in the top 10%.

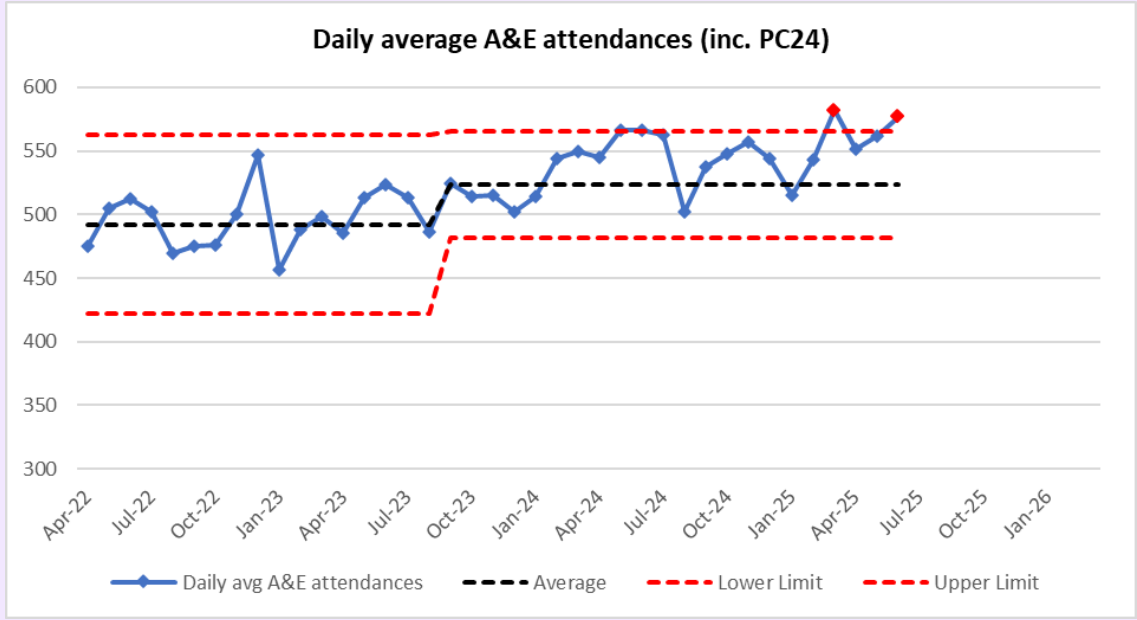
Ambulance 60-minute handover performance also deteriorated in Winter and has now recovered close to previous levels. This is reflected in our benchmarking position where we also remain in the top 20% of Trusts nationally.

A&E 4-hour performance has improved significantly since Mar-25 driven partly by length of stay improvements and improved patient flow across our hospitals supporting timelier outflow of patients from our Emergency Department (ED) waiting for admission. In 2025/26 year to date, we have performed better than our operational plan for 4-hour performance. 4-hour performance has been at the highest sustained level seen since 2022/23 quarter one. Our benchmarking position has also improved during this period, indicating that we have improved more than other Trusts in the country.

A&E 12-hour performance deteriorated during Winter, in line with seasonality seen in the past three years. Performance has since improved to low levels and has been inside plan throughout 2025/26 to date. Movements in our benchmark position suggests that other Trusts in the country have seen similar trends during this period; although, our current relative position is the best we have seen since Aug-24.

The A&E performance position is positive given attendances to our A&E department have been at some of the highest levels we have ever seen (as demonstrated in the adjacent chart with two of the last four data points triggering special cause variation due to the high levels). Such performance improvements in the context of unprecedented demand pressure is a testament to the great work that has been taking place at all points of the patient pathway to improve flow, reduce waiting times, and subsequently reduce the risk of delay-related harm and improve patient experience.

Additional data



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

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact

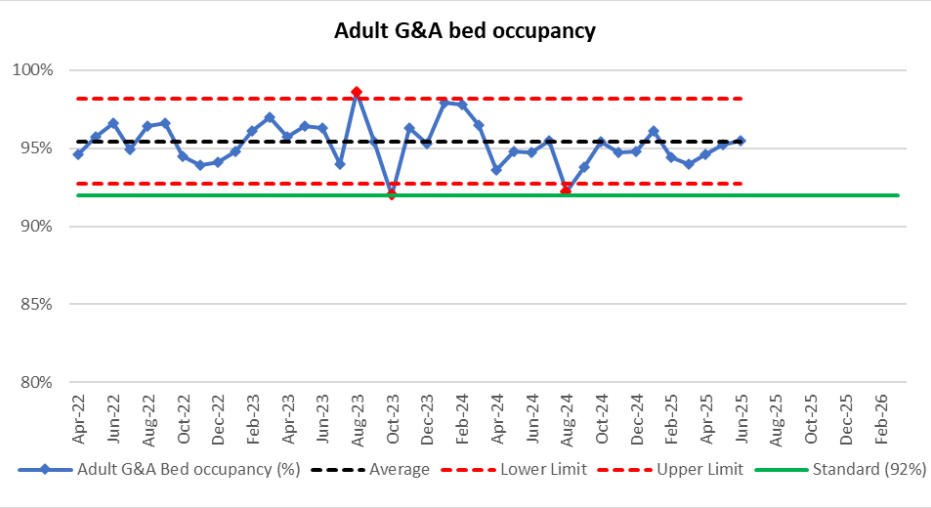
Surges in Accident and Emergency (A&E) attendance demand.	• Admission and attendance avoidance with system partners include:
	  - Focus on frailty attendances: Call before you convey; use of urgent care response teams.
	  - Development of alternatives to ED workstream in line with the Emergency Care Improvement Plan.
	  - Development of Acute Frailty Unit commencing early Oct-25.
		• Reduction in out of area conveyances.
		• Reduction in category 3 ambulance conveyances.
		• Reduction in over 65-year-olds where length of stay is one day plus.
		• Reduce overnight admission conversion rate.

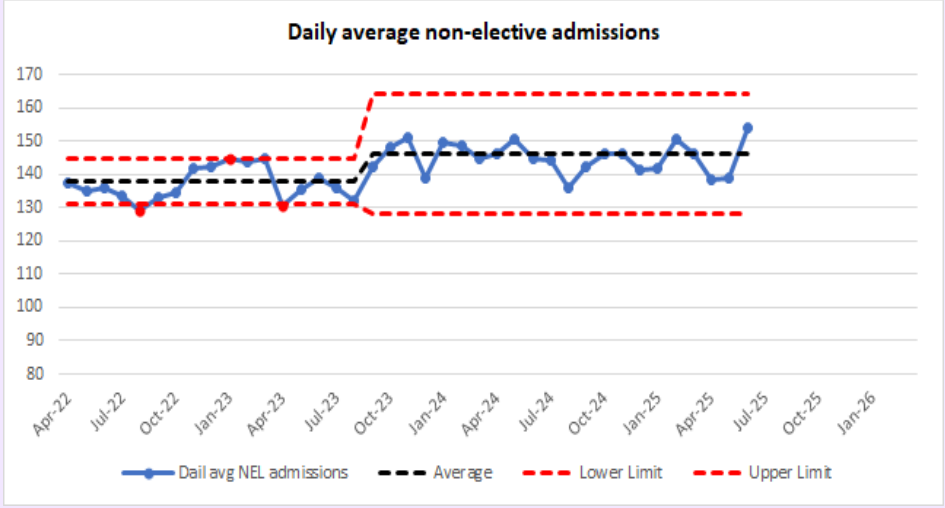
	• Optimise approach to Same Day Emergency Care (SDEC) for patients who would otherwise be admitted to hospital.	• Increase in patients through Frailty and Surgical SDEC. • Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our Emergency Department (ED). • Decrease in mean time in department for non-admitted patients identified with a Clinical Frailty Score (CFS) >6.
	• Implement learnings from the Criteria to Admit audit – workshop planned in Sep-25.	
	• Develop recommendations following Recommended Summary Plan for Emergency Care and Treatment (RESPECT) audit.	
	• Work with systems partners to better understand the increase in the number of Mental Health presentations in ED.	• Reduce ED overcrowding and improve staff to patient ratio through reduction in 1:1s required.
Insufficient staffing to manage A&E demand.	• Consultant cover five days per week at Newark Urgent Treatment Centre from Aug/Sep-25.	• Decrease in mean time in department for non-admitted patient to <180 minutes.
	• Recruit five new ED Consultants following review of all vacancies with a move to Consultant on site cover until 2am.	
	• Implement ED Nervecentre task list to improve visibility of tasks and escalations to progress patients care and journey.	
A&E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Wards have begun to go two-over when in high local escalation level as part of our Full Capacity Protocol to accommodate more patients on our wards earlier in the day and thereby improve hospital flow and bedded capacity reducing clinical risk due to overcrowding in ED.	• Time to initial assessment for arrivals to A&E seen within 15 minutes to greater than 60%. • Reduce and sustain 12-hour length of stay to less than 2%.
	• New Clinical Decisions Unit opened Apr-25 and Majors rebuild planning commenced.	
	• Patient flow actions detailed on the following slides.	

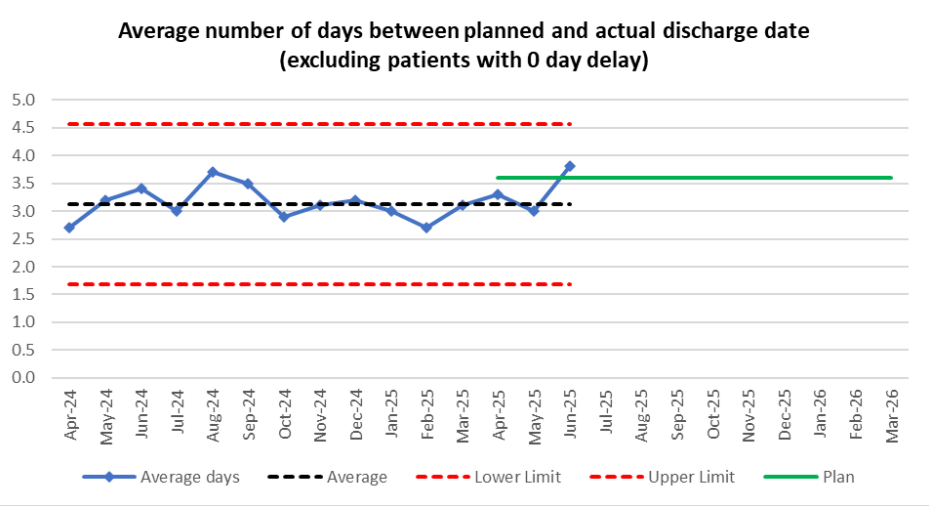
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

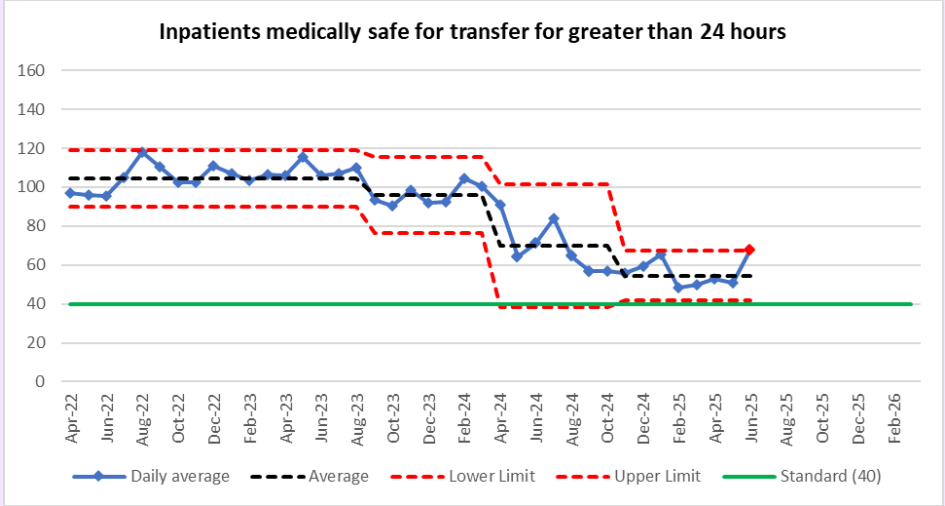
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

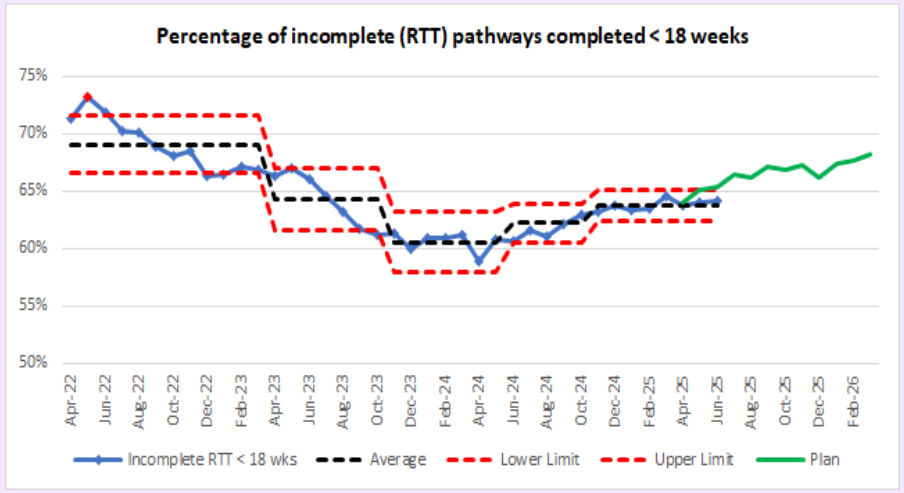
- General and Acute (G&A) bed occupancy is trending within statistical process control limits; with no unexpected variation.
- The number of patients Medically Safe For Transfer (MSFT) for greater than 24 hours was running at all time low levels to Jun-25 driving a continued step change reduction in the statistical process control chart. However, in Jun-25 the number of patients delayed leaving our care has increased to show special cause variation with a breach of the upper control limit. Recording changes for pathway 2 (P2) patients has temporarily increased the number of medically safe for transfer (MSFT) patients from the end of Jun-25; the aim is to enable greater grip on discharge planning.
- Reduced length of stay for patients aged 65 and over, predominantly due to reduced discharge delays has significantly improved patient flow supporting 4-hour emergency access performance recovery (and recovery in other associated urgent and emergency care metrics).

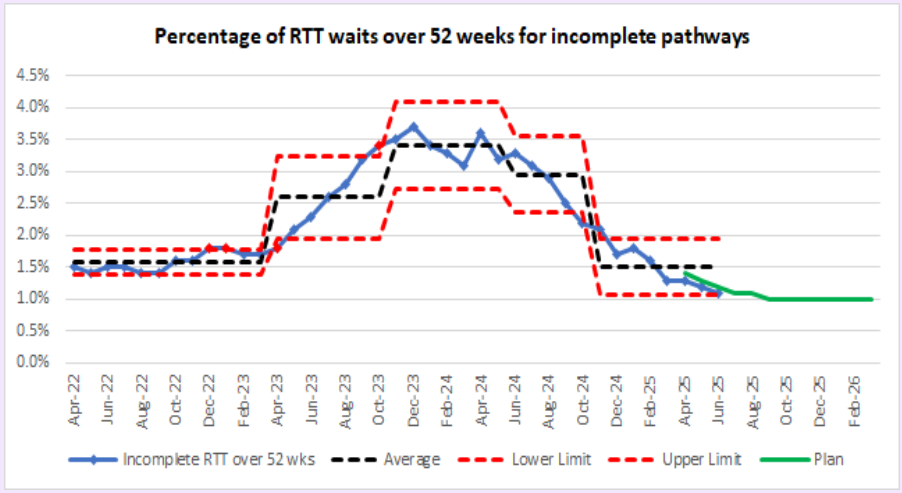
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• Long length of stay (LOS) meetings embedded for both pre and post medically safe patients.	• LOS meetings identify opportunities for alternative pathways and early engagement with partner agencies to support discharge.
	• Dedicated ward Discharge Coordinators engaging early with patients and families.	• Early identification of potential barriers to discharge. • Enables early engagement with partner agencies to support discharge including local councils, housing office and house clearance services.
	• The 'Getting the Basics Right ' programme championed by the Chief Operating Officer and Chief Medical Officer continues to focus on board rounds and ward processes to support consistency of clinical documentation and clear recording of decisions.	• Review of ward processes especially around TTOs (To Take Out medications) will help us ensure people can be discharged in a timely way. Focus on 7-day LOS will now have a positive impact on pre medically safe planning.
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 sent to relevant wards and checked for completion later in the day.	• Improve LOS for complex discharges across our hospitals. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges (good progress already seen).
	• Use of 'Criteria to Reside' letters is encouraging families to engage with discharge planning.	
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. EMED Group and Ambicorp conveyances are now under local and system-wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges (good progress already seen).
Insufficient community capacity to meet supported discharge demand.	• Working with health and care partners (predominantly adult social care) to resolve issues with a lack of Packages of Care (POCs) which is delaying patient discharge.	• Reduce discharge delays for patients requiring mental health beds and reduce the number of medically safe patients in our hospitals. • Improves hospital flow, which enables improved ED performance and patient experience.
	• Working with partners within Nottinghamshire and Derbyshire on timely transfer of inpatients requiring support from mental health services. There has been increasing pressure in this area due to mental health bed capacity constraints. New targets to prevent 24 hour stays in ED for mental health patients resulting in increased focus on mental health discharges.	

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

Sherwood Forest Hospitals NHS Foundation Trust

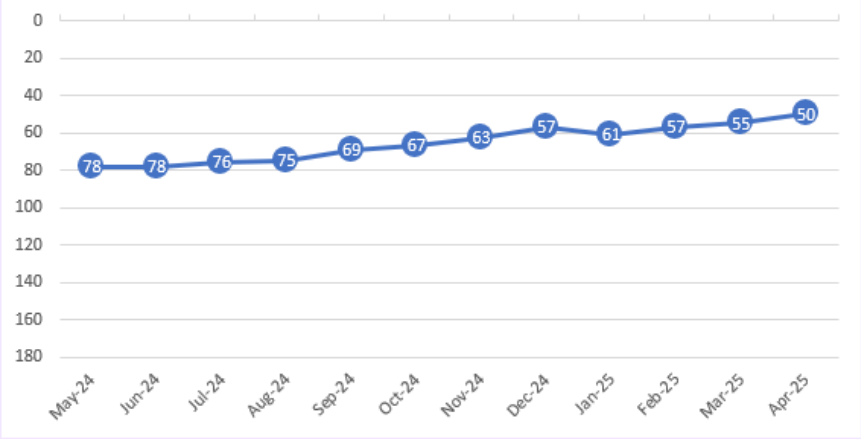
Data



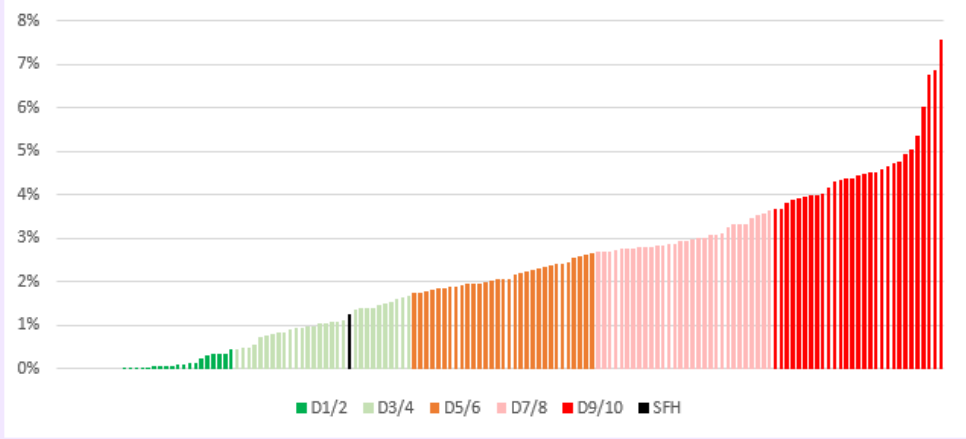


Benchmarking Position and Standings

Incomplete RTT pathways +52 weeks



Apr 25 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

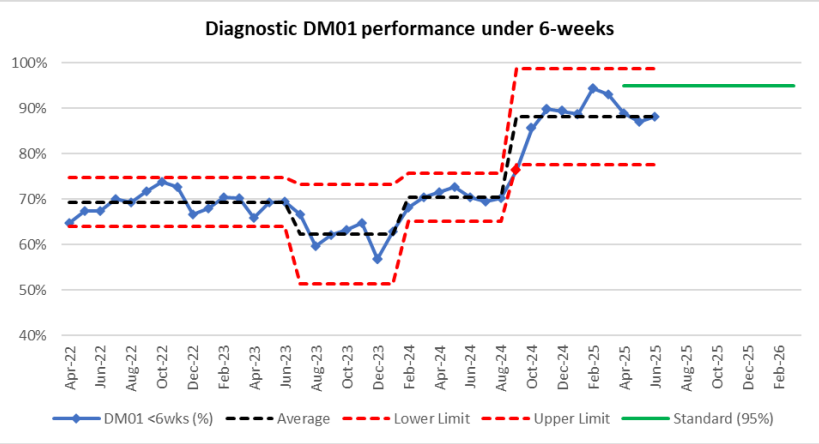
- Referral to Treatment (RTT) 18-week performance at SFH increased throughout 2024/25 and has stabilised at circa 64%; this is amongst our strongest position for the last two years and we are presently forth best in the region. However, performance is currently worse than our operational plan for 2025/26 which is set to deliver the mandated 5% improvement on our Nov-24 position.
- 52-week wait pathways continue to reduce, and we are currently performing better than our operational plan to achieve 1% of the total incomplete PTL (Patient Tracking List) size by the end of 2025/26. Our 52-week wait benchmarking position continues to improve relative to the rest of the country (our position is improving whereas the national position has deteriorated).

Root causes	Actions and timescale	Impact
Insufficient surgical capacity within key specialities to meet demand affecting reported positions for long waits at a provider level.	• Cross-provider PTL and support for patients in place.	• Equalise waits across the system. • Treat longest waiting patients first regardless of provider.
	• Mid-week insourcing to increase ENT capacity in place and from the end of 2025/26 quarter one extended to weekends.	• Two to three list per week increasing ENT capacity to further reduce in long waits in a sustainable way.
	• Additional equipment to increase Functional Endoscopic Sinus Surgery (FESS) delivered Mar-25 enabling more patients to be booked.	• Increase the volume of FESS that can be booked each week by up to two patients per week.
Insufficient anaesthetic capacity (current deficit of seven WTE consultant vacancies) increasing the risk of list cancellation due to insufficient staffing cover.	• Strategy for anaesthetic staffing levels and recruitment plan in place including: – Insourcing up to eight lists per week and covering additional gaps with increased hours for part-time clinicians since Mar-25. – Consultant acting up from Aug-25.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations.
Insufficient capacity to reduce first appointment backlogs within routine baseline capacity.	• Outsourcing ENT first appointments to commence Aug-25. • Locum appointments commenced in Jul-25 to release consultant capacity for clinics. Clinic capacity review to increase first appointments from Sep-25. • Independent sector provision for first appointments in place. Review of insourcing and outsourcing opportunities for Ophthalmology underway to identify suitable opportunities to commence end of 2025/26 quarter two.	• Reduce waits for first outpatient appointments • Improve Trust performance against first activity trajectory.
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.	• PTL will be ‘clean’ and represent only those patients genuinely waiting treatment. • Reduction in overall incomplete position through validation.
	• Leadership team agreed to recruit to vacancies in Jul-25 following several colleagues leaving in 2025/26 quarter one. Recruitment to commence immediately.	

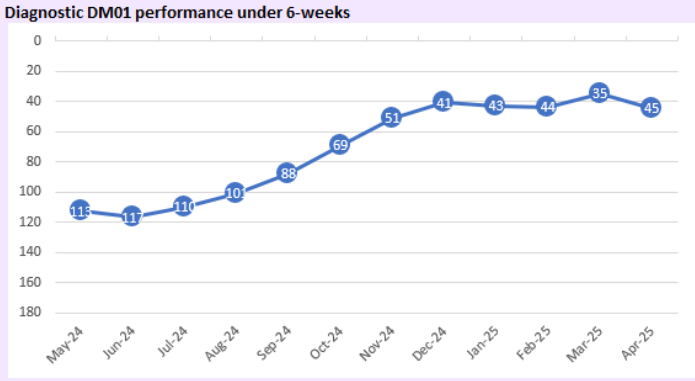
Indicators in Focus: Diagnostics (1/2)

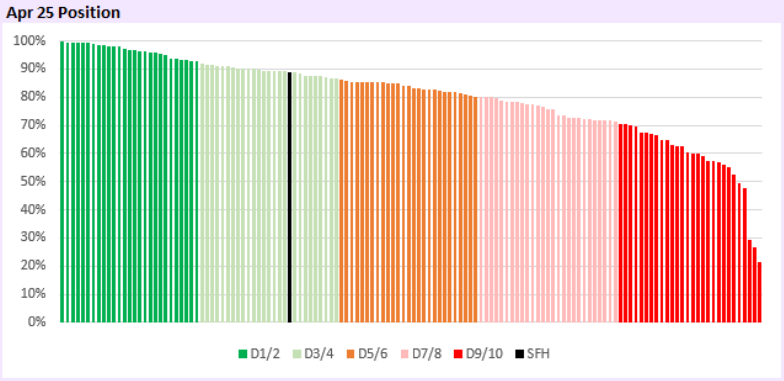
Sherwood Forest Hospitals NHS Foundation Trust

Local data



Benchmark position





Performance observations

- Our diagnostic DM01 performance has reduced during 2025/26 to date following significant improvement and a peak in performance in the second half of 2024/25. Our benchmarking position has remained stable since the improvements we observed in 2024/25 with our position being better than the national average.
- The 2024/25 improvement and subsequent deterioration in 2025/26 was driven by Echocardiography following the introduction and then the release of insourcing capacity. Echocardiography is the main driver of overall Trust DM01 performance, and trends in the service generally result in a similar overall position trend.
- There has also been a deterioration in CT (specifically CT Cardiac) and Sleep Studies DM01 performance due to ongoing demand and capacity challenges.

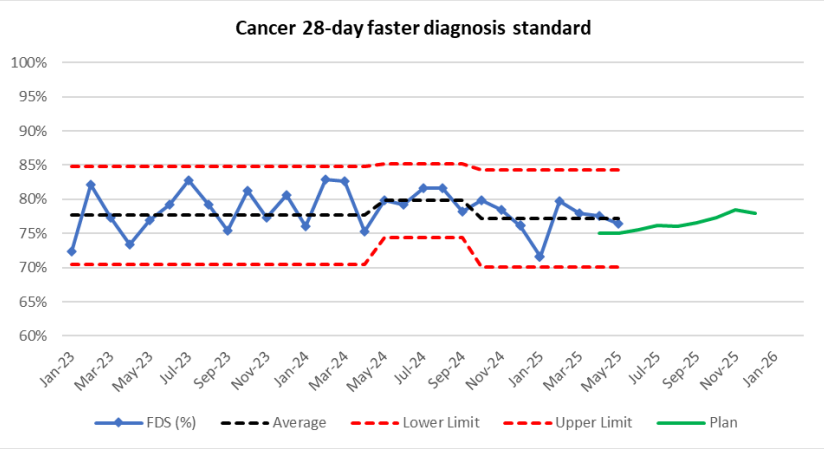
Indicators in Focus: Diagnostics (2/2)

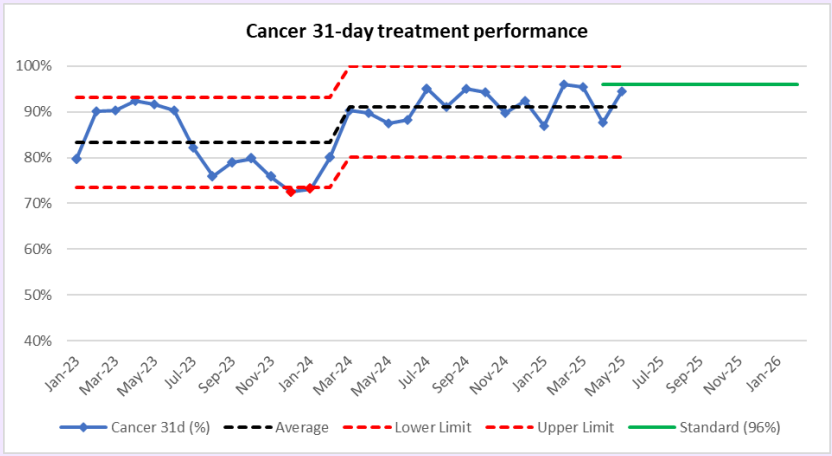
Root causes	Actions and timescale	Impact
Insufficient Echocardiography baseline capacity to reduce the number of patients waiting.	• Insourcing recommenced to increase capacity and deliver above planned activity levels from Jun-25.	• Reduction in backlogs to eliminate patients waiting over 13-weeks and improve DM01 performance.
	• Review of specialist bubble and stress echocardiogram pathways underway to optimise capacity and patient pathway management.	• Reduced waits for specialist tests and improved DM01 performance.
	• Identified clinical time for rota planning to ensure rotas are planned to a minimum of four weeks in advance, commencing Jul-25.	• Advanced booking of appointments and enablement of patient choice.
Sustained growth in CT Cardiac and insufficient available capacity of specialist workforce.	• Arrival and testing of the new CT scanner completed, and regular CT cardiac radiologist-led capacity established from Jun-24.	• Increased capacity and reduction in long waiters. • Improved DM01 performance.
	• Review of clinical pathways to expand the volume of patients eligible for Radiologist-led capacity.	• Release Consultant Cardiologist capacity. • Reduction in long waiters. • Improved DM01 performance.
Insufficient baseline capacity to reduce backlogs in Sleep (impacted by an increase in out of area referrals throughout 2024 which has now stablised in 2025).	• Business case to right-size the service in development to address the capacity deficit.	• Improved DM01 performance.
	• Increase in technician and physiologist capacity to issue sleep study devices following a successful bid to purchase an additional 11 devices	• Reduction in long waiters and prevent of 13-week breaches.

Indicators in Focus: Cancer (1/3)

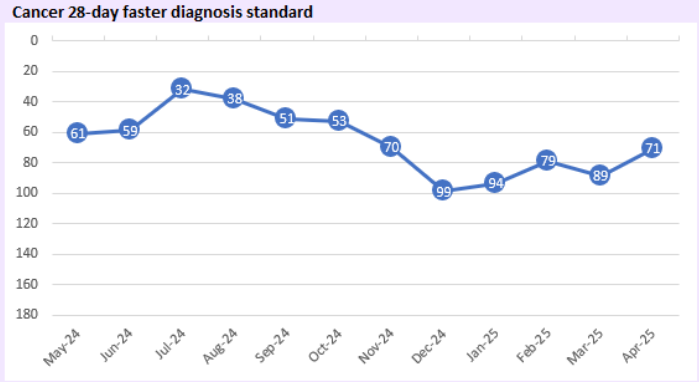
Sherwood Forest Hospitals NHS Foundation Trust

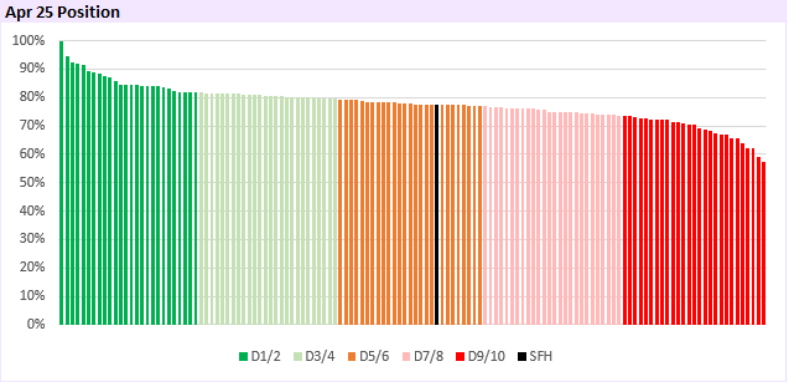
Local data

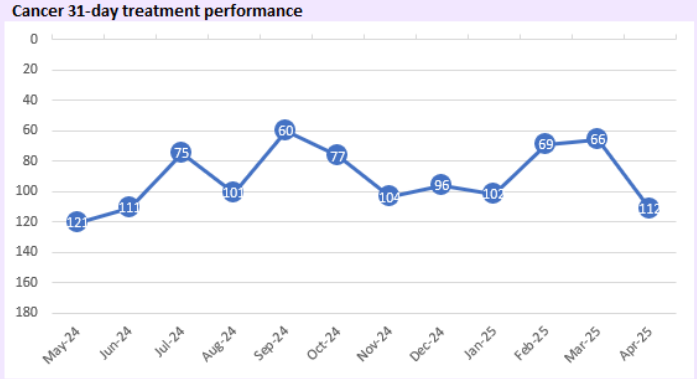


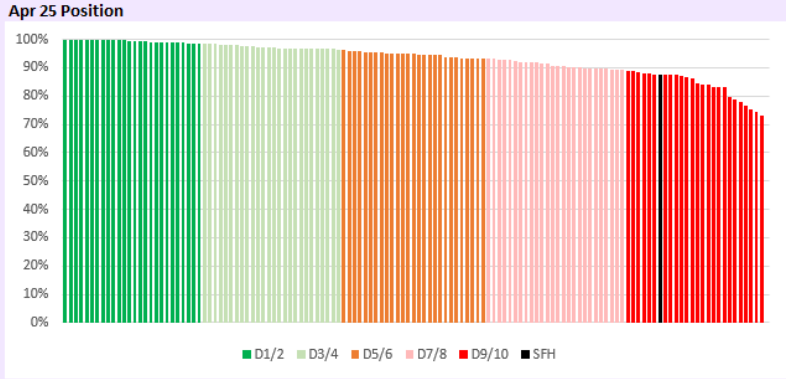


Benchmark position





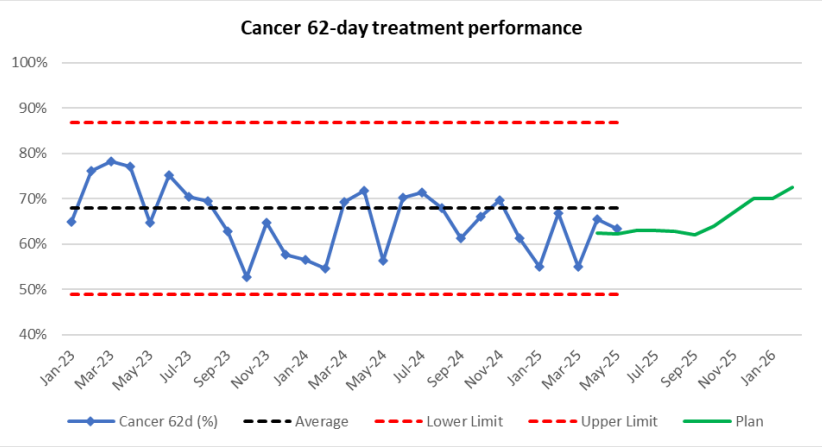




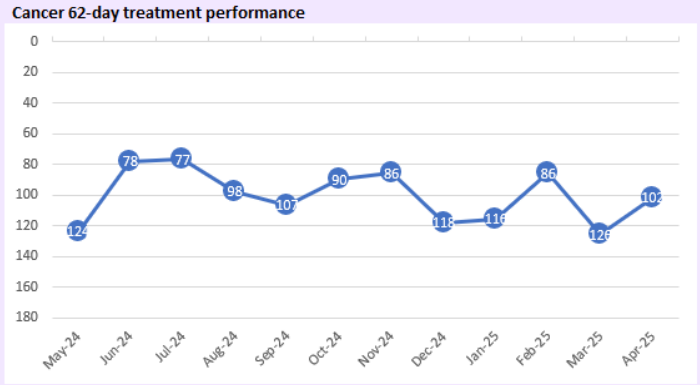
Indicators in Focus: Cancer (2/3)

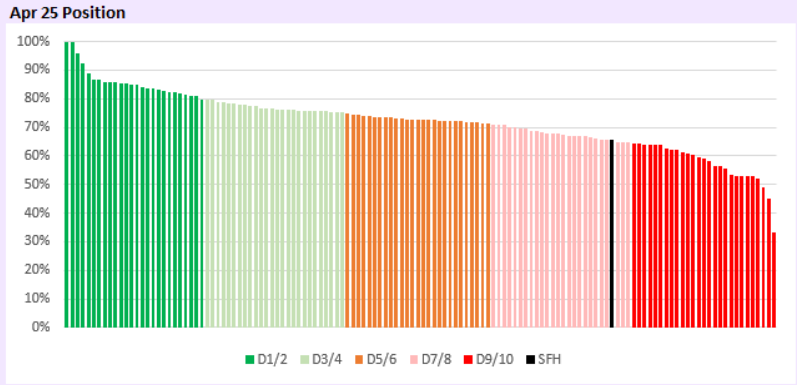
Sherwood Forest Hospitals NHS Foundation Trust

Local data



Benchmark position





Performance observations

- Cancer 28-day Faster Diagnosis Standard (FDS) is currently stable and is better than our operational plan, which requires improvement to 80% by the end of 2025/26 as part of the national ambition. Our benchmark position is in the interquartile range (mid-pack) nationally.
- Cancer 31-day treatment performance (first treatment) has varied in recent months, closing in May-25 at 94.4%. This is below the 96% national standard which is our operational plan. Our variable position is reflected in our benchmark position which typically is in the lower quartiles nationally. To benchmark in the upper quartile, we need to exceed the 96% national standard.
- Cancer 62-day treatment performance has shown variation. We have performed better than our plan throughout 2025/26, closing at 63.3% in May-25. We have further work to do this year to sustainably recover the position and achieve our plan for the second half of 2025/26. The operational plan requires improvement to 75% by the end of 2025/26 as part of the national ambition. Like 31-day treatment performance, we benchmark in the lower quartile nationally.

Indicators in Focus: Cancer (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact
Insufficient Histopathology workforce to meet demand creating pathway delays across multiple tumour sites.	• Recruitment process for additional Consultant capacity completed in May-25. Successful appointment of two substantive consultants which are now in post (in addition to a locum consultant) and another substantive consultant to start in Jul-25. Successful recruitment to six WTE Medical Laboratory Assistant (MLA) posts.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
	• East Midlands Cancer Alliance funding to implement seven-day working across histopathology is underway and due to commence 2025/26 quarter three.	
	• Go live of a new Cellular Pathology Laboratory Information Management System (LIMS).	
	• Ongoing pay per point scheme to support additional cancer reporting.	• More than 2,800 additional points reported.
Insufficient clinical triage and decision-making workforce capacity in Upper Gastrointestinal (UGI).	• East Midlands Cancer Alliance funding confirmed at the end of 2025/26 quarter one to increase clinically-led triage capacity to streamline the front end of the pathway and to implement a navigator to support with patient engagement and the timely management of clinical decisions.	• Improvement in first seen within seven days, reducing the time on the overall pathway.
Insufficient capacity to meet demand in Lower Gastrointestinal (LGI).	• Introduction of nurse-led clinics and results reviews and consultant snippet letters for faster diagnosis in place from Mar-25. Consultant daily hot clinics commenced at the end of 2025/26 quarter one.	• FDS performance increase, sustaining 60% in Q1. • 62-day backlog reduced to 12 in Jun-25 (from 38 at the start of 2025). • First seen within 7-days sustained >50%.
Insufficient general anaesthetic capacity to meet UGI and LGI demand.	• General anaesthetic Endoscopy capacity to move from ad hoc lists to weekly allocated capacity. Clinical governance approval now in place and capacity commenced at the end of Jun-25.	• Consistent capacity for cancer patients.
Increase in complex patients requiring multiple investigations in Lung.	• Review of patients over day 62 to understand the increase in complexity driving up the number of patients on the backlog, despite the tumour site performing well against the optimal timed pathway.	• Identification of actions to impact backlog reduction and 62-day performance.
Insufficient capacity to meet demand for surgical and oncological breast treatment and an increase in patient complexity requiring multiple investigations and additional surgical time.	• Business case development underway to implement an alternative clinical approach to establishing tumour location.	• Reduction in re-excision to improve productivity and patient experience.
	• Where possible theatre capacity is being increased, working closely with histopathology due to the implication on lab time by increasing breast cancer case volumes but further impact by case complexity and duration.	• Increase timely surgical capacity, restricted to 10 cases per week due to histopathology capacity.
	• Implementation of triage multidisciplinary team (MDT) to increase decision timeliness to manage demand from quarter two.	• Improvement in 62-day performance.
	• Joint Oncology PTL in place with NUH (as the service provider) to escalate patient pathways and identify capacity.	
Increase in Urology demand driving insufficient capacity and complex patients requiring multiple investigations.	• Successful capital bid for Local Anaesthetic Transperineal Prostate (LATP) machine at Newark. The pathway will be further streamlined to reduce waits for patients where pre-op is not required and through flexing clinical capacity where demand for specific tests is required.	• Reduction in LATP waits.
	• Recruitment of substantive consultant commencing 2025/26 quarter two.	• Improvement in cancer waiting times standards.

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Best Value Care

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Domain Summary: Best Value Care

Overview	Lead: Chief Financial Officer

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

The month three position is a deficit of £1.8m, which is in line with the planned deficit in month.

Given the challenging nature of the financial plan there are key risks. These include non-delivery of efficiency, unfunded national pay awards if no further funding flows into the organisation, finalisation of 25/26 contracts with Integrated Care Boards (ICB) in line with Trust income plan, emergency care pathway growth, under delivery of elective activity, payback of 24/25 financial support within the Nottinghamshire system and the financial impact of industrial action.

The annual Financial Improvement Programme (FIP) target is £45.8m in 2025/26. Month three saw a year to date (YTD) delivery of £6.0m against a YTD plan of £8.8m. To support efficiency delivery, a Financial Efficiency Delivery Specialist unit has been created. This is a multidisciplinary group combining leads from Finance, the Improvement faculty, analytical and clinical colleagues.

The 2025/26 Capital Expenditure Plan has been prepared and submitted as part of the overall financial plan with an in-year plan of £39.12m. Expenditure for Jun-25 totalled £0.44m, which was £3.0m under plan, with the variance relating to the quarterly phasing of the Electronic Patient Record (EPR) system.

Closing cash on 30-Jun was £18.07m, a reduction of £4.33m in month. The large cash balance is due to the receipt of capital funding in 2024/25 quarter four of £24.49m, additional ICB funding received in Mar-25 and working capital support of £8.31m received in Mar-25. This balance will reduce in 2025/26 as closing capital creditors are paid. There remains an underlying pressure on available revenue cash resource due to the requirement to deliver significant efficiency savings in 2025/26, which will be managed by extending payment terms to suppliers if required.

The Trusts agency expenditure in Jun-25 is £1.01m and YTD £2.63m which is 32% lower than the 2024/25 quarter one expenditure due to the increased grip and control placed through the medical agency programme alongside some Elective Recovery Fund (ERF) schemes not having been fully re-instated during 2025/26. The 2024/25 run rate was £1.14m with £1.05 in the second half of the year and £1.03m in quarter four. Total agency expenditure as a proportion of our total pay spend is 2.96% 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 Jun-25 is £1.70m and YTD is £5.48m which is 28% lower than the 2024/25 quarter one expenditure. The target reduction set in the Trust plan was 15% therefore we are significantly exceeding performance.

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

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Scorecard: Best Value Care

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Financial Performance	Financial surplus / deficit	n/a	≥£0.00m							✗-£0.90	✗-£0.70	✗-£0.20		✗-£1.80				
	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗-£0.17	✗-£0.79	✗-£0.10	✗-£2.68	✗-£2.60	✓£7.14	✓£0.00	✓£0.00	✓£0.00	✓£0.01	✓£0.00				
Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓£4.70	✗-£1.97	✗-£0.20	✓£0.26	✗-£0.04	✓£0.15	✗-£0.81	✗-£0.72	✗-£1.30	✓£0.08	✗-£2.83				
	Risk adjusted efficiency forecast to plan (%)	n/a	100%							✗46.5%	✗55.0%	✗56.6%		✗56.6%				
Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£13.70	£2.63				
	Reported bank expenditure	No Standard	No Standard	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£30.55	£5.48				
Rate of Productivity	Implied productivity growth (YTD compared to last year)	3.1%	2%	✓6.9%	✓5.4%	✓4.6%	✓3.3%	✓4.3%	-	-	-	-		-				
Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%							✗24.7%	✗33.5%	✗62.6%		✗47.6%				
	BPPC - Value of bills paid within target	n/a	≥95%							✗69.2%	✗71.8%	✗69.3%		✗70.9%				
	Operating expenditure days	n/a	≥5							✓ 16	✓ 16	✓ 13		✓ 13				
Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£1.41	£1.01	£1.92	£2.43	£1.62	£18.40	✗£0.35	✗£1.40	✗£0.44	✓£33.58	✗£1.88				

Indicator in Focus: Financial Performance

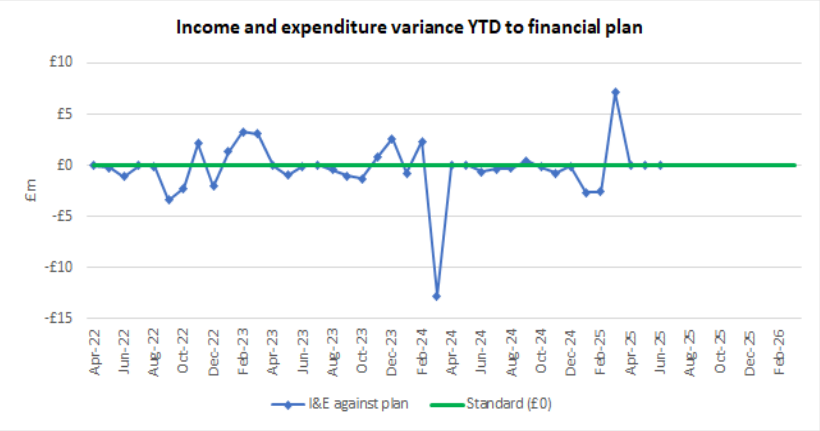
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust financial plan, which is a break-even position for 2025/26. This is aligned to the Trust's share of the 2025/26 Revenue Plan Limit set for the Nottingham and Nottinghamshire ICB by NHS England.
- The Trust is in line with the planned deficit of £1.8m in as at 2025/26 month three.

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.
Pay award.	• Current plan assumes a national pay award of 2.8%. If the national pay award is higher than this with no further funding, then it will cause pressure on our income and expenditure position.	
Variable activity plan.	• We need to ensure as a Trust we maintain our variable elements of our activity to ensure we maintain the level of income associated with this.	
Industrial Action.	• There is no national funding available to cover this and we will need to minimise costs where possible, as well as recovering the lost activity in line with the variable activity plan.	
Finalisation of 25/26 contract with ICBs	• Trust is still negotiating 25/26 contract values with Nottinghamshire and Lincolnshire ICBs, if contract values are not in-line with Trust internal assumptions then it will cause pressure on our income and expenditure position	
Payback of 24/25 financial support within the Nottinghamshire system	• Current plan does not assume any payback of the financial support that delivered the 24/25 financial position. • The payback value expected from SFH is £4.1m. There is an expectation this is transacted through a reduced contract value in 25/26. Any payback will cause pressure on our income and expenditure position.	

Data



Indicator in Focus: Efficiency

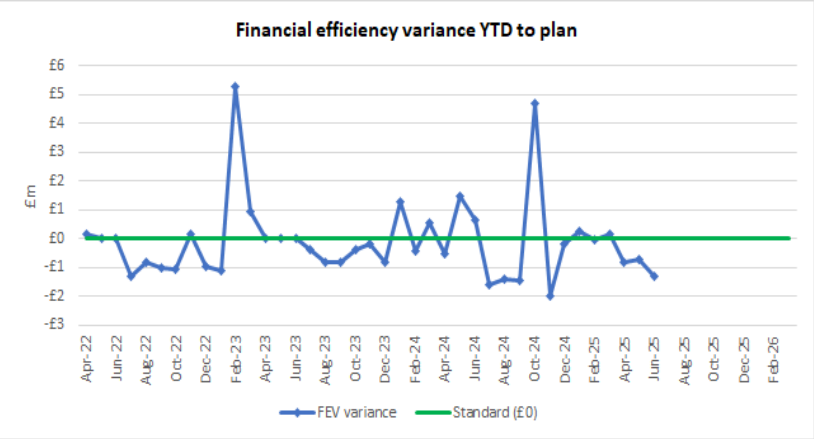
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust Financial Improvement Plan (FIP).
- The Trust has a £45.8m efficiency programme for 2025/26, which is currently £2.83m behind plan.

Root causes	Actions and timescale	Impact
Resources to support delivery.	• Financial Efficiency Delivery Specialist unit (FEDs) has been established. This is a multidisciplinary group looking at supporting the efficiency delivery. This unit combines leads from Finance, the Improvement faculty, analytical and clinical colleagues. The unit will look to support delivery and identify potential gaps, de-risk aspects of the programme and ensure the 'route to cash' for all savings opportunities is transparent. • The current weighted forecast reported to NHS England is full delivery of the target.	Deliver annual plan.
Risk adjusted forecast.	• Currently the weighted target is £26.23m which is 57.2% of the target. An increase to this is required at pace, supported by the new FEDs.	
	• A weekly report, highlighting movements (particularly in the context of scheme maturity) will be developed and used to ensure 'real time' monitoring.	
Non-delivery of Financial Improvement Programme.	• Given we are only at the beginning of the financial year, this is a risk. However, the actions above with FEDs establishment and de-risking the FIP programme will ensure the continued focus on efficiency delivery.	

Data



Indicator in Focus: Variable Pay

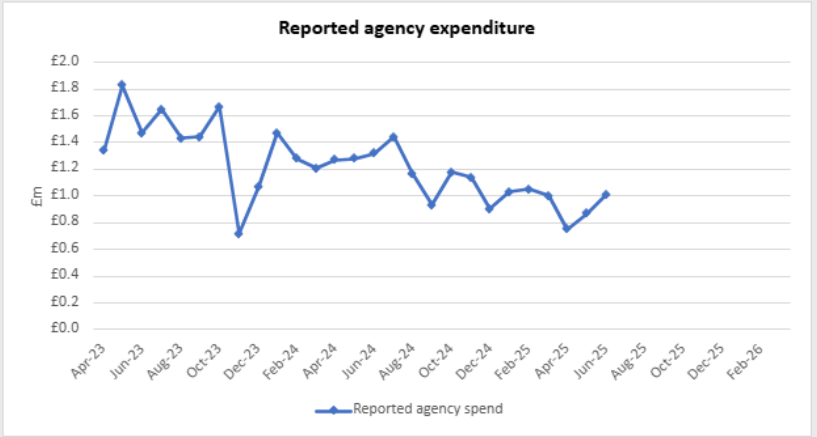
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the planned agency expenditure for 2025/26.
- The Trust has reported agency expenditure of £2.63m YTD; this is £0.27m adverse to the planned level of spend.
- Agency expenditure in accounts for 2.96% of our total pay bill YTD, a reduction from our 2024/25 run rate.
- The 40% agency reduction target for 2025/26 is currently 32% YTD.

Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required 40% reduction in agency expenditure compared to our month eight 2024/25 forecast.	Reduced agency run rate to achieve financial plan.
	• Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews and Divisional Finance Committees.	
	• Medical posts being filled and reviewed at medical specialty groups.	
	• All medical agency bookings that are above cap are reviewed at bi-weekly vacancy control panels. There are still shifts filled over cap, but this has begun to reduce.	
	• From Jul-24, the use of off-framework agencies is not permitted. Any exceptions are to be approved by the Chief Executive Officer. All internal escalation forms have been updated to reflect this.	

Data



Indicators in Focus: Cash and Liquidity

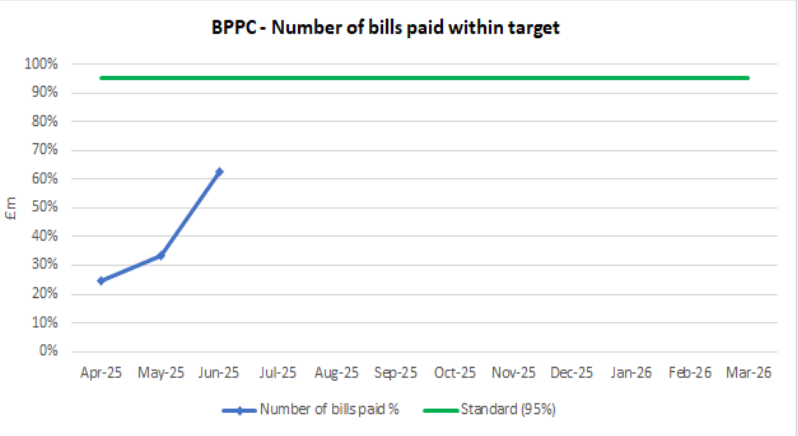
Sherwood Forest Hospitals NHS Foundation Trust

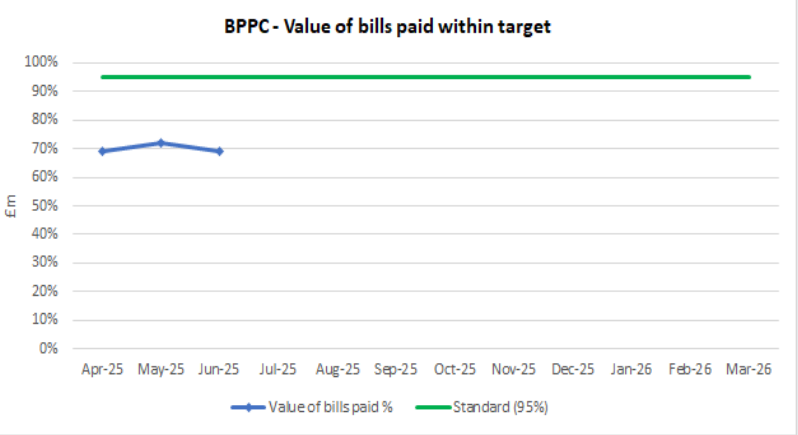
Overview and national position

- The standard is the minimum cash balance (£1.45m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of June-25, cash in bank was £18.07m which is on plan and was above the minimum cash balance.
- The submitted plan for 2025/26 does not require revenue borrowing Public Dividend Capital (PDC), however, there is significant capital PDC £32.93m planned in-year to support the ICB allocation and National schemes.

Root causes	Actions and timescale	Impact
Standard is the plan and the minimum cash balance required by DHSC of £1.45m as part of our support.	• Management of available cash balances to accounts payable payments due. • Prioritisation matrix of supplier payments agreed at the Trust Management Team.	• Requirement to ensure minimum balance is met/ maintained. • Disruption to services if suppliers cannot be paid in a timely manner.
Plan requires significant capital PDC in year £15.23m to support the ICB allocation.	• Capital PDC cash support from DHSC which will be submitted in 2025/26 quarter two.	• Extended payment terms to suppliers. • Failure to achieve Better Payment Practice code (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

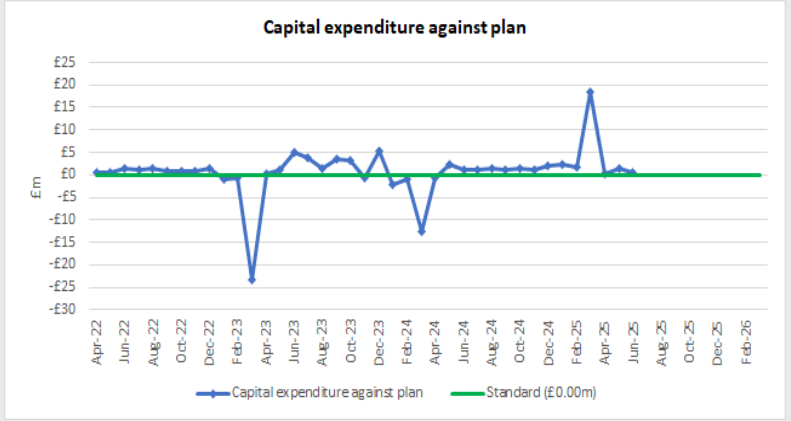
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the 2025/26 Capital Expenditure Plan.
- The plan requires capital borrowing support from the Department of Health and Social Care (DHSC).
- There are known risks due to the value of pre-commitments in the 2025/26 plan.
- Return to Constitutional standards funding requires further supporting submissions in 2025/26 quarter one and detailed monitoring to ensure delivery in-year to plan.

Root causes	Actions and timescale	Impact
Pre-commitments to Trust priorities limiting business as usual capital.	• Monitoring of spend to ensure pre-commitments deliver within plan. • Allocation agreed with ICS partners for 2025/26.	Delivery of Capital Expenditure Plan.
Requirement for Public Dividend Capital (PDC) to support ICB plan £15.23m and National Schemes £17.70m.	• PDC request to be prepared and submitted in 2025/26 quarter two.	Spending at risk without formal approval, impacting available cash to meet revenue payments as they fall due.
Significant national funding for return to constitutional standards for which submissions are required to NHS England.	• Submission of additional information in 2025/26 quarter one to enable Memorandums of Understandings to be issued in quarter two. One case still outstanding to be submitted 25 Jul-25. • Monitoring of in-year spend to ensure delivery to funding envelope.	Overspends impacting in other capital delivery requirements.

Data



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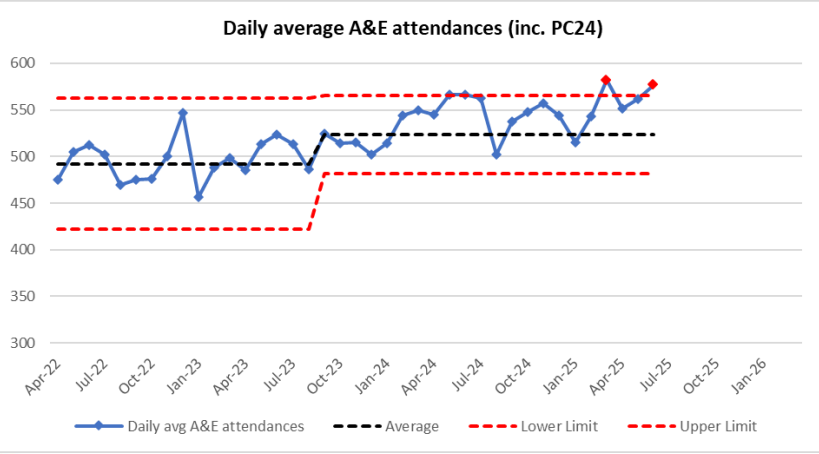
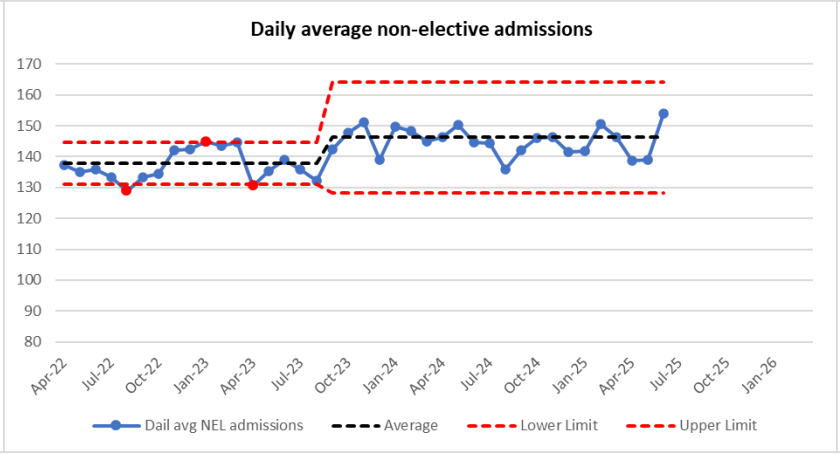
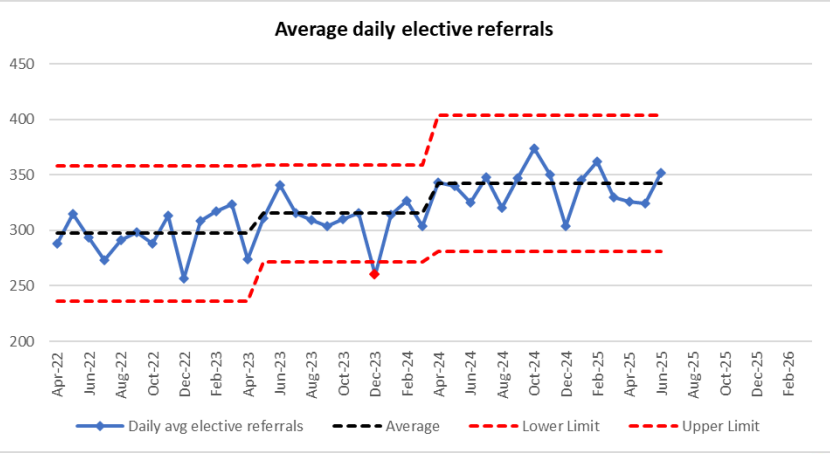
Activity Data and Trends (1/2)

Based on daily averages

At a Glance	Indicator	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD
Urgent Care	A&E attendances (inc. PC24)	547	557	544	515	543	582	552	562	577	547	564
	Non-elective admissions	146	146	141	142	150	146	139	139	154	145	144
Electives	Elective referrals	374	350	304	346	362	330	326	325	352	341	334
	Outpatients - first appointment	349	347	294	327	339	323	318	309	313	347	313
	Outpatients - follow up	889	851	748	875	907	855	849	810	779	852	813
	Outpatients - procedures	278	258	236	287	278	254	257	253	241	265	250
	Day case	126	126	110	127	126	116	114	116	123	122	118
	Elective inpatient	16	15	12	12	13	13	13	14	13	14	14
Diagnostics	Diagnostics	506	514	462	496	518	490	476	464	477	479	472







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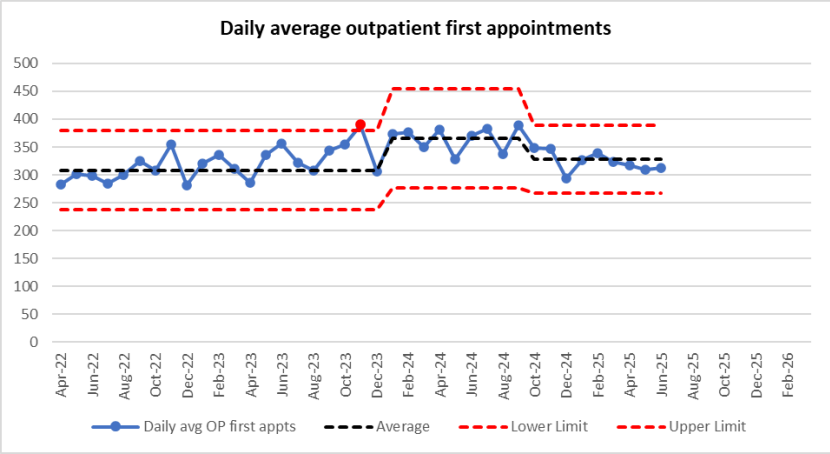
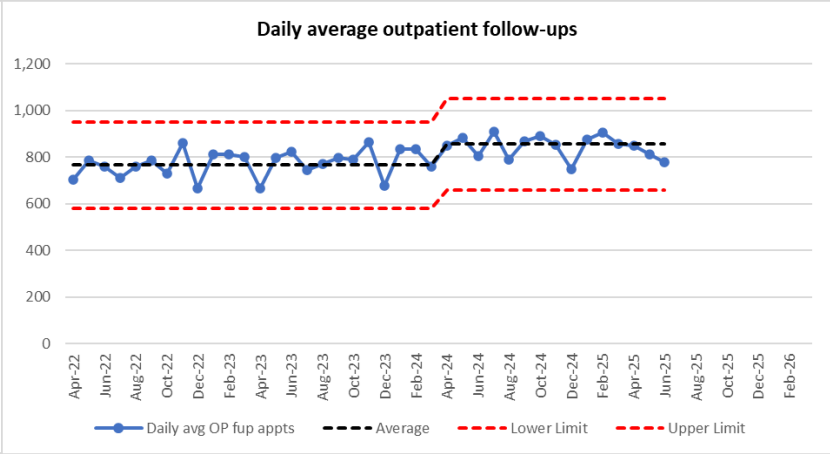
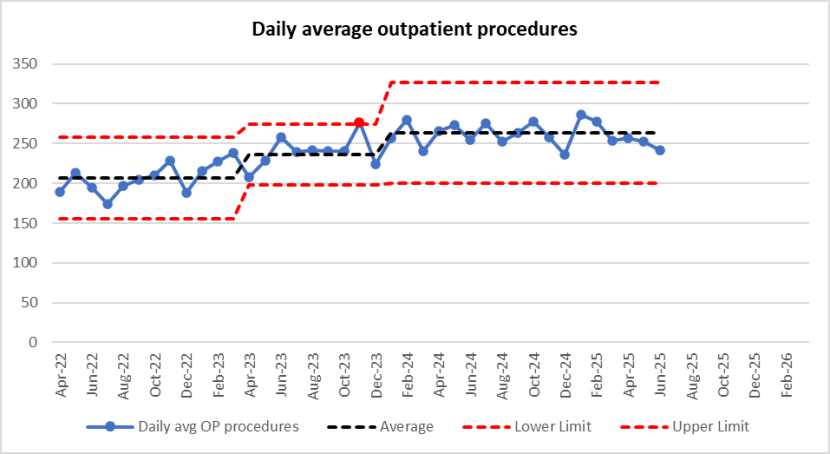
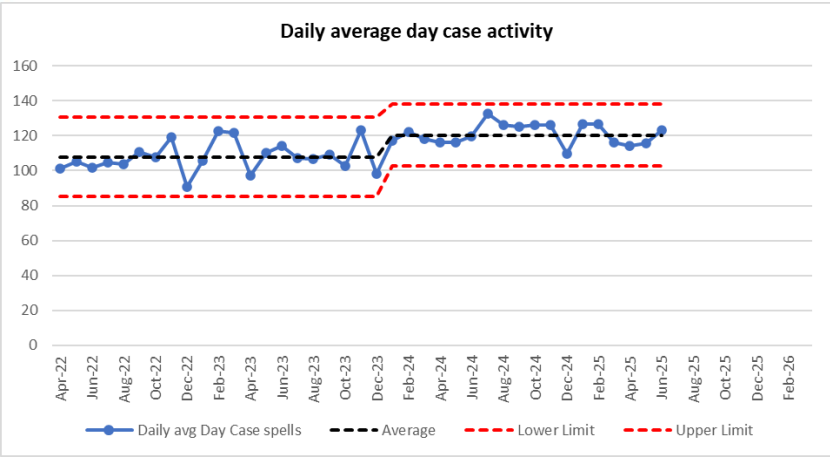
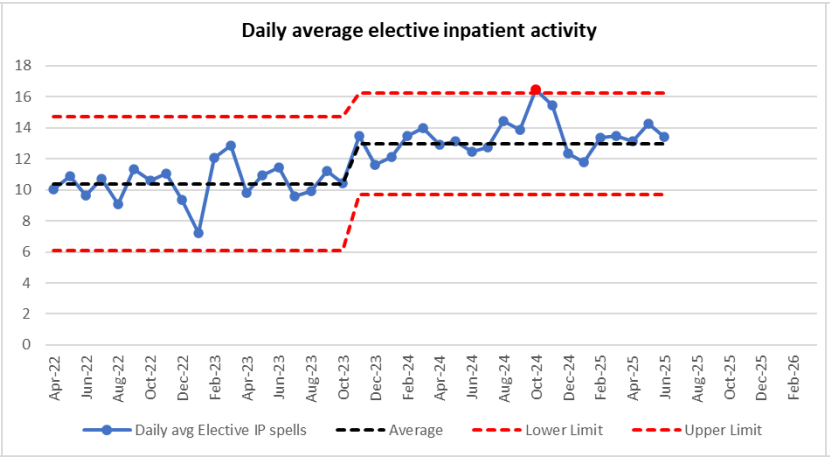
Activity Data and Trends (2/2)

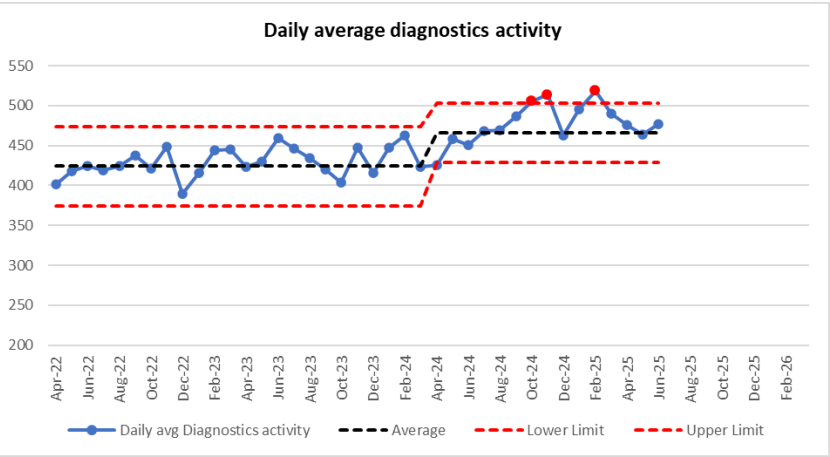












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Appendix A: Integrated Scorecard & Graphs for each indicator

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

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Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

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

How are we different?

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

Why are we different?

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

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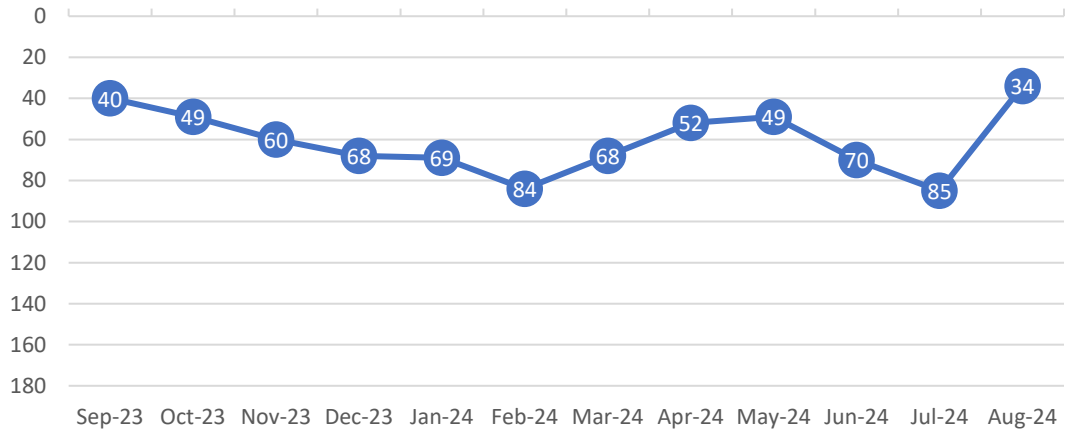
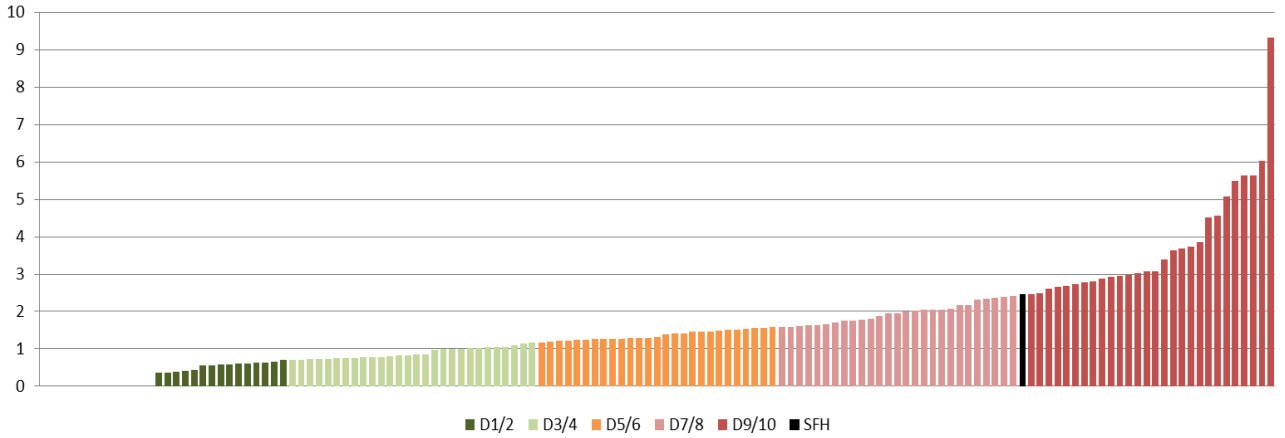
Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



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

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

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

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

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

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Appendix C: Data Quality Indicator Guidance

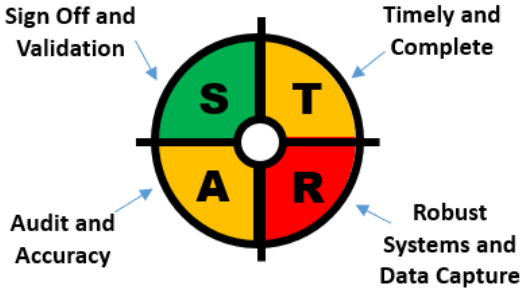
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

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

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

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

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



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

June 2025

Cover Page | Charts | Definitions

Integrated Report

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

Category	At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.9	2.4	3.0	2.4	2.6	2.1	1.7	2.6	1.9		2.1				
		Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 2	✗ 1				
		MRSA reported in month	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0				
		Cdifficile reported in month	≤13 qtr	4	7	4	6	4	5	5	7	5	6	✗ 55	✗ 18				
		Number of gram-negative bloodstream infections reported in month	n/a	No Standard	5	8	0	5	1	5	6	3	6	0	15				
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.2	0.1	0.0	0.1	0.2	0.0	0.1	0.2	0.0	0.1	0.1				
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 6	✓ 0				
		Patient Safety Incident Investigations (PSII) & Duty of Candour	No Standard	No Standard	1	0	2	2	1	0	5	12	9	17	26				
		Percentage of inpatient Service Users undergoing risk assessment for VTE	n/a	≥95%	✗ 92.2%	✗ 91.9%	✗ 82.4%	✗ 80.9%	✗ 82.9%	✗ 86.6%	✗ 87.7%	✗ 86.6%	✗ 86.6%		✗ 87.0%				
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 0.8	✓ 0.8	✓ 0.4	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 0.9	✓ 1.4				
		Compliments received in month	No Standard	No Standard	204	160	147	140	152	184	155	115	141	1831	411				
	Effective	SHMI	As expected	As expected	✓ 106	✓ 106	✓ 106	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 107	✓ 105				
		Still birth rate	≤4.4	≤4.4	✓ 3.4	✗ 10.3	✓ 0.0	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 0.0	✓ 4.3	✓ 2.3				
		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%	-	-	✓ 7.1	-	-	✓ 7.1	-	-	-	✓ 6.9	-				
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✓ 8.0%	✗ 9.5%				
		Time to hire	n/a	≤53.1 days				✓ 49.0	✓ 34.0	✓ 27.0	✓ 23.0	✓ 21.0	✓ 29.0		✓ 24.3				
		Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.7%	✓ 0.5%				
		Appraisals	≥90%	≥90%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 89.0%	✗ 89.6%				
		Mandatory & statutory training	≥90%	≥90%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 91.5%	✓ 92.8%				
		Medical job plan compliance	n/a	≥95%				✗ 57.0%	✗ 86.1%	✗ 76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%		✗ 64.1%				
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.9%				
		Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 35.3%	✗ 43.6%	✗ 47.1%	✗ 47.7%	✗ 47.8%	-	-	-	-	✗ 47.8%	-				
		Employee relations management	<17	<21	✗ 19	✗ 20	✗ 18	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✗ 21	✗ 21				
	New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 7.3%	✓ 7.8%	✗ 9.1%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✗ 8.9%	✓ 6.2%				
		Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 4.0%	✗ 3.0%				
		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%	✗ 45.1%	✗ 43.1%	✗ 48.1%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 52.9%	✓ 37.9%				
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 91.4%	✗ 91.1%				
		Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 0.4%				
		ED 4-hour performance	≥76%	≥Plan	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 71.0%	✓ 77.7%				
		ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.5%	✗ 4.2%	✓ 1.7%	✗ 2.1%	✓ 1.7%	✓ 1.8%	✗ 3.4%	✓ 1.8%				
		Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	16	17	31	26	19	18	21	19	23	58				
		Adult G&A bed occupancy	≤92%	≤92%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 94.5%	✗ 95.1%				
		Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	3.1	3.2	3.0	2.7	3.1	✓ 3.3	✓ 3.0	✗ 3.8		✓ 3.4				
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 57	✗ 56	✗ 59	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 64	✗ 57				
	Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 6.0%	✓ 6.0%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 11.1%	✓ 6.0%	✓ 11.0%				
		Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	62.9%	63.2%	63.8%	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	64.6%	✗ 63.9%				
		Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	2.2%	2.1%	1.7%	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	1.3%	✓ 1.2%				
	Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥95%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✓ 93.1%	✗ 88.9%				
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 79.9%	✓ 78.4%	✓ 76.1%	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	-	✓ 78.3%	✓ 77.0%				
		Cancer 31-day treatment performance	≥Plan	≥96%	✓ 94.3%	✗ 89.8%	✗ 92.4%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	-	✓ 91.9%	✗ 91.2%				
		Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 66.1%	✗ 69.7%	✗ 61.2%	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	-	✗ 64.4%	✓ 64.4%				
Best Value Care	Financial Performance	Financial surplus / deficit	n/a	≥£0.00m							✗ -£0.90	✗ -£0.70	✗ -£0.20		✗ -£1.80				
		Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£0.17	✗ -£0.79	✗ -£0.10	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✓ £0.01	✓ £0.00				
	Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £4.70	✗ -£1.97	✗ -£0.20	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✓ £0.08	✗ -£2.83				
		Risk adjusted efficiency forecast to plan (%)	n/a	100%							✗ 46.5%	✗ 55.0%	✗ 56.6%		✗ 56.6%				
	Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.18	£1.14	£0.90	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£13.70	£2.63				
		Reported bank expenditure	No Standard	No Standard	£2.36	£2.41	£2.61	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£30.55	£5.48				
	Rate of Productivity	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✓ 6.9%	✓ 5.4%	✓ 4.6%	✓ 3.3%	✓ 4.3%	-	-	-	-		-				
	Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%							✗ 24.7%	✗ 33.5%	✗ 62.6%		✗ 47.6%				
		BPPC - Value of bills paid within target	n/a	≥95%							✗ 69.2%	✗ 71.8%	✗ 69.3%		✗ 70.9%				
		Operating expenditure days	n/a	≥5							✓ 16	✓ 16	✓ 13		✓ 13				
	Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£1.41	£1.01	£1.92	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.40	✗ £0.44	✓ £33.58	✗ £1.88				
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)			547	557	544	515	543	582	552	562	577	547	564				
		Non-elective admissions			146	146	141	142	150	146	139	139	154	145	144				
	Electives	Average daily elective referrals			374	350	304	346	362	330	326	325	352	341	334				
		Outpatients - first appointment			349	347	294	327	339	323	318	309	313	347	313				
		Outpatients - follow up			889	851	748	875	907	855	849	810	779	852	813				
		Outpatients - procedures			278	258	236	287	278	254	257	253	241	265	250				
		Day case			126	126	110	127	126	116	114	116	123	122	118				
		Elective inpatient			16	15	12	12	13	13	13	14	13	14	14				
	Diagnostics	Diagnostics			506	514	462	496	518	490	476	464	477	479	472				

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

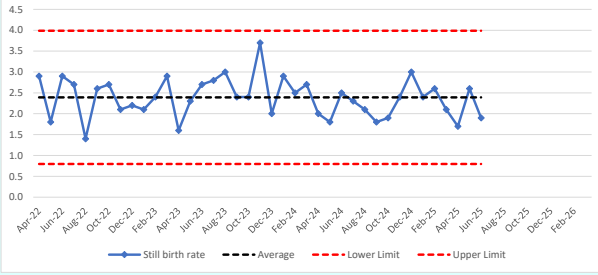
June 2025

Cover Page | Definitions

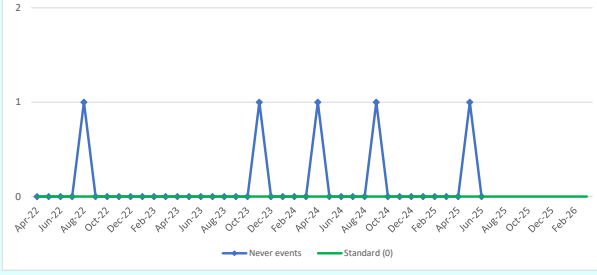
Charts

Quality of Care

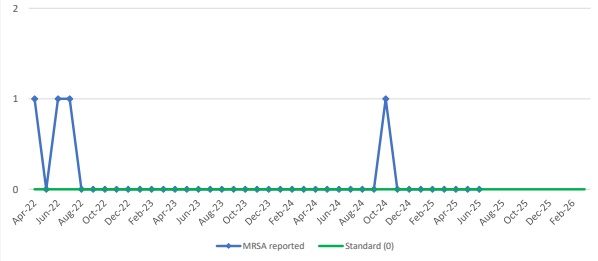
Rate of inpatients to suffer a new hip fracture



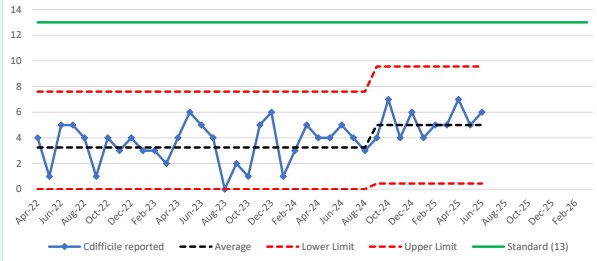
Never events



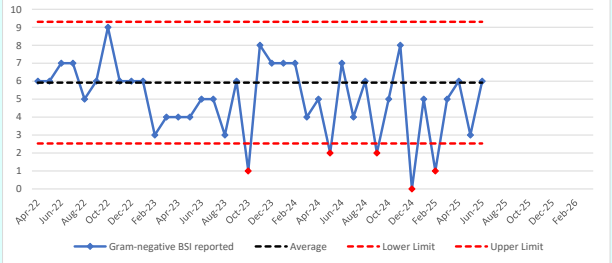
MRSA reported in month



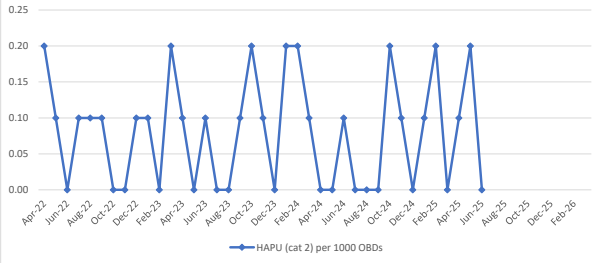
Cdifficile reported in month



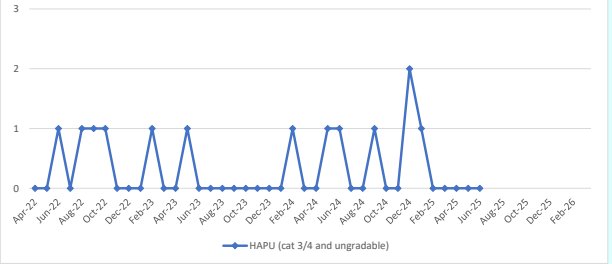
Number of gram-negative bloodstream infections reported in month



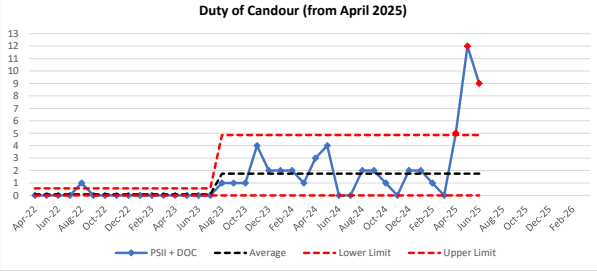
HAPU (cat 2) per 1000 occupied bed days with a lapse in care

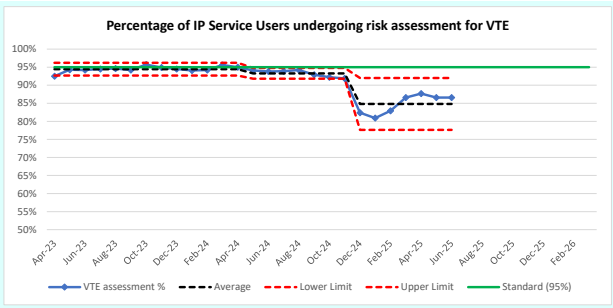


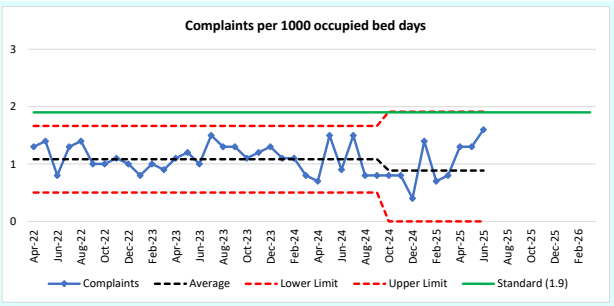
HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care

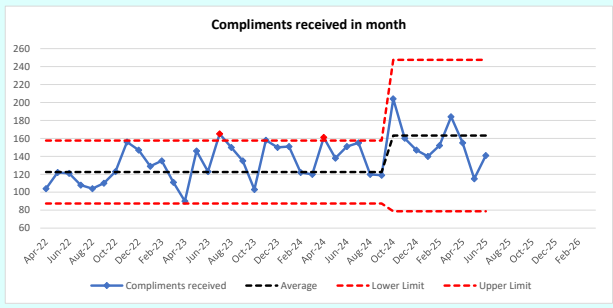


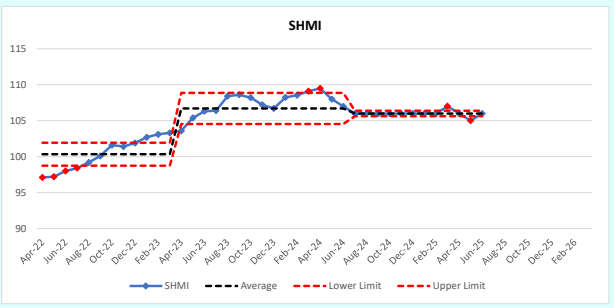
Patient Safety Incident Investigations (PSII) + Duty of Candour (from April 2025)

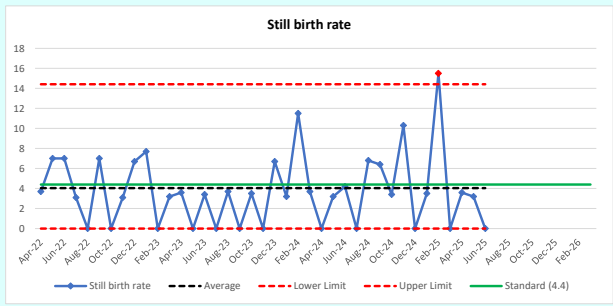


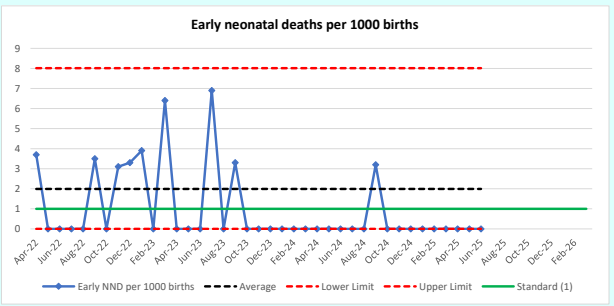

Percentage of IP Service Users undergoing risk assessment for VTE
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
VTE assessment %
Average
Lower Limit
Upper Limit
Standard (95%)


Complaints per 1000 occupied bed days
3
2
1
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Complaints
Average
Lower Limit
Upper Limit
Standard (1.9)


Compliments received in month
260
240
220
200
180
160
140
120
100
80
60
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Compliments received
Average
Lower Limit
Upper Limit

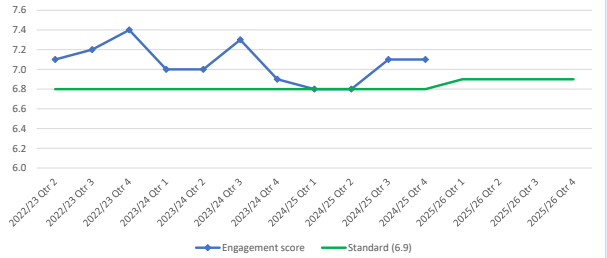

SHMI
115
110
105
100
95
90
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
SHMI
Average
Lower Limit
Upper Limit


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

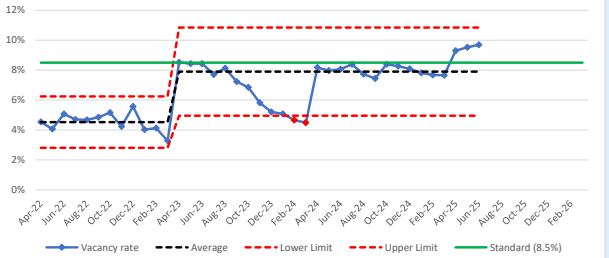

Early neonatal deaths per 1000 births
9
8
7
6
5
4
3
2
1
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard (1)

People and Culture

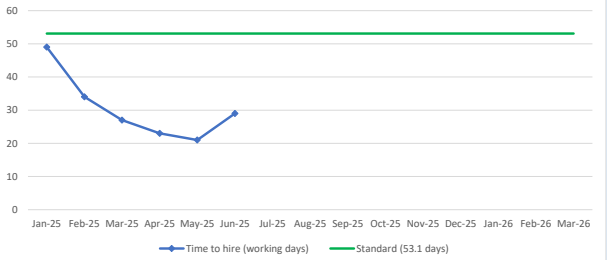
Engagement score



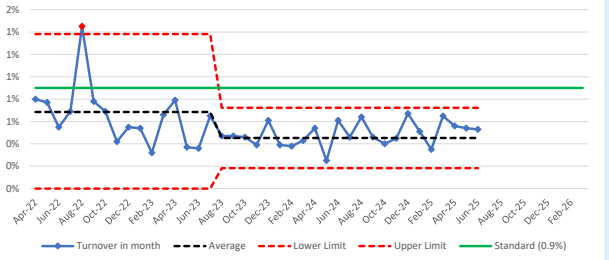
Vacancy rate



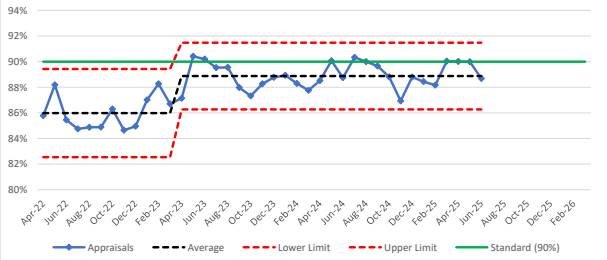
TIme to hire



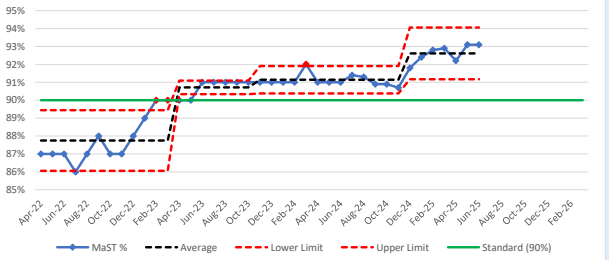
Turnover in month



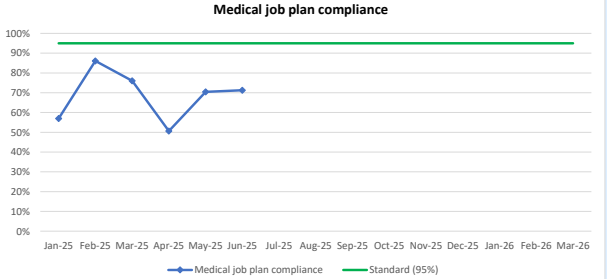
Appraisals



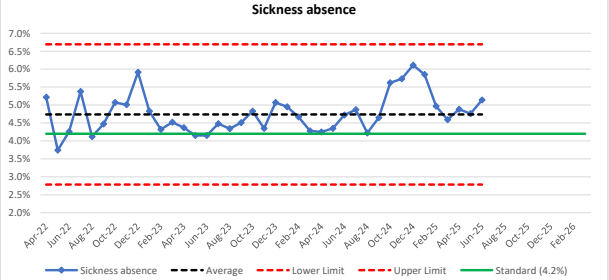
Mandatory & statutory training



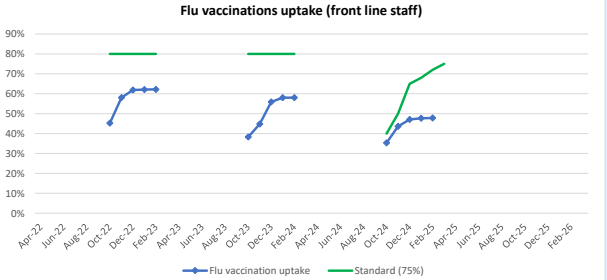
Medical job plan compliance



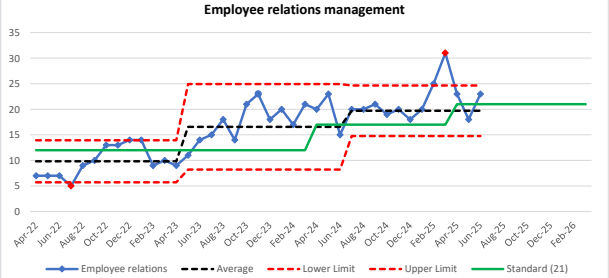
Sickness absence

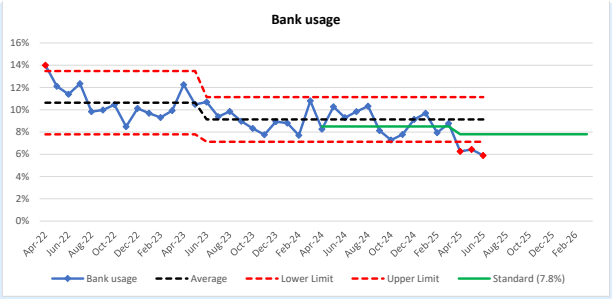


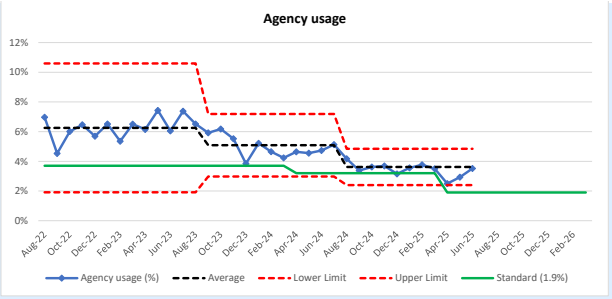
Flu vaccinations uptake (front line staff)

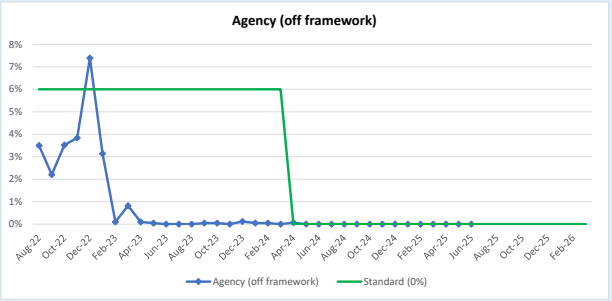


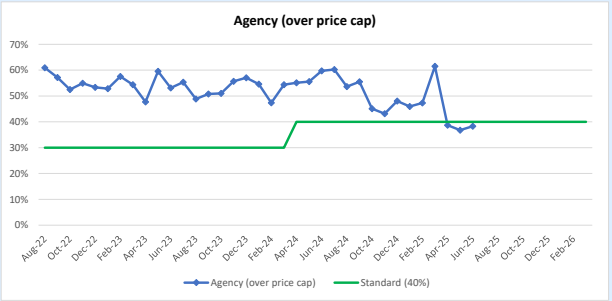
Employee relations management




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

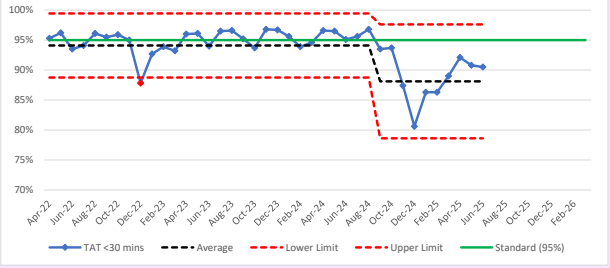

Agency usage
12%
10%
8%
6%
4%
2%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency usage (%)
Average
Lower Limit
Upper Limit
Standard (1.9%)


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

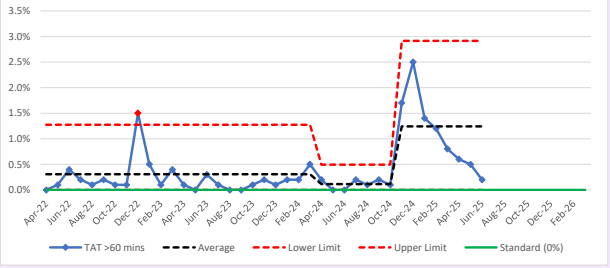

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency (over price cap)
Standard (40%)

Timely Care

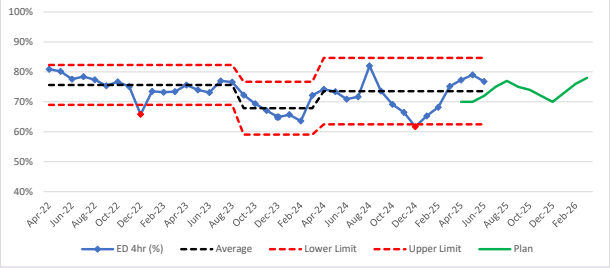
Ambulance turnaround times <30 mins



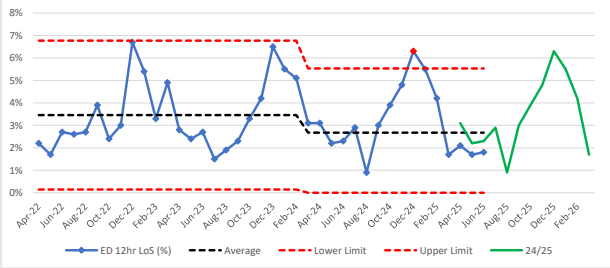
Ambulance turnaround times >60 mins



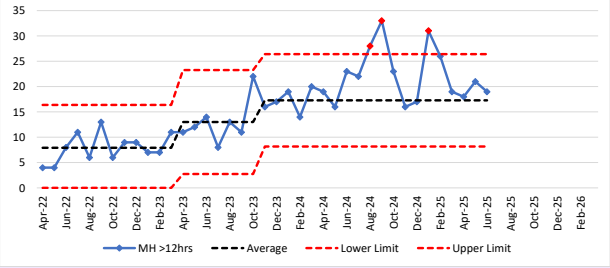
ED 4-hour performance



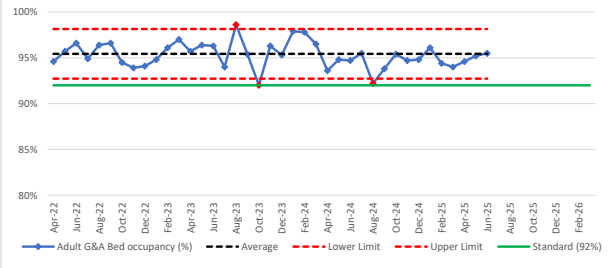
ED 12-hour length of stay performance



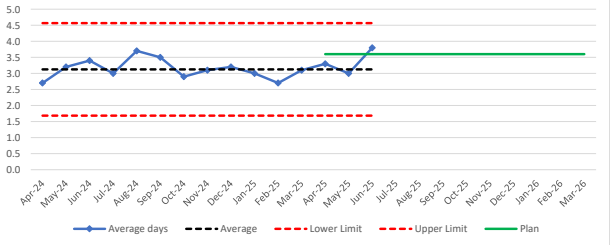
Mental health patients spending over 12 hours in A&E



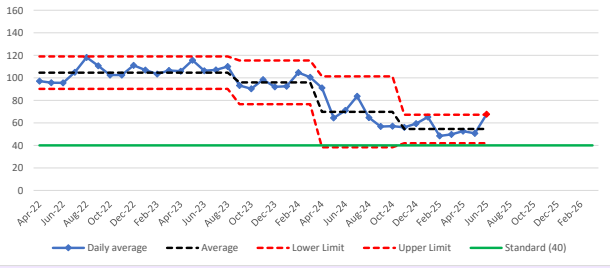
Adult G&A bed occupancy

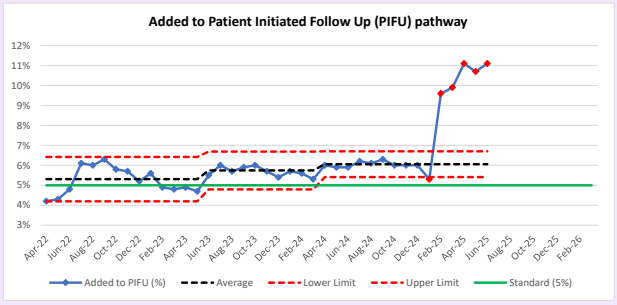


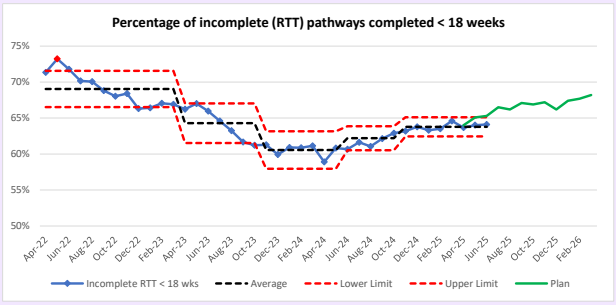
Average number of days between planned and actual discharge date (excluding patients with 0 day delay)

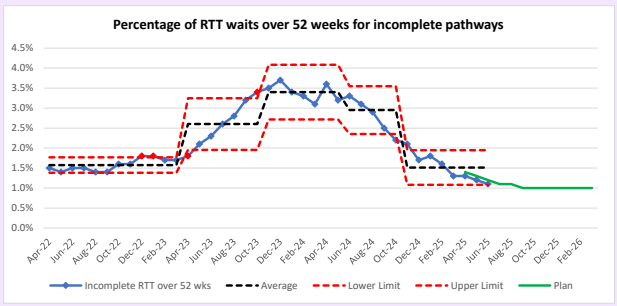


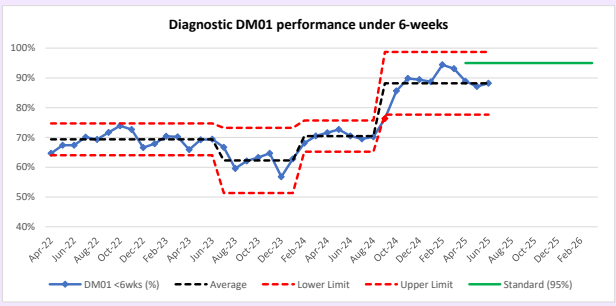
Inpatients medically safe for transfer for greater than 24 hours

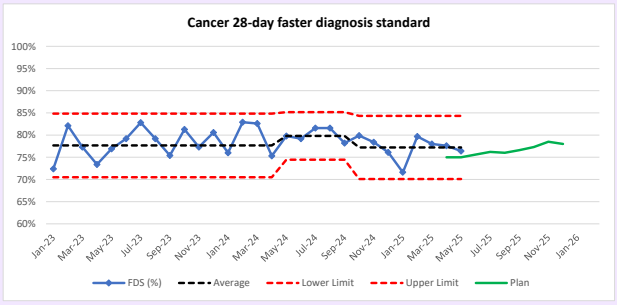


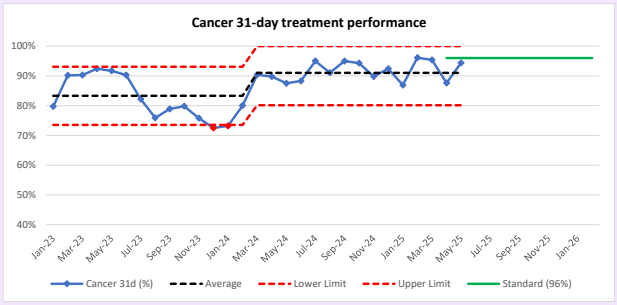

Added to Patient Initiated Follow Up (PIFU) pathway
Added to PIFU (%)
Average
Lower Limit
Upper Limit
Standard (5%)

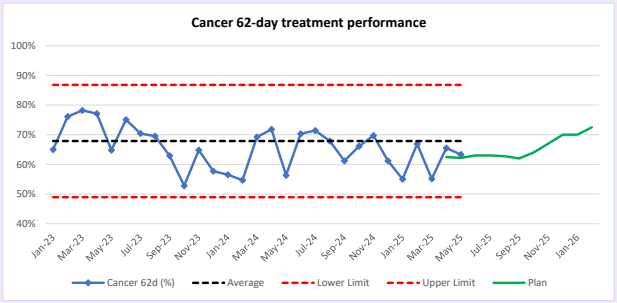

Percentage of incomplete (RTT) pathways completed < 18 weeks
Incomplete RTT < 18 wks
Average
Lower Limit
Upper Limit
Plan


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


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

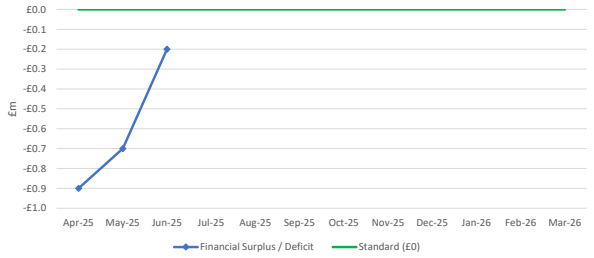

Cancer 28-day faster diagnosis standard
FDS (%)
Average
Lower Limit
Upper Limit
Plan


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

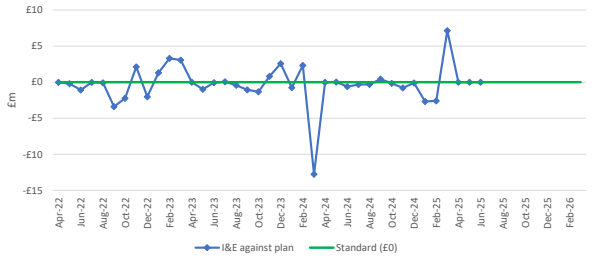

Cancer 62-day treatment performance
Cancer 62d (%)
Average
Lower Limit
Upper Limit
Plan

Best Value Care

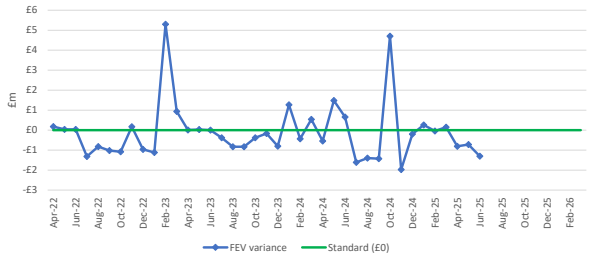
Financial Surplus / Deficit



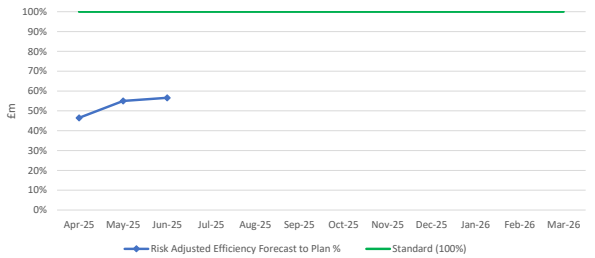
Variance YTD to financial plan



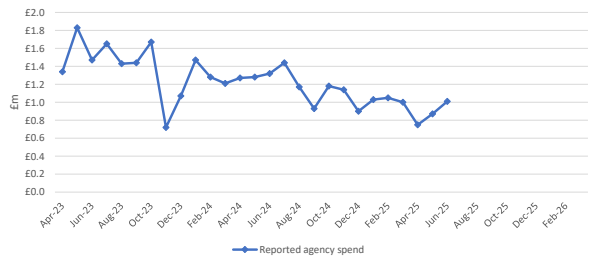
Financial efficiency variance YTD to plan



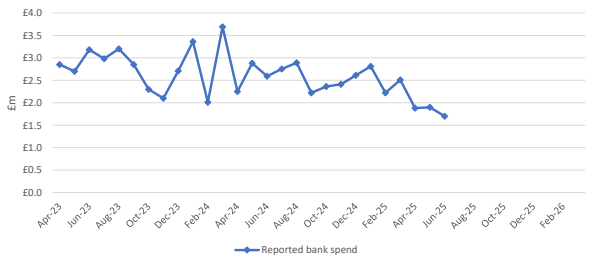
Risk adjusted efficiency forecast to plan (%)



Reported agency expenditure

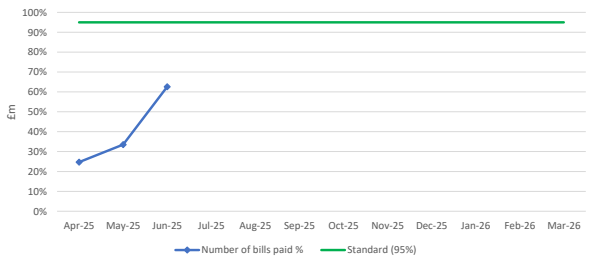


Reported bank expenditure

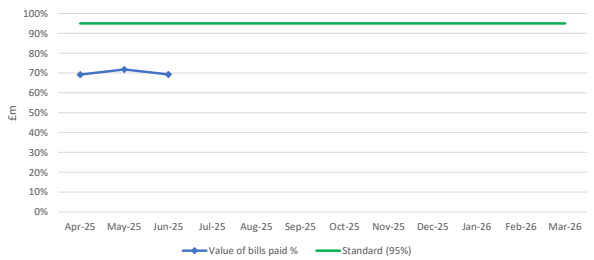


Implied productivity growth (YTD compared to last year)

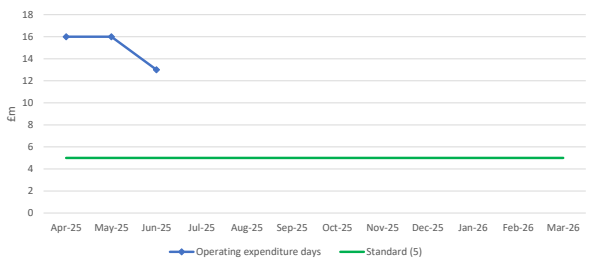
BPPC - Number of bills paid within target



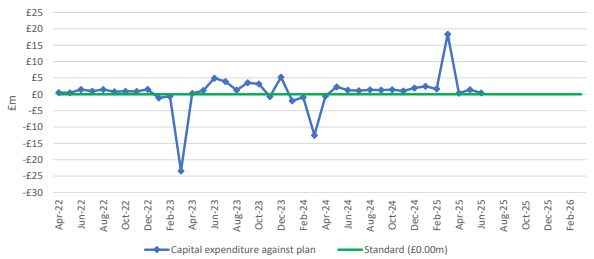
BPPC - Value of bills paid within target



Operating expenditure days

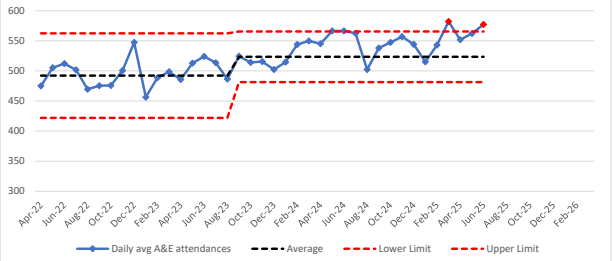


Capital expenditure against plan

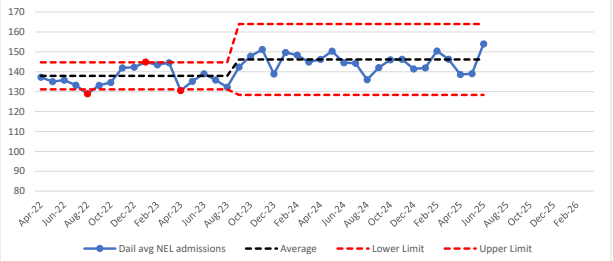


Activity (for context)

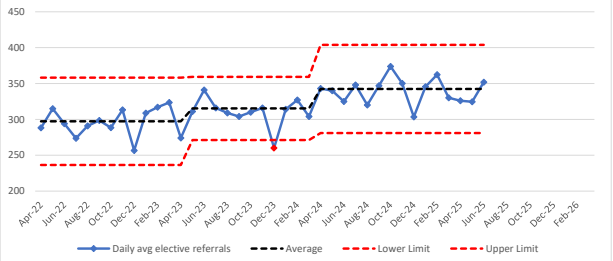
Daily average A&E attendances (inc. PC24)



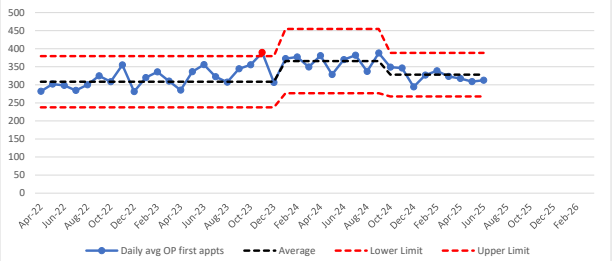
Daily average non-elective admissions



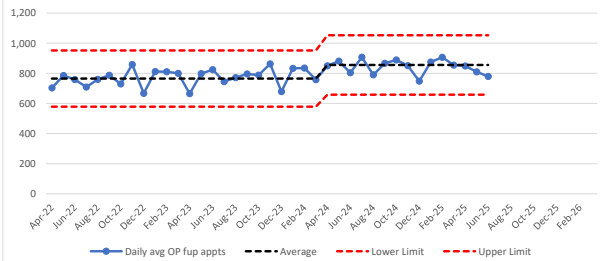
Average daily elective referrals



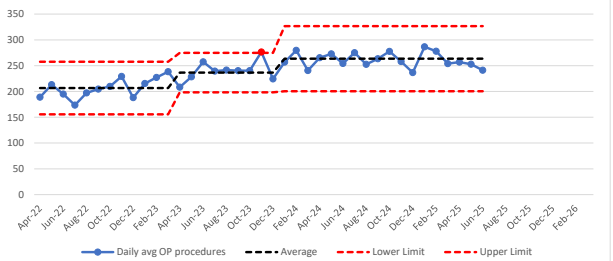
Daily average outpatient first appointments



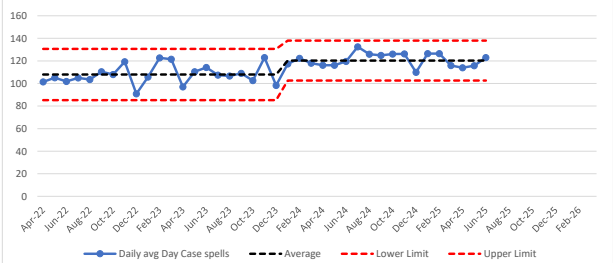
Daily average outpatient follow-ups



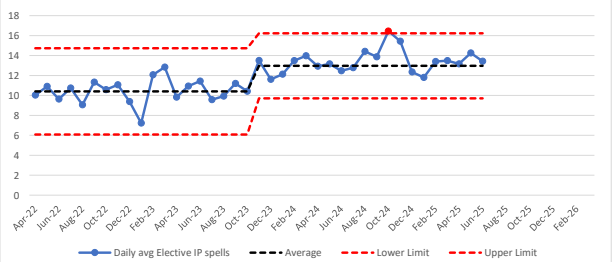
Daily average outpatient procedures



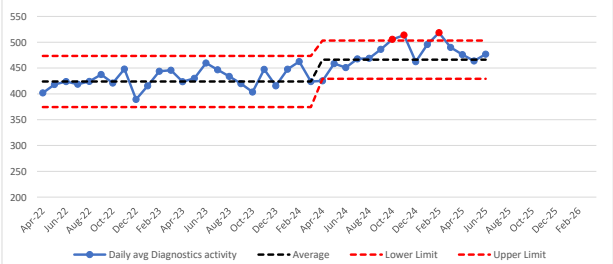
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

June 2025

Timely Care Benchmarking

Apr-25

At a Glance	Indicator	Source	Rate	Rank	Of	Decile
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	92.5%	24	175	2
	Ambulance turnaround times >60 mins	Summary Emergency Department Indicator Table (SEDIT)	0.5%	31	175	2
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	77.3%	51	141	4
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	2.6%	24	175	2
	SDEC rate	Summary Emergency Department Indicator Table (SEDIT)	34.3%	101	180	6
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	92.8%	68	179	4
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	10.6%	4	134	1
	Incomplete RTT pathways +52 weeks	RTT waiting times data	1.2%	50	152	4
	Incomplete RTT pathways +65 weeks	RTT waiting times data	0.1%	99	152	7
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	88.9%	45	136	4
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	77.6%	71	132	6
	Cancer 31-day treatment performance	Cancer Waiting Times standards	87.6%	112	132	9
	Cancer 62-day treatment performance	Cancer Waiting Times standards	65.5%	102	132	8

Sherwood Forest Hospitals NHS Foundation Trust

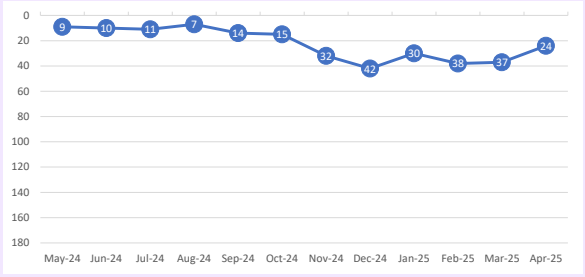
Integrated Performance Report 2025/26

June 2025

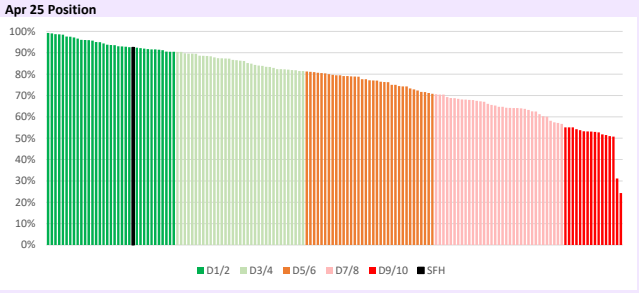
Timely Care Benchmarking Charts

Timely Care Benchmarking

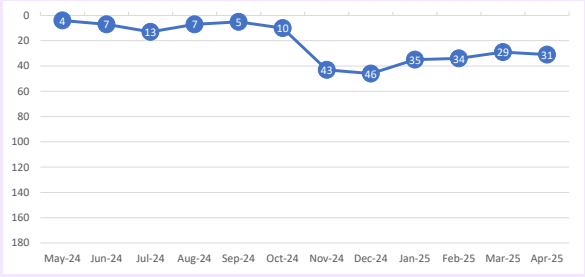
Ambulance turnaround times <30 mins



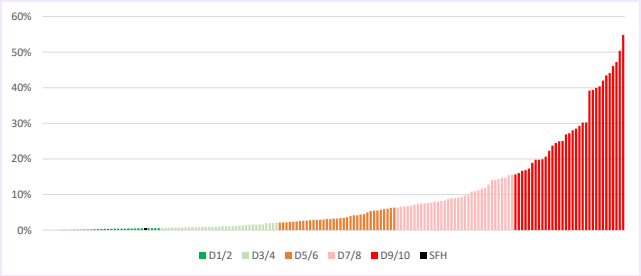
Apr 25 Position



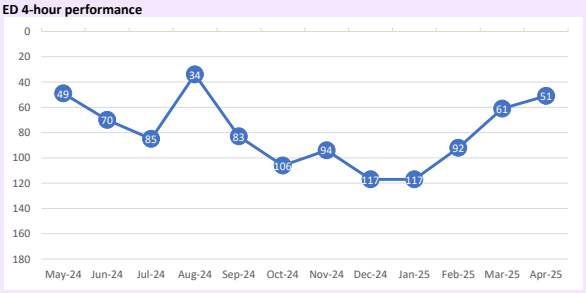
Ambulance turnaround times >60 mins



Apr 25 Position



ED 4-hour performance



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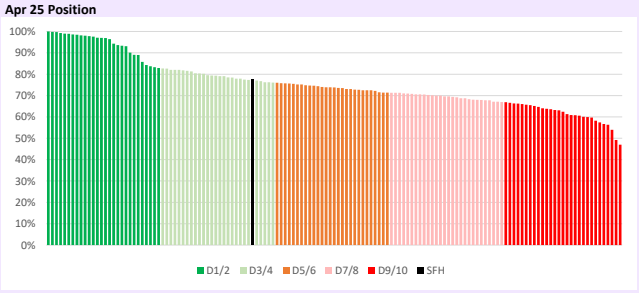
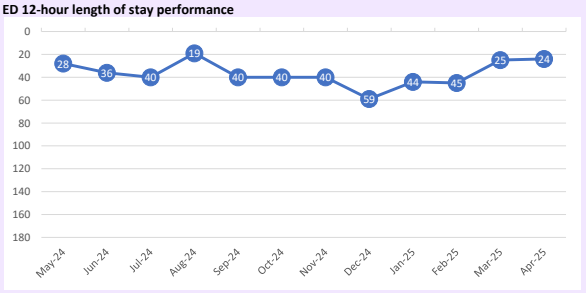


ED 12-hour length of stay performance



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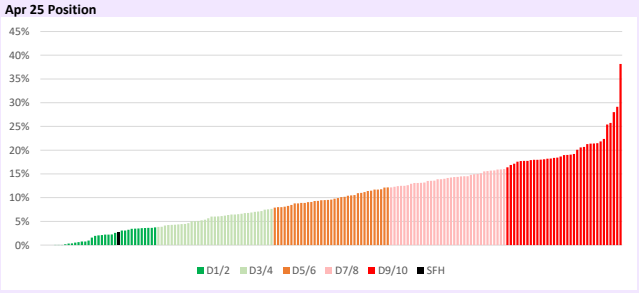
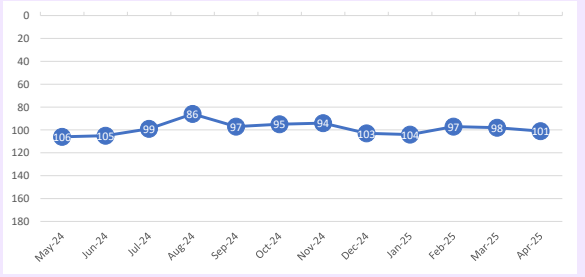


SDEC rate



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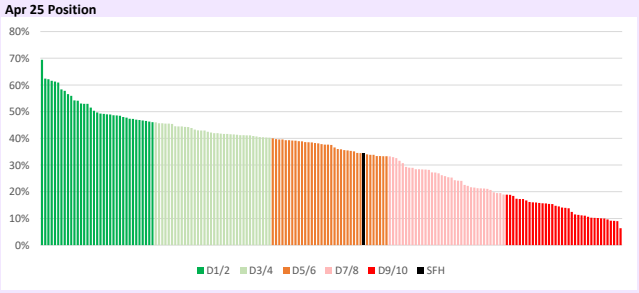
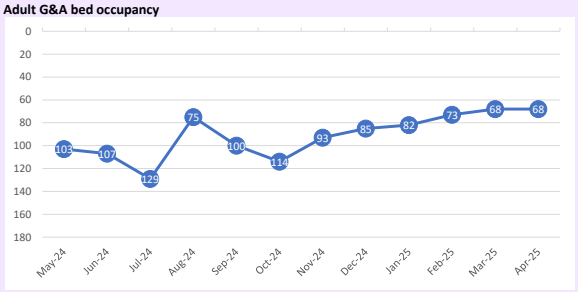


Adult G&A bed occupancy



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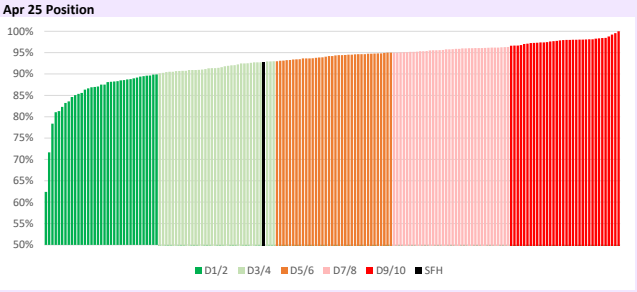
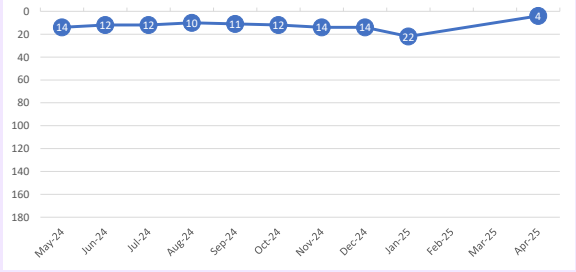


Added to Patient Initiated Follow Up (PIFU) pathway



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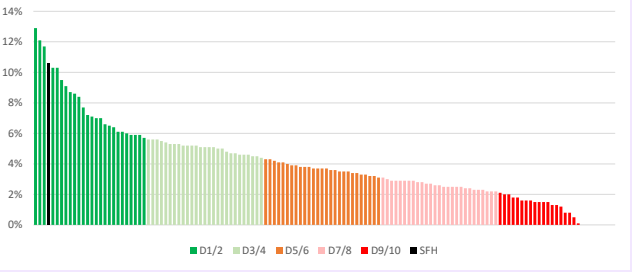
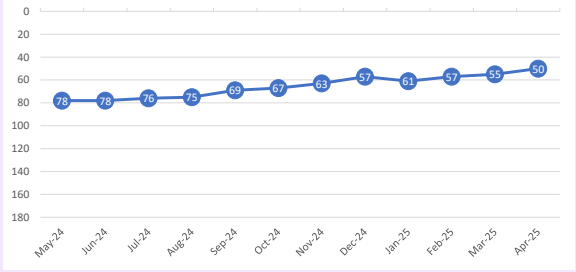


Incomplete RTT pathways +52 weeks



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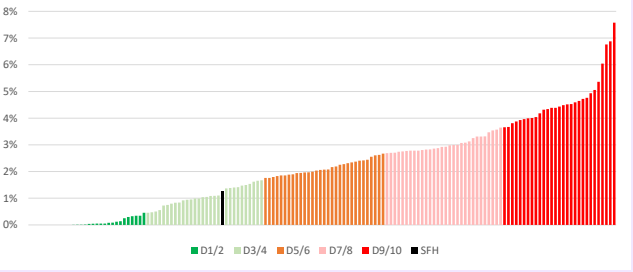
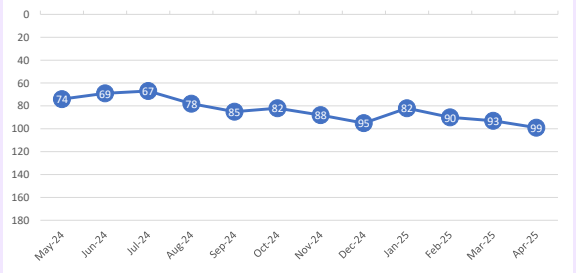


Incomplete RTT pathways +65 weeks



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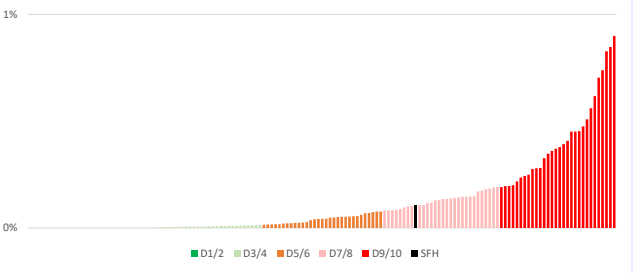
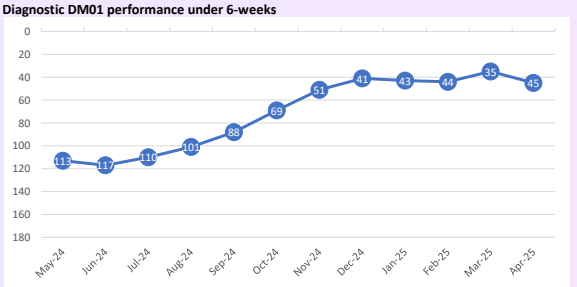


Diagnostic DM01 performance under 6-weeks



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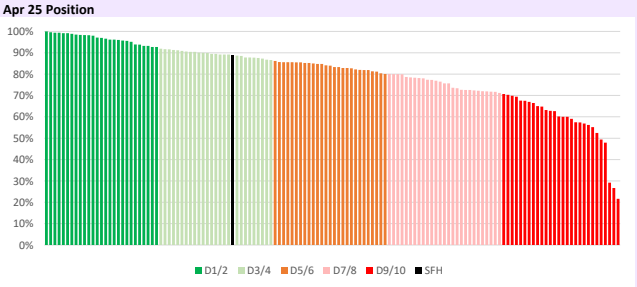
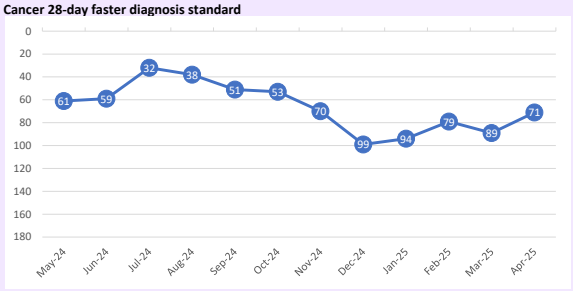


Cancer 28-day faster diagnosis standard



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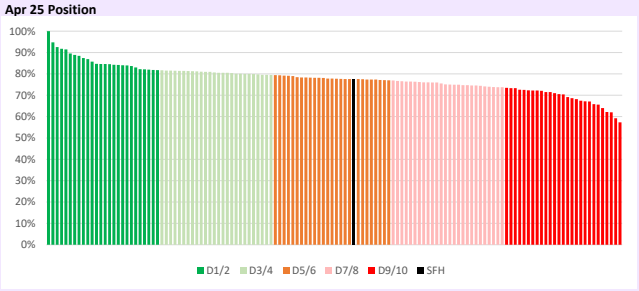
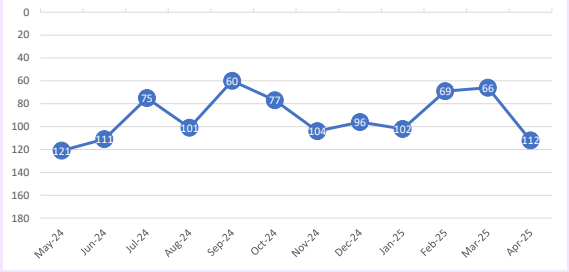


Cancer 31-day treatment performance



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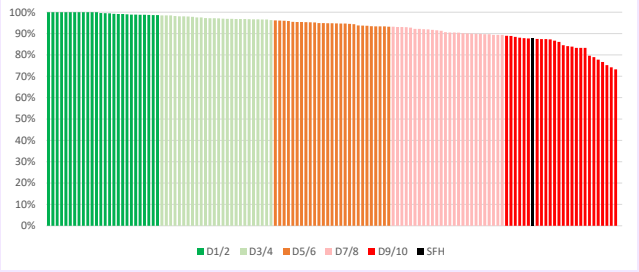
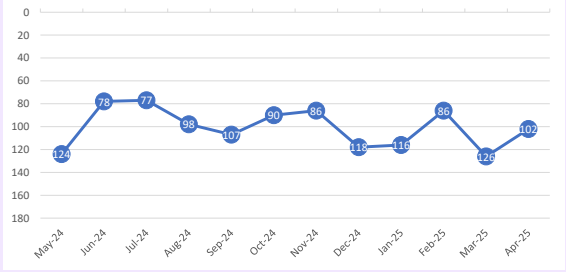


Cancer 62-day treatment performance



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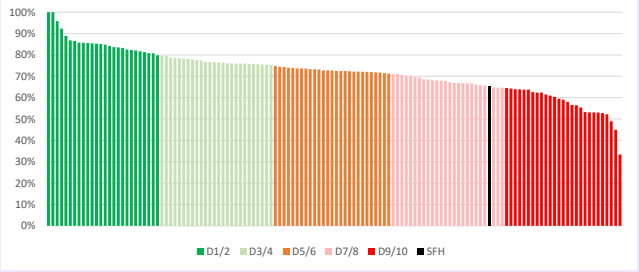

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Draft Winter Plan	**Date:**	7 August 2025
Prepared By:	Mark Bolton, Associate Director of Operational Performance		
Approved By:	Simon Illingworth, Chief Operating Officer		
Presented By:	Mark Bolton, Associate Director of Operational Performance		

Purpose

Trust Board is requested to review and approve the work completed to date on our draft 2025/26 Winter Plan.	**Approval**	✓
	Assurance	
	Update	
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Draft considered by: Trust Management Team and Winter Planning Group.

Acronyms

CARE: SFH values (Communicating and working together; Aspiring and improving; Respectful and caring; Efficient and safe).
CRE: Carbapenem-Resistant Enterobacterales
D&V: Diarrhoea and Vomiting
EMAS: East Midlands Ambulance Service
GP: General Practitioner
NEMS: Nottingham Emergency Medical Services (provider)
SFH: Sherwood Forest Hospitals NHS Foundation Trust

All other acronyms are defined within the paper.

Executive Summary

The attached presentation describes our key principles and approach to Winter Planning at SFH in 2025/26 and is based on the Integrated Emergency Management approach structured under the four headings:

1. Anticipate and assess
2. Prevent
3. Prepare
4. Respond and recover.

Our Winter Plan has been developed with engagement across corporate and divisional teams via our Winter Planning Group. We have learnt from previous years and incorporated learning into our plan. Outputs of our annual bed modelling exercise are presented together with proposed mitigations; some of which remain in the development phase. The proposed schemes represent the current 'best offer' available and together with some exceptional actions (such as running bed occupancy at 96%) leave us with a small residual peak bed gap of 10 beds in Jan-26 against our nominal state. This level of gap should be able to be mitigated through the deployment of escalation actions. Successful delivery of the plan would allow elective operating to continue over Winter and patient outlying would be reduced.

Summary information is also presented around vaccination plans, our communications approach, areas of system focus, and escalation and contingency plans.

It should be noted that our Winter Plan will continue to evolve, and it forms part of a wider process across the Integrated Care System (ICS) which is not yet complete.

Trust Board is asked to note the progress in developing our 2025/26 Winter Plan and approve work completed to date. Work will continue to develop, refine, operationalise and monitor the plan. Specific Christmas and New Year plans will be developed in Nov-25 and early Dec-25.

We have a Board Assurance Statement (please see appendix A) to be completed and returned to NHS England on 30 Sep-25. This will be completed and shared with Trust Board together with a copy of the final Winter Plan on 2 Oct-25.

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Winter Plan 2025/26

This document describes the development of the SFH winter plan for 2025/26 to date.

August 2025

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Key Principles for Winter Planning

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised, and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (inc. Covid-19)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment due to infectious disease outbreaks e.g. Influenza, Covid-19, Strep A, Norovirus, Carbapenem-resistant Enterobacterales (CRE) etc.

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Approach to Winter Planning

SFH winter plan based on the Integrated Emergency Management approach:

1. **Anticipate and assess** issues in maintaining resilient services:
    - Key winter pressure drivers identified – likely epidemiology of winter 2025/26
    - Lessons learned from 2024/25
    - Demand modelled
    - Risks identified
2. **Prevent** the likelihood of occurrence and effects of any such issues:
    - Prevent and manage infection including vaccination and patient/staff testing
    - Effective population, patient and staff communications (system approach)
3. **Prepare** by having appropriate mitigating actions, plans and management structures in place:
    - Mitigating actions and flow priorities inc. staff and support service plans; staff well-being
    - Extent to which elective activity is protected, and patient outlying is reduced
    - Specific plans for Christmas and New Year period
4. **Respond and recover** by enacting plans and contingencies as required:
    - Escalation triggers and actions
    - Contingency plans for surges in demand beyond anticipated levels in our ‘nominal’ state.

Key Winter Pressure Drivers

Traditionally, key drivers for our winter pressures relate to:

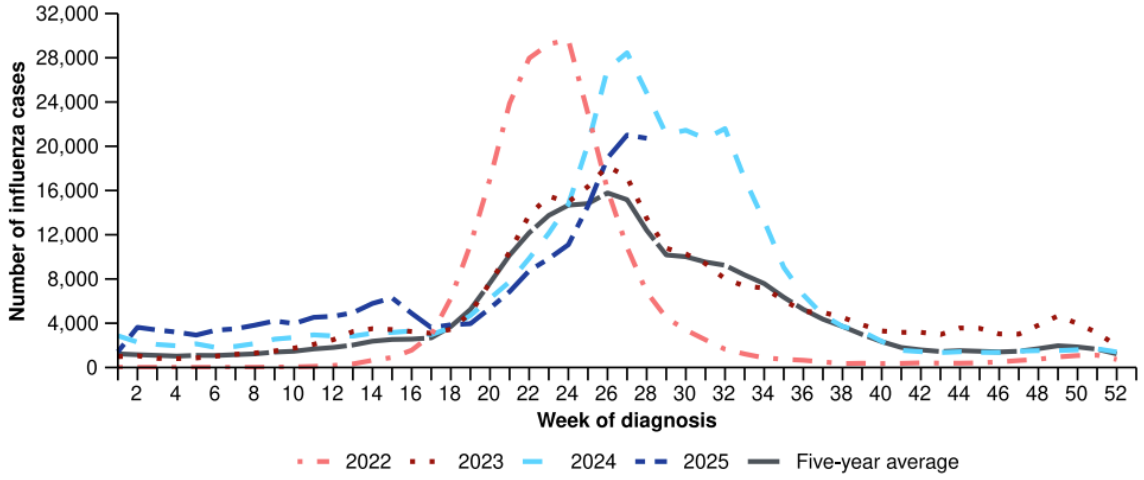
- Higher acuity as evidenced by National Early Warning Scores (NEWS2) leading to longer hospital average length of stay
- High prevalence of influenza
- Increase in attendance/admissions in Respiratory (inc. Respiratory Syncytial Virus) and Healthcare of the Elderly
- Increase instances of infection (norovirus, D&V, CRE etc)
- Increase in number of beds occupied for patients that have been medically safe for transfer (MSFT) for greater than 24 hours awaiting discharge

In the ‘living with Covid-19’ era there is a degree of uncertainty around what the epidemiology of winter may be like in 2025/26.

We will learn from the Southern Hemisphere.

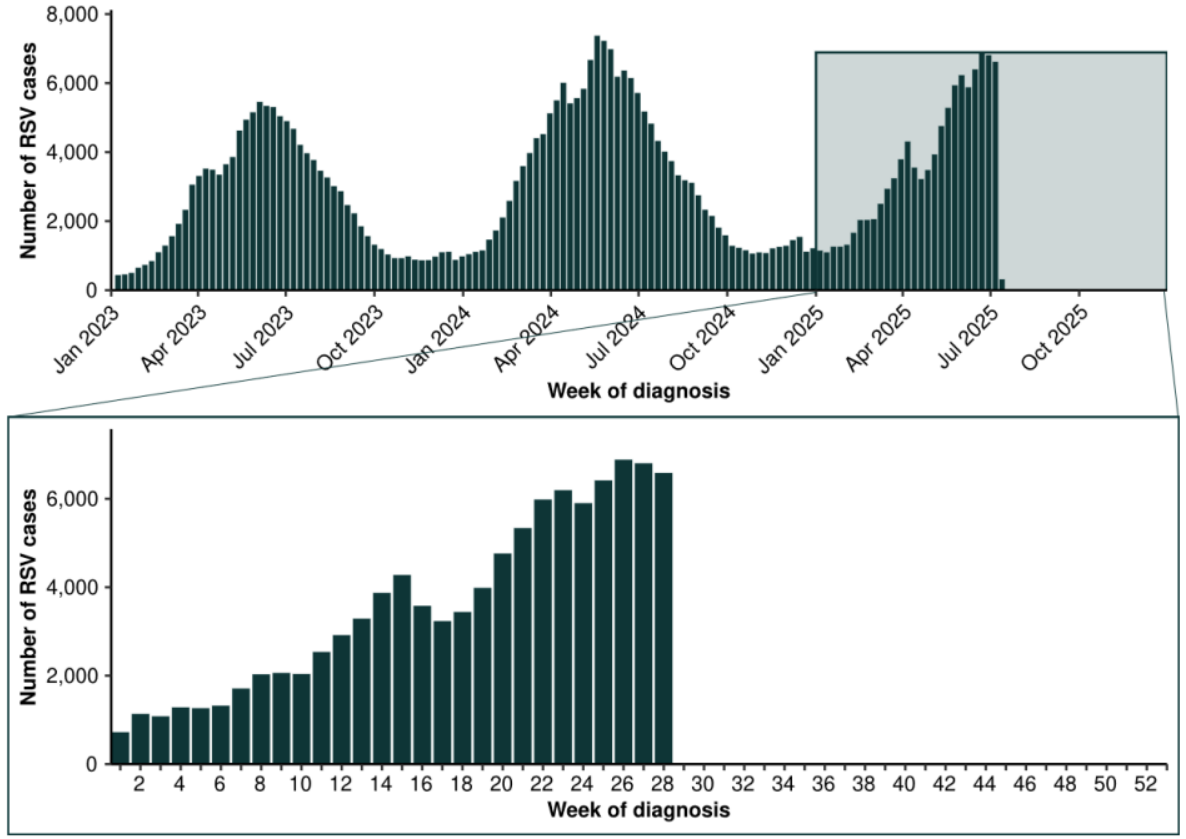
Australia Influenza Season

Figure 4: Notified influenza cases and five-year average* by year and week of diagnosis, Australia, 2022 to 13 July 2025



- In Australia they have seen:
  - Influenza tracking higher in 2025 in the 'off-peak' period than previous year. The main peak marginally later and at a lower level than 2024
  - RSV tracking at similar levels to 2024 and higher than 2023
- Current modelling assumes equivalent levels and timing to winter 2024/25.

Figure 8: Notified RSV cases by year and week of diagnosis*, Australia, 2023 to 13 July 2025



Source: Australian Respiratory Surveillance Report

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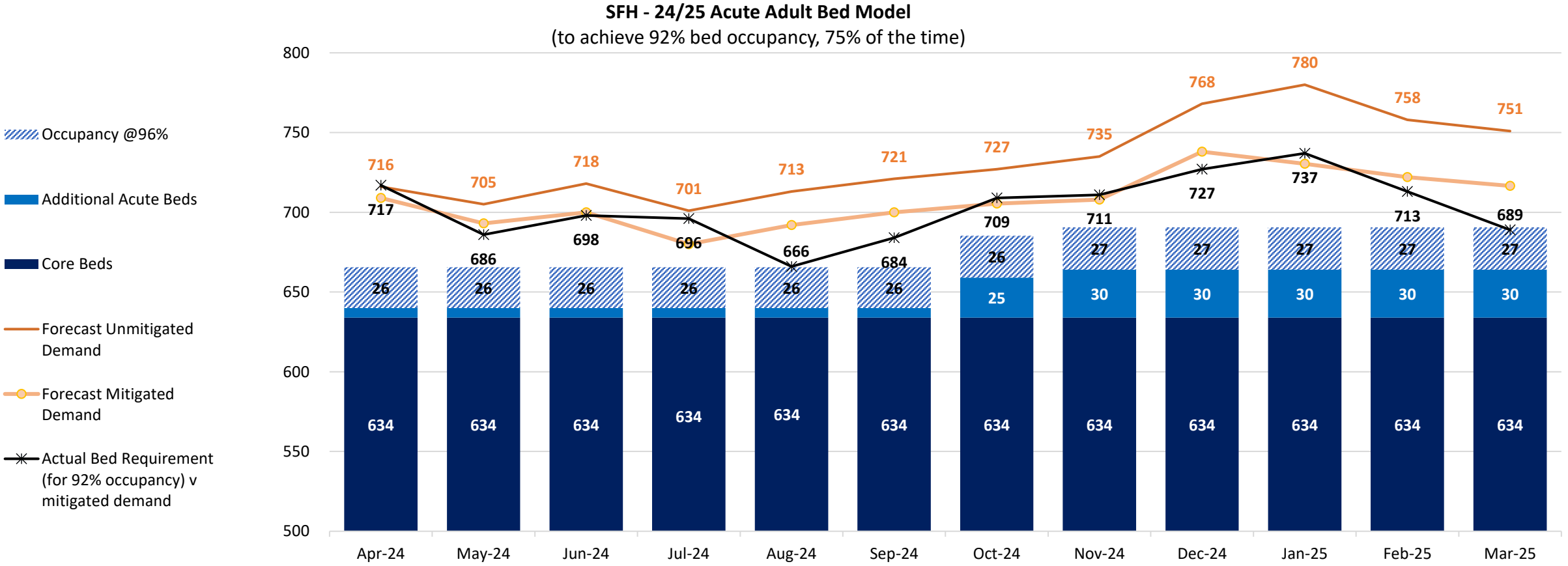
Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2024/25 Bed Model



Actual bed requirement (black line) tracked closely to forecast mitigated demand (light amber line) providing confidence in our modelling.

Variance in Aug-24 was driven by lower-than-expected admission demand. Mar-25 was driven by reduced length of stay mainly for >65-year-olds.

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Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

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Reflecting on our 2024/25 Spend

- The winter reserve for 2024/25 was £2,364,200 of which £2,276,800 was to spend over the winter period (£87.4k spent in Apr-24)
- £1.71m spent between Oct-24 and Mar-25 against a plan of £2.27m
- The underspend was driven by:
  a) Two large schemes were not able to be mobilised in line with the original plan:
     1. Expansion of surgical Same Day Emergency Care (SDEC)
     2. Surgical day case overnight use
  b) Two approved schemes were not mobilised:
     1. Cardiology afternoon Percutaneous Coronary Intervention (PCI)
     2. Bridging of packages of care over Christmas and New Year

  Staffing challenges were the primary reason for the difficulty in mobilising all schemes
- As a result of the curtailment of some schemes, circa £562k was returned to support Trust financial bottom line.

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Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Reflecting on our 2024/25 Schemes

Scheme evaluations have taken place for all non-bedded schemes. A summary is below:

Seek to mainstream as business as usual (if not, repeat/modify for 2025/26)

- **Complex endoscopy pathway improvement.** *Uplifted a Nurse to become a Specialised Nurse for clinical vetting and pre-op. Qualitative feedback strong.*
- **Orthogeriatric resident doctors.** *This scheme provided cover during periods of leave for existing resident doctors and helped reduce Hospital Out of Hours requests and reduced length of stay in the patient cohort.*
- **Acute Frailty Unit/Frailty Same Day Emergency Care (SDEC).** *Part of geriatrics transformation business case. Supported timely geriatric reviews and reduced cohort length of stay.*
- **Additional weekend Consultant on Short Stay Unit (SSU).** *Looking to mainstream dedicated weekend SSU Consultant until 16:00 (instead of finishing at 12 noon).*
- **Additional Radiology support.** *Looking to mainstream keeping X-Ray open an extra hour (until 6pm) during weekdays.*

Repeat in Winter 2025/26

- **Doubling of respiratory physicians at weekends.** *Mobilised for the past 3-years and supports increased seasonal demand in this specialty. Increased weekend discharges across wards 21 and 43 over winter.*
- **Weekend trauma theatre operating lists.** *Provision of additional trauma capacity over the winter period added value, improved patient experience and reduced bed demand by treating patients sooner.*
- **Children's Assessment Unit (CAU) increased opening hours.** *Reviewing year-round opening; however, will still be need to expand further over winter to meet seasonal demand and support our Emergency Department (ED). Mobilised for the past 2-years and supported increased admissions to CAU from both GPs and ED.*
- **Bedded schemes.** *Schemes to seasonally increase our bed base were enacted fully over winter with all beds well utilised. It is recognised that the seasonal use of additional Stroke beds adversely impacts on the rehabilitation space for Stroke.*

Modify for Winter 2025/26

- **Increase medical bed base by temporarily reducing elective orthopaedic activity.** *We need to consider how interdivisional working can take place to allow flexibility in our bed base without having to reducing elective orthopaedic activity in this manner.*
- **Expansion of surgical SDEC.** *Insufficient demand to justify extending opening hours of existing surgical SDEC offer. Consider the surgical SDEC offer i.e. widen to other specialities. Also, consider the overnight and weekend opening of surgical SDEC spaces for inpatient care.*

Do not repeat or modify

- **Discharge Coordinator on SSU.** *Difficult to build relationships required and embed to be impactful when in post for a short timeframe.*
- **Additional portering for Discharge Lounge.** *No longer required due to change of model.*
- **Surgical day case overnight use.** *Challenging to find appropriate patients to occupy beds meant that use was limited. Recommend reviewing the use of the Surgical SDEC beds for potential weekend/overnight opening instead.*

Performance Observations from 2024/25 (1/2)

Headline performance observations from winter 2024/25 are:

- Ambulance handover performance deteriorated significantly from Nov-24. This linked to increased crowding in ED together with changes to Clinical Frailty Scoring and STREAM processes (the latter two designed improve patient experience and outcomes). The deterioration in handover performance was worse in winter 2024/25 than previous years. However, SFH still benchmarked well regionally and nationally.
- Emergency Department (ED) attendances were very high through 2024/25, consistently above levels seen in the previous three years. Mar-25 saw extremely high growth across type 1 and type 3 (the latter driven by unprecedented demand at our Newark Urgent Treatment Centre).
- Maximum occupancy in ED at King's Mill Hospital (KMH) reached high levels for an unprecedented, sustained period during early winter. This is linked to outflow challenges as patients waited in ED for admission to a hospital bed.
- 4-hour performance has deteriorated each winter, continuing in 2024/25 with a record low in Dec-24 when outflow challenges peaked with patients on average waiting over 4-hours for admission from the decision to admit. 12-hour length of stay showed similar seasonality to 4-hours. Improvements in Mar-25 have been seen which were sustained as hospital flow improved. Reduced length of stay for patients aged 65 and over (particularly in their medically safe element of their stay), eased bed pressures and enabled patients to transfer out of ED in a timely basis.
- Non-elective activity has remained stable throughout 2024/25, albeit at high levels. Feb-25 saw a significant increase, like the previous year. The improved position in Mar-25 was not driven by reduced attendance or admission demand – it was driven by reduced length of stay.

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Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

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Performance Observations from 2024/25 (2/2)

- NEWS2 scores indicate seasonal rise in acuity. Winter 2024/25 saw a more severe rise than the previous year.
- Bed occupancy remained well above 92% (circa 95%) throughout the last few years, averaging close to 96% on weekdays. In Winter 2024/25 we had more beds open than ever before driven by using one-over spaces. The number of open beds reduced as we came out of the peak Winter period of Dec-24/Jan-25.
- Medically safe for transfer patient numbers reduced significantly through 2024/25 to low levels not seen since the pandemic. This reduction in discharge delays has supported reduced length of stay, releasing beds when they are needed to provide timely outflow to ED.
- Elective and day case activity has been high during Winter 2024/25; however, sometimes activity levels were not as high as our plan.
- Increased validation has helped to reduce the Patient Tracking List (PTL) size. Referral To Treatment (RTT) long wait reductions seen earlier in the year levelled off over the winter period.
- The curtailment of Orthopedics for six weeks in Dec-24/Jan-25 presented significant challenges in the specialty. Maintaining activity was not possible, and while urgent pathways were facilitated, progress on reducing elective long waits was adversely impacted.
- Cancer performance has been challenged, with histopathology capacity issues. Diagnostic performance improved significantly this Winter as recovery plans (unrelated to our Winter plan) delivered.
- Further detail (graphs and evidence) supporting the performance observations is available as a separate pack on request.

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Winter Plan Area

Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Lessons Learned from 2024/25

What worked well

- **Bed model was accurate** and should be regarded as reliable for future planning
- **Bedded schemes opened as planned** with wrap around services
- We survived winter with **significantly less spot purchased beds from Ashmere** (peak of 16 this winter; 39 last winter)
- **Surge and escalation plans** (including full capacity protocol [FCP]), when enacted, **supported de-escalation**
- Extending **weekend trauma operating lists** supported our response to increased trauma demand **preventing patients waiting in beds for surgery**
- **Clinician feedback very positive regarding medical** (acute frailty unit), **paediatric** (CAU increased hours), and **surgical schemes** (trauma lists)
- Some **smaller schemes** such as an additional weekend consultant on SSU **were successful**
- We **recovered hospital flow** from Mar-25 which was delivered through **length of stay reductions** as we sustainably **reduced discharge delays**. This enabled improvement in A&E 4-hour performance

Areas for improvement

- The planned **expansion of Surgical SDEC** and **Surgical Day Case overnight use** schemes were not mobilised in line with our plan, and therefore did not produce the anticipated impact. The underspend (circa £450k) was used to support the Trust financial bottom-line
- Due to bed constraints during peak winter periods, our **wards** at times were **required to go 'one and two-over'.** We require capacity to be able to flex up and down our bed base at KMH to meet patient needs during peak periods
- Some of our people chose to work **additional hours** over and above contract, including clinical bank shifts and overtime. Look to agree 2025/26 schemes early to support recruitment to support wellbeing of existing staff
- **Newark UTC attendance surge** (12% growth) was beyond levels forecasted and was challenging to respond to. Work undertaken by the System Analytical Intelligence Unit (SAIU) has revealed that challenges in accessing same day GP access is likely to be driving this increased demand
- We were required to **curtail elective orthopaedic operating for 5-6 weeks** to release capacity for non-elective (NEL) demand. Preference is to maintain year-round elective operating. While urgent Orthopaedic pathways were facilitated, **long elective waits were adversely impacted** by the curtailment

A draft Quality Impact Assessment (QIA) has been completed for Winter 2025/26 and will be embedded once finalised/agreed.

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Winter Plan Area			
Anticipate & Assess	Prevent	Prepare	Respond & Recover

NHS Sherwood Forest Hospitals NHS Foundation Trust

Lessons Learned from Regionally-led Stress Test Exercise

Placeholder slide for outputs from the stress test exercise scheduled for Sep-25.

Bed Model: 2025/26 Approach

- Separate models in place for adult, paediatric, maternity, critical care and day case demand/bed bases
- Bed requirement in our adult model is based on:
  - 75th percentile of hourly demand
  - Goal to achieve 92% bed occupancy. We also consider a 96% bed occupancy scenario (which is operationally deliverable at SFH whilst still maintaining flow)
- **Capacity:** Operational view of core capacity based on beds that were consistently open in 2024/25. Beds that flex up and down in line with demand are considered as escalation beds and not part of core bed stock. Note: as in 2024/25 there is no provision in our baseline for a decant ward due to no physical space being available; deep cleaning will be facilitated through a rolling bay-by-bay programme
- **Demand Assumptions:** 2024/25 outturn adjusted as follows for the initial version of the adult bed model ('nominal' state):
  - 0% growth in elective; 4.9% growth in overnight non-elective; and 3.7% growth in zero-day non-elective activity on 2024/25 actuals (aligned to operational plan)
  - Winter orthopaedic demand maintained during Jan-26 at the average level seen in 2024/25
  - No change in Length of Stay (LOS)
  - Medically Safe for Transfer (MSFT) during Apr-25 to Jul-25 adjusted down to reflect reductions observed and sustained in MSFT since Aug-24
  - Accident and Emergency (A&E) bed waiters capped at 30-minutes from decision to admit. Balance of bed wait added to Urgent and Emergency Care demand
  - Where day case length of stay exceeds 16 hours, demand included in our inpatient bed model
  - Aug-25 and Mar-26 are adjusted to reflect more typical seasonality, after unusually low bed demand in those months in 2024/25
- Further detail relating to the bed model is available as a separate pack on request.

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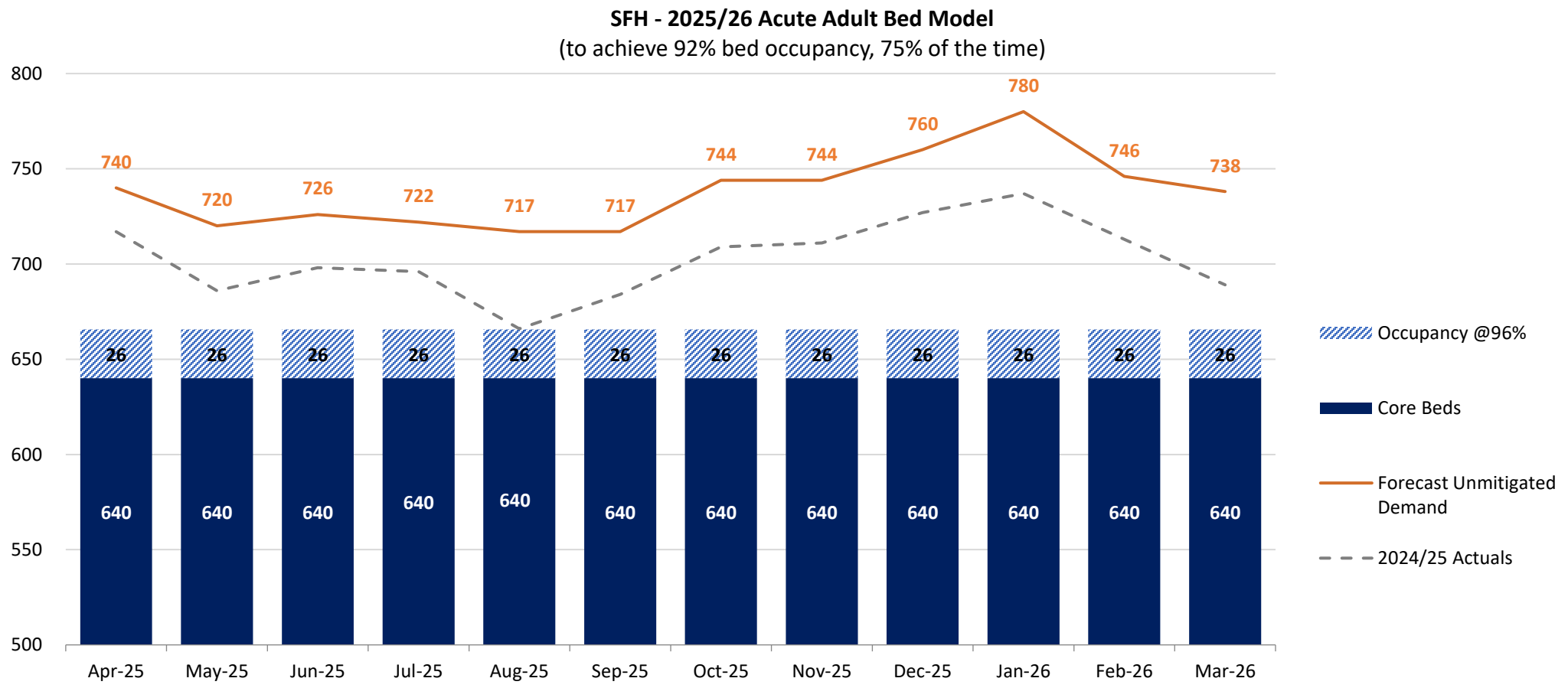
Adult Bed Model: 2025/26 Pre-Mitigated Chart

Significant year-round bed gaps exist to meet forecast unmitigated demand at both 92% and 96% bed occupancy based on a do-nothing scenario (without any mitigations).

Peak demand month is Jan-26 with a forecast gap at 96% occupancy of 114 beds.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bed Gaps @92% occupancy	-100	-80	-86	-82	-77	-77	-104	-104	-120	-140	-106	-98
Bed Gaps @ 96% occupancy	-74	-54	-60	-56	-51	-51	-78	-78	-94	-114	-80	-72

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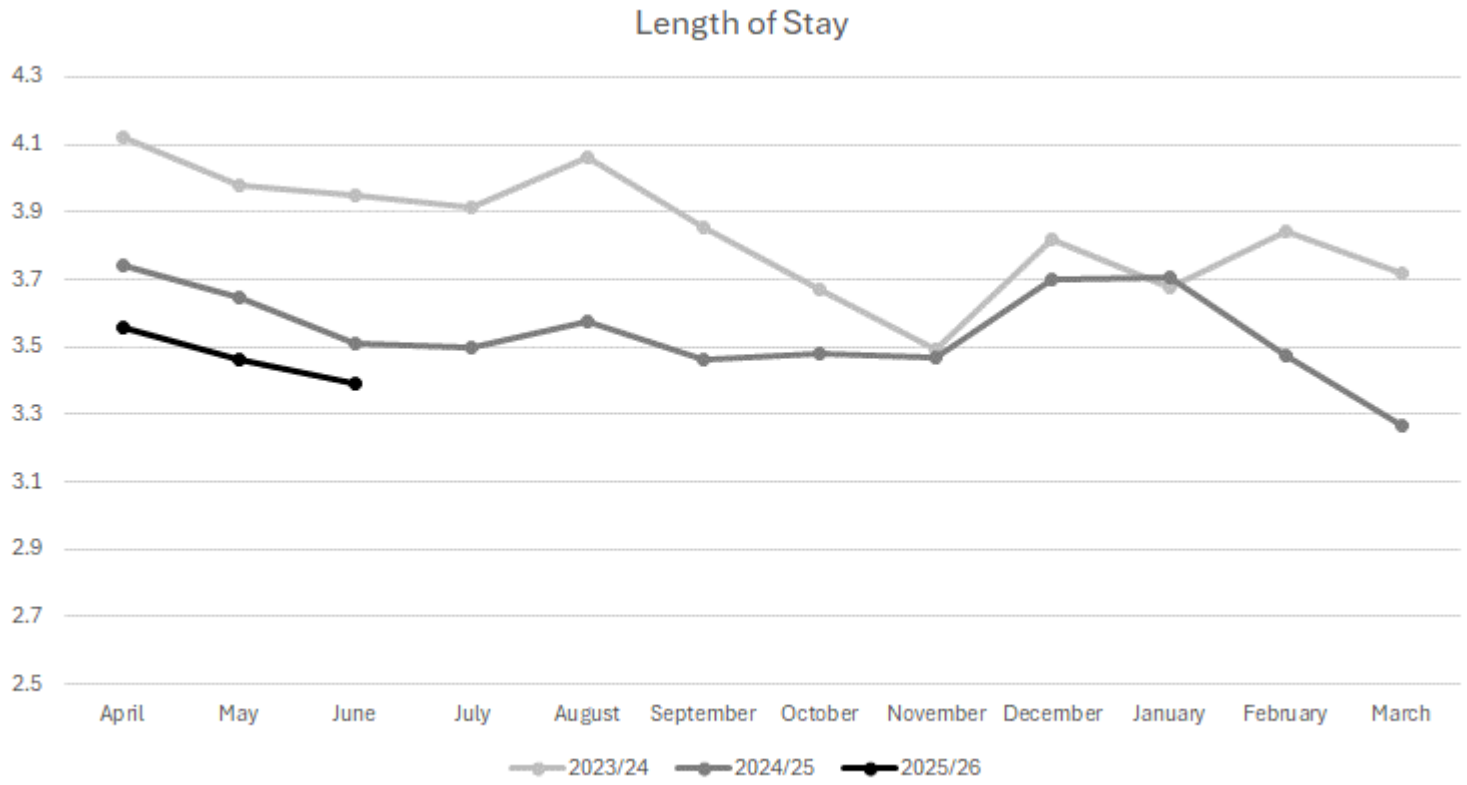
Length of Stay (LOS) trends

Reduced acute LOS has driven reduced number of occupied bed in 2025 calendar year

The baseline assumption in the bed model is that LOS is equivalent to the previous year. Indications at month three is that LOS is trending lower in 2025/26 than in 2024/25

Sustainability in this reduced LOS is key to support confident forecasts for the remainder of 2025/26

2025/26 year to date (YTD) position indicates that some level of conservative mitigation could be added to the bed model. However, it is unclear how sustainable ongoing LOS improvements are.



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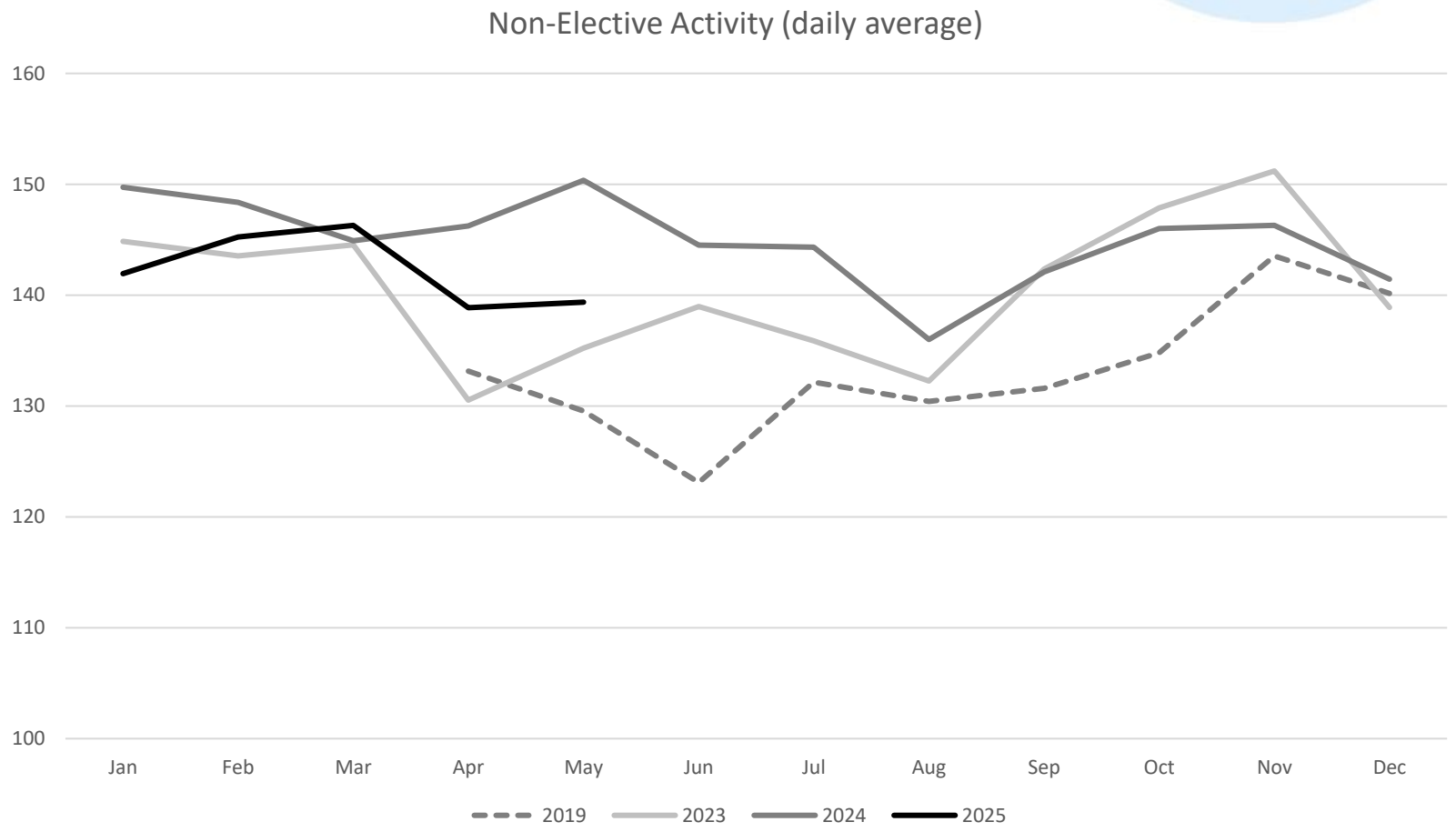
Non-Elective (NEL) activity trends

Aside from Mar-25, NEL activity in 2025 has been lower than in 2024 when considering SLAM data

The baseline assumption in the bed model is that NEL activity would grow in line with the 2025/26 activity plan

2025/26 YTD position indicates that we could add a mitigation to the baseline bed model to remove the NEL growth for 2025/25 as this has not materialised. There is a risk that NEL demand could grow later in the year; this will now be considered as a surge scenario rather than part of our 'nominal' state.



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Bed Model: Paediatric and Critical Care

Occupied beds in paediatrics, NICU and CCU is projected on the basis that **2025/26 is a repeat of 2024/25**

At the end of Jun-25, the projections are broadly in line with actuals.

	2025									2026		
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paeds (Ward 25)	23	22	21	22	17	24	25	28	24	20	22	23
NICU	11	13	13	13	12	12	13	15	14	13	13	14
Critical Care Unit	14	13	14	12	13	12	13	13	14	14	15	14

Bed Model: Day case

- This table shows the capacity requirements in each of the day case wards. It is based on the 75th percentile of demand at midday
- Only patients with a length of stay of 0-16 hours are included within the analysis
- As of Jun-25, the projections are marginally lower than the levels experienced which can be accommodated in the day case footprint. For medical day case there is a bigger variance with actual demand double that of last year.

	2025									2026		
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Day Case Unit	26	27	23	27	24	26	27	26	24	30	24	25
Medical Day Case Unit	2	3	3	4	3	5	5	5	4	7	4	5
Minster	10	9	8	10	8	11	10	11	11	10	10	9

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Winter Risks

IF

- Physical space is insufficient to meet demand
- Unable to provide sufficient medical, nursing or support services staff to meet demand
- Unable to maintain a resilient workforce
- Insufficient equipment to meet demand
- Insufficient system capacity to maintain system flow and the timely transfer of medically safe patients (including impact of any decommissioning discussions)
- Experience an influenza pandemic or significant norovirus or CRE outbreak (or any other infectious disease)
- Experience any significant issues with the fabric of our buildings or other infrastructure e.g. ICT

THEN

May not deliver resilient services over winter

RESULTING IN

- Adverse impact on patient safety
- Inability to deliver appropriate services to our patients (particularly on elective pathways)
- Adversely impact on our reputation causing undesirable media coverage and a loss in confidence from the population we serve
- Reduced staff morale, resilience and retention
- Lack of compliance with national performance standards or local planning commitments causing undesirable regulatory action

Existing dashboards, systems and process exist to identify when the risk items are triggering a live issue that will be managed operationally through five-times daily Capacity and Flow meetings.

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Prevent and Manage Infection

- SFH has in place a series of guidance and policies that are followed throughout the year to avoid, manage and contain infections including any cases of Diarrhoea and Vomiting (D&V), Influenza and Norovirus

Influenza vaccination plan

- Led by Occupational Health, based on previous seasons with trained teams of peer vaccinators
- Focused approach to Health Inequalities to improve uptake amongst related groups within our workforce
- Strong Communication strategy which will be responsive to the progress with uptake
- Drop-in ‘grab a jab’ pop-up flu clinics in high traffic staff areas
- Plan based on delivery of five percentage point improvement on last year
- Vaccines offered to patients with a length of stay greater than 21 days and to patients being discharged to care homes

Flu Plan 2025-26

Covid-19 vaccination

- There has been no national communication around any intent to offer healthcare staff Covid-19 vaccinations in 2025/26

RSV vaccination plan

- As advised in Jul-25, we will adopt national policy which is to offer the Nirsevimab passive immunisation for at risk infants in line with the Green Book criteria

Respiratory mask fit testing

- Focus on improving compliance in high-risk areas for appropriate mask fit testing to be complete on one mask and recorded on the Electronic Staff Record (ESR)
- Levels of Personal Protective Equipment (PPE) stock deemed to be sufficient for the anticipated winter pressures will be in place.

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Communications

SFH will work with system partners to deploy consistent messaging over winter

The focus will be on the Influenza vaccination campaign and supporting people to get the help they need at the right time, in the right place. Educating the public about which services are most appropriate for their needs will empower the public to keep well this Winter, and support a reduction in pressure on services

SFH communications will:

- Draw on national and system-produced material wherever possible
- Mobilise our system and place partners to support our activity
- Be bold and proactive in how we communicate pressures – encourage and support understanding of operational pressures among all audiences
- Support Team SFH colleagues' wellbeing and show we CARE (our values).

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Approach to Identifying Mitigating Schemes

- The Winter reserve for 2025/26 is **£2,495,000**. We are working to an allocation of **£1,800,000** to allow **£695,000** cost avoidance
- Based on our learning and reflections on 2024/25, we identified the following schemes to repeat in 2025/26:
  - Doubling of respiratory Physicians at weekends
  - Additional weekend Consultant on Short Stay Unit
  - Weekend trauma theatre operating lists
  - Children's Assessment Unit increased opening hours
  - Bedded schemes (Lindhurst and Stroke escalation beds but **not** the medical cover to convert a surgical ward in Jan-26)
- We are reviewing bed reconfiguration options (see later slide)
- The Winter Planning Group has been meeting to develop mitigation plans
- Quality Impact Assessments (QIAs) will be completed for all mobilised schemes.

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Elective Activity over Winter 2024/25

- Our ambition is that any adverse impact/compromise on elective care/activity and associated patient experience, income and performance is minimised and assessed on a patient-risk basis
- It is recognised that in 2023/24 and 2024/25 it was necessary to reconfigure the surgical bed base and transfer elective orthopaedic beds to Medicine in the peak of winter (from Christmas to end of January). This was enacted in a planned manner
- Our intention in 2025/26 remains to provide sufficient mitigation against anticipated demand pressures to enable elective operating to continue year-round. To do this, we need to provide full mitigation of the ‘nominal’ state in the bed model and the ‘nominal’ state forecast assumptions to be correct e.g. level of patient demand on our services
- Our ambition is to significantly reduce patient outlying from medicine into surgery, which will be supported by bed reconfigurations (see the next slide).

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Winter Mitigations: Bed Schemes

- There are limited options in our adult bed base available without reconfiguration
- Our 2025/26 plan for our adult bed base includes:
  - Review the use of day case and Same Day Emergency Care (SDEC) spaces to maximise the use of space 24/7. The aim is to reconfigure space to create a winter ward (in winter) and a decant facility (in summer) whilst also rightsizing areas to reduce the requirement to outlie patients. A provisional mitigation has been quantified for this item whilst detailed work continues.
  - Potential for continuous and planned use of escalation beds over winter (full 6-month period of Oct-25 to Mar-26)
  - Improve to privacy and dignity of one and two-over spaces across our medical bed base by installing curtains and bed head services for an additional bed space per bay. This proposal requires capital investment and will be brought to our Trust Management Team for consideration aside from our Winter plan as it relates to patient experience year-round. One and two-over spaces are mobilised as part of our escalation actions included in our Full Capacity Protocol (FCP)
- A bid has been submitted to the East Midlands Children's and Young Persons (CYP) Network for funding to increase our paediatric level two high dependency capacity from two to four beds over winter
- There is sufficient flexibility within our paediatric bed base to flex the number of beds to match anticipated demand.

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Winter Mitigations: Bed & flow scheme summary

Scheme	Timeframe	Impact	Cost
Bed schemes (increasing capacity)			
Stroke escalation beds (KMH)*	Oct-25 to Mar-26	6 beds	*To be added to final version*
Lindhurst escalation beds (MCH)*	Oct-25 to Mar-26	5 beds	
Winter ward (supported by reconfiguration) (KMH)	Oct-25 to Mar-26	24 beds at peak	
Additional soft FM support team for winter pressures/beds	Oct-25 to Mar-26	Support above schemes and ED	
Flow schemes (reducing demand)			
Acute Frailty Unit (no cost from winter reserve)	Oct-25 onwards	Peak at 14 beds	Part of geriatrics transformation case
Enhancements to our Virtual Ward offer	Nov-25 to Feb-26	5 beds	*To be added to final version*
Additional weekend Consultant on SSU*	Oct-25 to Mar-26	In baseline as repeat scheme	£65k
Doubling respiratory Physicians at weekends*	Dec-25 to Feb-26	In baseline as repeat scheme	£23k
Weekend Trauma Theatre Operating Lists*	Deployed over winter as needed	In baseline as repeat scheme	£79k
Children Assessment Unit (CAU) increased opening hours*	5 months (likely Nov-25 to Mar-26)	In baseline as repeat scheme	£208k
Further strategic enhancements in clinical staffing	Dec-25 to Jan-26	2 beds	*To be added to final version*
GP direct access communication to ensure appropriate referrals/access	Throughout winter	Support demand avoidance	
Considering bridging capacity for Pathway 1 discharges	Dec-25 to Jan-26	5 beds	
	Total	**61 beds**	

**Repeated schemes from 2024/25*

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Adult Bed Model: 2025/26 Capacity Mitigations Profile

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Capacity Mitigations	**0**	**0**	**0**	**0**	**0**	**0**	**23**	**23**	**23**	**35**	**23**	**23**
Seasonal use of escalation beds	0	0	0	0	0	0	11	11	11	11	11	11
- Ward 53/54 Stroke							6	6	6	6	6	6
- Lindhurst MCH							5	5	5	5	5	5
Winter ward (day case/SDEC utilisation)							12	12	12	24	12	12

- Bed model assumes seasonal use of Emergency Admissions Unit (EAU) over winter to 46 beds
- Use of EAU to maximum capacity of 52 would be considered under the Full Capacity Protocol (FCP)
- Our FCP also includes the use of one and two over beds that do not form part of our bed model or winter mitigations; they would be considered during any surges in patient demand.

***Note:** Red numbers are provisional*

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Adult Bed Model: 2025/26 Demand Mitigations Profile

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Demand Mitigations	**39**	**38**	**39**	**39**	**38**	**39**	**48**	**55**	**65**	**68**	**58**	**52**
LOS improvements (sustain 25/26 Q1)	7	6	6	6	7	7	7	7	7	7	6	6
Demand management (reverse growth as per 25/26 Q1)	32	32	33	33	31	32	33	33	34	35	33	32
Acute Frailty Unit							8	10	12	14	14	14
Virtual Ward enhancements								5	5	5	5	
Strategic enhancements in clinical staffing									2	2		
P1 bridging capacity									5	5		

- Length of Stay (LOS) improvements and demand management reversal of growth are transacted in the bed model as mitigations based on the actual position delivered at the end of 2025/26 quarter one
- Acute Frailty Unit impact aligned to numbers stated in approved business case with gradual increase following ‘go-live’ in early Oct-25.

***Note:** Red numbers are provisional*

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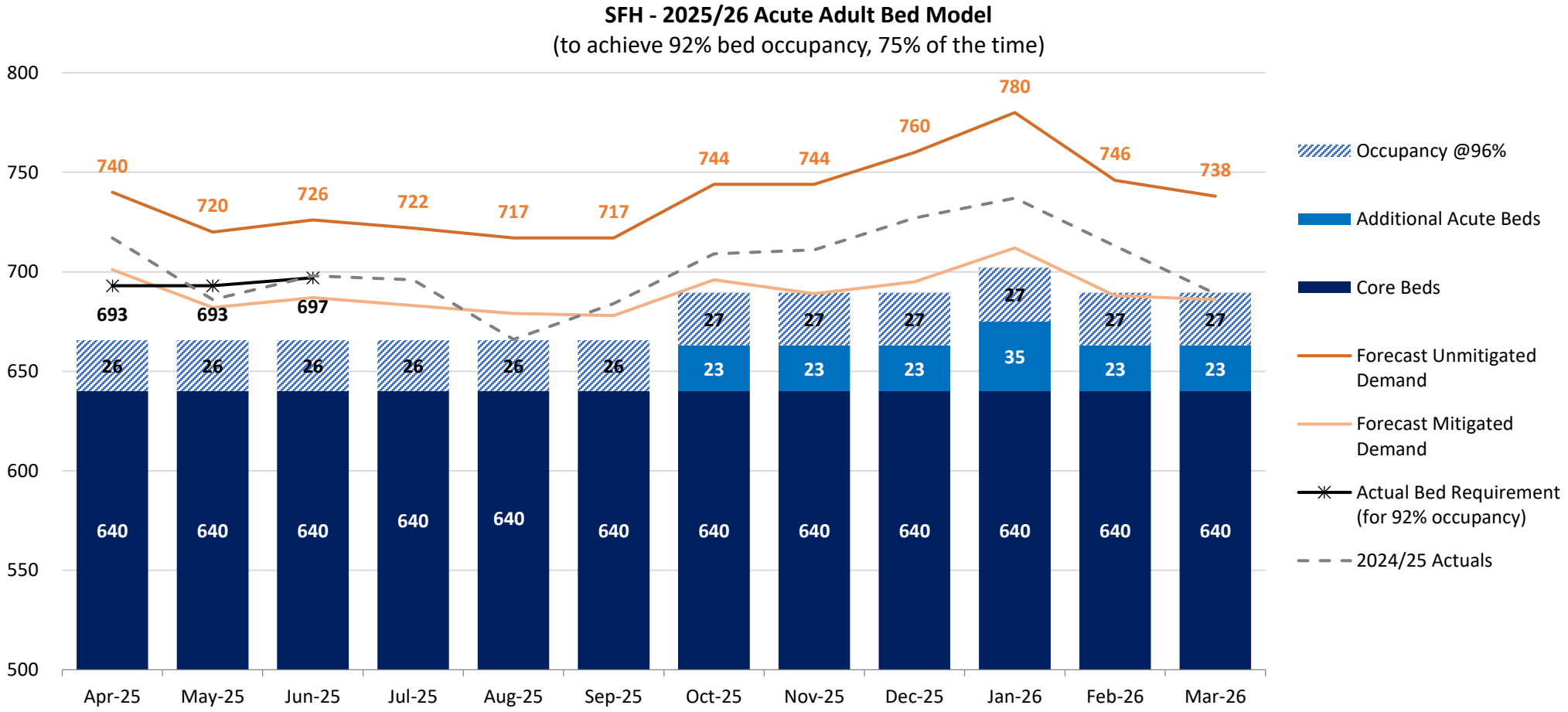
Adult Bed Model: 2025/26 Mitigated Chart

The proposed schemes together with exceptional actions (96% bed occupancy) leave us with a peak bed gap over winter of 10 beds (Jan-26).

FCP actions would provide a bridged position at 96% occupancy assuming no non-elective demand growth (as per 2025/26 quarter one).



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bed Gaps @92% occupancy	-61	-42	-47	-43	-39	-38	-33	-26	-32	-37	-25	-23
Bed Gaps @ 96% occupancy	-35	-16	-21	-17	-13	-12	-6	1	-5	-10	2	4

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Winter Mitigations: Indicative Workforce Implications

- The table to the right will express a summary of the workforce needed, by staff group, to support the proposed winter schemes
- We will insert details of how we plan to address the workforce needs considering current pressures and initiatives
- We will have the detail by scheme to support the engagement of staff.

Staff Group	WTE
Unregistered Nurse	*To be added to final version*
Registered Nurse	
Medical	
Therapy	
Total	

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Key Areas of System Focus

- Nottingham and Nottinghamshire Integrated Care System/Board (ICS/ICB) are overseeing the system Winter plan
- Initial drafts of provider ‘plans on a page’ have been shared
- Key features of system partner plans that could support SFH are:
    - Increase Urgent Care Coordination Hub (UCCH) activity in system by 72 calls per day by Mar-26 with refined exclusion criteria for category three calls manually passed between EMAS and UCCH and use of code automation pathway to reduce errors and standardise processes. Expansion of direct access pathways to UCCH to all care homes
    - Improve catheter and ‘long lie’ patient pathway with refinements to referral process to District Nurses for UCCH
    - Increase use of SFH ‘call before convey’ advice line by EMAS, NEMS and GPs to increase overall ‘call before convey’ activity and reduce referrals to ED for ‘non-emergency’ patients
    - Targeted education programme to GP practices with high referrals to ED
    - Increase percentage of appropriate patients on end of life register with Respect with EMAS able to view via Notts Care Record.

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Existing Interventions that Support Maintaining Quality of Care

- Enhanced Emergency Department staffing to support increased attendance demand including paediatric Registered Nurses 24/7
- Same Day Emergency Care offering across medical and surgical pathways
- Hospital Out Of Hours team
- Discharge Coordinators
- Discharge Lounge
- Getting basics right improvement programme.

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Staff Wellbeing

Psychologically safe teams

- Encourage good, meaningful conversations to show support to colleagues and enable teams to develop strong working relationships
- Ensure colleagues have access to free Wellbeing Conversations training to help them navigate difficult times
- Encourage an empathetic approach to colleagues during challenging events

Rest, Refuel, Rehydrate

- Lead by example by taking breaks, planning breaks and supporting colleagues to rest, refuel and rehydrate
- Promote all aspects of health and wellbeing related training and specifically coping under pressure
- Ensure areas are supported in the lead up to winter to have access or knowledge of available rest areas and ensure essentials are available in all areas

Burnout and Stress

- Target promotion and support areas with high anxiety, stress depression sickness absence and high burnout score in Staff Survey
- Promotion of financial wellbeing resources and support to reduce and address money worries
- Raise awareness of VIVUP and other support services for staff to access throughout and following difficult times

"Boost" Vaccinations

- Continue to encourage all staff to access a free Flu vaccine from the Occupational Health and Peer Vaccinator teams
- Ensure colleagues are aware of how to access a Covid-19 vaccine through the National Booking System or on site offers as eligibility dictates.

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Escalation Plans and Contingencies

- **Full Capacity Protocol** (FCP) and **Operational Pressures Escalation Levels (OPEL) 4 action cards** in place that include:
  - Identified areas of surge capacity (suite of options dependent on level/type of pressure/risk)
  - Actions for clinical teams to undertake to regain patient flow
  - Review of the balance between urgent and emergency care and planned care pathway activity
- **SFH command centre** six times daily email status updates shared seven days a week and viewable 24/7 by SFH colleagues in SQL Server Reporting Services (SSRS). The command centre provides real-time monitoring and reporting of pressures
- **System control centre** in place; OPEL escalation status of system partners visible
- **On call structure** in place 24/7 to provide senior oversight and support to 24/7 Duty Nurse Management team
- The SFH named **Executive accountable for the winter period** is Simon Illingworth, Chief Operating Officer
- **Industrial action** planning takes place to deal with any notified instances of action throughout the year; this will sit alongside our winter plan for any instances over the winter period.

Concluding Remarks

- This document summarises the key components to our 2025/26 draft Winter plan and is the cumulation of work undertaken by Divisional and Corporate colleagues over the Spring and Summer period
- Winter mitigations have been presented that will fit within the winter reserve. This should be regarded as our ‘best offer’. Our plans will continue to evolve over the coming weeks/months
- The proposed schemes together with exceptional actions (bed occupancy of 96%) leave us with a peak bed gap of 10 beds in Jan-26. We have not yet achieved a route to bridging the whole gap over winter. The consequences of not bridging the bed gap include: (1) bed occupancy being higher than 96%; (2) patients waiting for admission in ED with associated patient experience and safety concerns; and (3) the need to enact Full Capacity Protocol actions. The proposal does allow elective operating to continue over Winter
- Specific Christmas and New Year plans will be developed in Nov-25
- Trust Board is requested to note the progress in developing the 2025/26 Winter Plan and approve the work completed to date
    - Further work will continue to develop and operationalise the plan in Aug-25 and Sep-25
    - The plan will be stress-tested during an NHS England-led session in Sep-25
    - The final version of our winter plan will be presented to Trust Board for approval in Oct-25
    - An update to the Council of Governors will take place following Trust Board approval in Oct-25.

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Timescales for Next Steps

7 August:	Draft Winter Plan reviewed by Trust Board
31 August:	Draft system Winter Plan available for NHS England national and regional teams
During September:	Regionally-led stress test of plans (tabletop NHS England hosted exercise). Winter Plans refined based on learning from stress test exercise
30 September:	Submission of Board Assurance Statement (embedded). Provider statements do not need to be assured by ICB before submission
2 October:	Final Winter Plan reviewed by Trust Board
November:	Final Winter Plan shared with Council of Governors

Board Assurance Statement

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.		
The Trust's plan was developed with appropriate input from and engagement with all system partners.		
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.		

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.		
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.		
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.		
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.		
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.		
8. A patient cohorting plan including risk-based escalation is in place and		

	understood by site management teams, ready to be activated as needed.		
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.		
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.		
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Well Led Action Plan - update	**Date:** 7th August 2025	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To request Board sign-off in relation to the first group of actions from the Well Led Developmental review conducted by Grant Thornton LLP and to provide an update in relation to progress with the remaining actions.	**Approval**	**X**
	Assurance	
	Update	
	Consider	

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

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

Executive Summary

Committees/groups where this item has been presented before
People Committee 29th July 2025 Executive Committee 30th July 2025
Acronyms
FTSU – Freedom to Speak Up
Executive Summary
The findings from the Developmental Well Led Governance Review undertaken by Grant Thornton LLP were reported to the Board at its meeting on 6th February 2025 at which the action plan and associated progress monitoring arrangements were agreed. The Actions fell into five categories: • Leadership – 4 actions • Improvement – 5 actions • Strategy – 7 actions • Partnerships – 6 actions, and • Freedom to Speak Up – 11 actions

Appendix 1 to this paper includes the eleven FTSU related actions against which current progress has been recorded. Four - Actions 1, 3, 4 and 10 – had closing dates on or before 30th June 2025. With the benefit of discussion at the People Committee on 29th July 2025, it was agreed their closure could be recommended to the Board for final sign-off at its meeting on 7th August
2025. The progress made against the remaining seven FTSU actions due on or before 30th September
2025 was also reported to the People Committee. The action lead confirmed a high level of confidence that they will all be completed within that timescale.

At its meeting the following day Executive team discussed the actions in the four remaining Categories as a result of which two actions in the Leadership section – Actions 2 and 3 - due by 30th June 2025 are recommended to the Board for sign off:

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	30/06/25	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.
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	30/06/25	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.

Progress against the remaining actions was discussed and concluded with a recommendation that some of the delivery dates should be more ambitious than those previously agreed by the Board. In particular, all five actions in the Improvement section and all six in the Partnerships section currently due by 31st May 2026, should be brought forward to 31st March 2026 along with three more - Actions 5, 6 & 7 - in the Strategy section.

The next scheduled paper to the Board is in December 2025 at which time progress will be reported, as previously agreed by the Board in relation to the second group of Actions due on or before 31st October 2025. The sign off of the remaining actions will be scheduled at the April 2026 meeting.

The Executive committee acknowledged there had been some unavoidable changes to action and task leads that have now been updated in the plan. The need to ensure evidence of the changes implemented as a consequence of the actions was also emphasised.
A record will be maintained centrally by the Director of Corporate Affairs to enable rapid one stop access.

Recommendation

The Board is asked to:

- follow the recommendation from the People Committee to sign off the completion of Actions 1, 3, 4 and 10 in the FTSU section of the report and note the progress towards the timely
- completion of the remaining actions in that section,
- follow the recommendation from the Executive Committee to sign off Actions 2 and 3 in the Leadership section, and
- agree to the reporting timetable being brought forward to conclude delivery of all actions by 31st March 2026

Appendix 1

Extract from the Grant Thornton LLP Well-Led Action Plan for development areas

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 Committee 29/07/25
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 will now pass to the FTSU Operational Meeting, attended by the Chief People Officer, the Director of Corporate Affairs and the FTSUG, for discussion.	

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	Terms of Reference for the FTSU Sub Cabinet were not approved and therefore an alternative approach has been agreed. Instead, a FTSU Operational meeting has been established that had its inaugural meeting instead on 25/6/25 and is developing its membership and purpose with reviewing outstanding FTSU cases and support for resolution its current focus.	People Committee 29/07/25
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 Committee 29/07/25
5	Responsiveness	Review concerns raised to understand trends and activity and use this intelligence to redesign	DoCA	DoCA	30/09/2025	Work is underway with NHIS to enhance the newly launched FTSU database to support the production of information to support managers	

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
		and promote pathways supported by clear support for managers to enable resolution.				and enhance reporting. This includes retrospectively populating the FTSU database with all the Q1 2025/26 information on cases opened in that period in order for a full year's reporting to be available.	
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	The Communications plan will be developed as an integral part of the FTSU Operational meeting's discussion with the benefit of input from the Chief People Officer.	
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 & Timescale Guidance was approved by the JSPF in May 2025 and a plan to roll out to the organisation is in progress.	
8	Responsiveness	Identify training requirements for	DoCA	DoCA	30/09/2025	Training requirements are an integral part of the FTSU	

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
		managers and determine frequency to empower and support managers to resolve concerns.				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 Group meetings and will influence the manner and pace at which training can be shaped and delivered in collaboration with the FTSUG.	
9	Support	Ensure appropriate training is provided to managers to ensure they are supported in listening to and resolving concerns raised.	DoCA	CPO	30/09/2025		
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 the terms of reference were not approved by the TMT, hence the alternative approach now being taken.	People Committee 29/07/25
11	Support	Consider how to make best use of FTSU	DoCA	FTSUG	30/09/2025		

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
		Champions – e.g. signpost, triage, cover/alternative point of contact for FTSUG.					

KEY:

ACE	Acting Chief Executive
DCE	Deputy Chief Executive
COO	Chief Operating Officer
DSP	Director of Strategy & Partnerships
CPO	Chief People Officer
DoCA	Director of Corporate Affairs
FTSUG	Freedom to Speak Up Guardian

Board of Directors Meeting in Public - Cover Sheet

Subject:	Application of Trust Seal	**Date:**	7th August 2025
Prepared By:	Rachel Bates, Corporate PA		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal in the period since the last report to the Board on 5th June 2025, ensuring transparency and accountability in its application.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

N/A

Acronyms

None

Executive Summary

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

Seal number 121

Between:
Sherwood Forest Hospitals NHS Trust (Trust), Central Nottinghamshire Hospitals PLC (Project Co) and AECOM Limited (External Consultant)

Details of the contract:
Letter of Appointment of Electrical Consultant (relating to electrical compliance requirements at KMH, MCH and Newark) signed by the Chief Financial Officer and Director of Corporate Affairs on Friday 13th June 2025.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Fit and Proper Person Framework compliance – Update	**Date:**	7th August 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To provide assurance to the Board of full compliance with the NHSE Fit and Proper Person Framework requirements for the reporting year ended 30th June 2025.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Acronyms

FPPT – Fit and Proper Person Test
FPP – Fit and Proper Person
ESR – Electronic Staff Record
SID – Senior Independent Director
NHSE – National Health Service England

Executive Summary

This report is the second annual update to the Board following the introduction of the new FPPT Framework requirements in force from 30th September 2023. The initial paper presented to the Board on 2nd May 2024 summarised the actions taken by the Trust in response to the requirements of the new Framework including confirmation that the core documents and systems were in place.

Since then, work has been carried out to capture the outcomes of the required annual checks (DBS, social media, insolvency, Charity Commission register of trustees, Companies House disqualified directors and professional registrations, where relevant) into the ESR system, that is the mandated storage repository. These checks have all been completed with no adverse

findings. This enabled the annual submission on the outcomes of the FPP assessments to be prepared for review by the Trust Chair and the SID. The resulting return (containing information as of 9th June 2025) was scrutinised and signed off by the SID (in respect of the Chair) and the Chair in relation to the rest of the Board on 26th June 2025. Due to the confidential nature of the return, the process has changed from last year and it was sent to the national coordinating centre (previously the NHSE Regional Director) on 26th June 2025 with receipt acknowledged on 1st July 2025 to complete the process.

Three Board members left during the reporting period and references were completed for all of them at the time they left using the prescribed Board reference template. These have been retained on file ready in the event the Trust is called upon to provide a reference. Future leavers will have references prepared in the same timely way.

Internal Audit

Further assurance is also provided from the internal audit carried out on the implementation and compliance with the new FPP Framework that was included as a core audit within the Internal Audit Plan for 2024/25. The internal audit report was issued on 10th October 2024 with significant assurance provided. Two low risk recommendations were made both of which were completed on time, reported to the Audit and Assurance Committee and referenced as supporting evidence in the FPP return and. They were to:
1.1 On an annual basis, obtain evidence from the Chief Financial Officer of his ongoing professional registration.
1.2 Verify through a review of the Charity Commission register of disqualified charity trustees that Board members have not been removed as charitable trustees.
These checks were completed as an integral part of the FPPT process for the period ended 30th June 2025 and will continue to be included in future years.

Separately, beyond the scope of the new Framework, and with the approval of the Board in May 2024, the Trust has extended the coverage of FPP testing to designated deputies to ensure greater assurance in the event a deputy is required to cover for an executive director role at short notice and/or for an extended period.

Recommendations:
That the Board:
• takes assurance from the details in this paper describing the implementation of the FPP Framework process for the period ended 30th June 2025 and be assured the Trust has met the 2025 FPP requirements in a full and timely manner, and
• notes the significant assurance provided by the FPP Internal Audit report on the application of the FPP processes at the Trust, and
• notes the extension of the FPP requirements to Executive Directors' designated deputies.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Data Security Protection Toolkit - final Submission	**Date:**	7th August 2025
Prepared By:	Jacquie Widdowson, Head of Data Security & Compliance		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan		

Purpose

The purpose of this report is to provide the Board with the final submission outcome of the Data Security Protection Toolkit.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Audit Committee

Acronyms

DSPT – Data Security Protection Toolkit
IG – Information Governance
IA – Internal Audit

Executive Summary

The Data Security and Protection Toolkit is an online self-assessment tool designed for health and social care organisations in England that helps them to evaluate their data security and protection practices, identify areas for improvement, and demonstrate compliance with national data security standards. The DSPT is particularly relevant for the Trust as it handles sensitive patient data and needs to ensure it is protected from breaches and cyberattacks to the extent possible.
With effect from the 2024/25 submission the DSPT transitioned to adopt the National Cyber Assessment Framework (CAF) as the basis for its cyber security and IG assurance.

The Trust's DSPT Final Submission on the new basis was made on 30th June 2025. Its outcome was all standards were achieved, and the overall score was Standards Met.

Updates on the progress of the DSPT will continue to be presented and monitored through the IG Committee bi-monthly.

Internal Auditor report

The overall internal auditor opinion, detailed in the accompanying document, indicates an overall low risk level with a high degree of assurance. It also records that the Trust has evidenced the indicators of good practice consistently across all of the outcomes reviewed and generally has shown good processes in place for reviewing and assessing the controls in place.

Four areas classified as low risk have been identified as requiring improvement. These relate to

- reviewing and updating the Data Protection Impact Assessment Policy and Procedure, as necessary,
- updating the Incident Response Plan to include clear reference to its response to cyber security and data breach, which includes the Trust's responsibilities as a data controller,
- updating the Information Sharing Policy to include scenarios where direct care information sharing decisions are required to be escalated to the IG Team,
- Ensuring data sharing agreements are subject to regular review.

Responsible action owners have been assigned and target completion dates agreed.

The level of assurance provided by the internal audit service reflects that the organisation's self-assessment against the DSPT aligns or deviates only minimally from the Trust's self-assessment.

All actions are scheduled for bi-monthly monitoring by the IG Committee and also as part of the Audit Committee's work in relation to the delivery of the Internal Audit Plan and closure of IA actions.

Recommendation

That the Board takes assurance from the outcome of the overall score of Standards Met in response to the Data Security Protection Toolkit final submission, supported by the overall internal auditor opinion of a low risk level with a high degree of assurance.

Data Security and Protection Toolkit

Sherwood Forest Hospitals NHS Foundation Trust

24 June 2025

2526/SFHFT/01

Final Report

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Distribution

Name, Job Title	For action	For information
Sally Brook Shanahan, Director of Corporate Affairs (SIRO)	✓	
Simon Roe, Chief Medical Officer		✓
Lauren Ward, Emergency Planning Officer & Business Continuity Officer	✓	
Jacqueline Widdowson, Head of Data Security & Privacy	✓	

The report has also been shared with the organisation's standard distribution list for internal audit reports.

Executive summary

Introduction and background

We have completed a review in respect of your Data Security and Protection Toolkit (DSPT) self-assessment. We examined the effectiveness of controls in place in accordance with the Global Internal Audit Standards in the UK Public Sector. We performed our review to provide an impartial and unbiased opinion.

Why data security and data protection issues require attention from Independent Assessors

Data and information are critical business assets that are fundamental to the continued delivery and operation of health and care services across the UK. The health and social care sector must have confidence in the confidentiality, integrity and availability of its information assets and must ensure that any personal data collected, stored and processed by public bodies is aligned to specific legal and regulatory requirements.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks and data breaches has been amplified by the introduction of the Network and Information Systems (NIS) Regulations and the UK General Data Protection Regulation (GDPR). As such, it is essential that health and social care sector organisations which are impacted by those regulations take proactive measures to defend themselves from cyber-attacks and data breaches and evidence their ability to do so in line with regulatory and legal requirements.

The Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit is one of several mechanisms in place to support health and social care organisations in their ongoing journey to manage cyber security and information governance risk.

The CAF-aligned DSPT allows organisations that have access to NHS patient data and systems to measure their performance against the five objectives of the CAF-aligned DSPT, providing valuable insight into the technical and operational security and governance of the information control environment and relative strengths and weaknesses of those controls. Another mechanism is to independently assess the security and governance of information control environments of health and social care organisations. Independent assessment providers help to strengthen the trust placed on the CAF-aligned DSPT submissions by health and social care organisations' boards, Department of Health and Social Care and NHS England by assessing the effectiveness of the organisation's security and governance of information controls. This approach ensures that the controls in place are effective in securing patient data throughout the organisation's estate, including staff handling of data and safe storage on the organisation's systems.

The role independent assessment providers play in helping to strengthen the reliance placed on the CAF-aligned DSPT submissions by health and social care organisations' boards, Department of Health and Social Care and NHS England is summarised in the National Data Guardian report, *Review of Data Security, Consent and Opt-Outs* and the Care Quality Commission report, *Safe data, safe care*. Both reports include the following recommendation: 'Arrangements for internal data security audit and external validation should be reviewed and strengthened to a

level similar to those assuring financial integrity and accountability' (NDG 6, CQC 6 Table of recommendations). Therefore, it is essential that independent assessment providers, including internal auditors, focus on the assessment of the effectiveness of health and social care organisations' security and governance of information controls, as opposed to simply focusing on the veracity of their CAF-aligned DSPT submissions.

Audit objective

The overall objective of our review was to assess the effectiveness of your data security and protection environment as assessed through the Toolkit.

In order to achieve this objective, we:

- assessed the overall risk associated with your security and information governance control environment, ie the level of risk associated with weak or failing controls and security and governance of information objectives not being achieved
- assessed the veracity of your self-assessment/DSPT submission, providing a level of confidence that the Toolkit submission reflects your risk and controls.

The scope of the audit is partially determined by NHS England. There are eight mandatory outcomes which are:

NHS England mandated in-scope outcomes for 2024/25	
A2.a	Your organisation has effective internal processes for managing risks to the security and governance of information, systems and networks related to the operation of your essential function(s) and communicating associated activities. This includes a process for data protection impact assessments (DPIAs).
A4.a	The organisation understands and manages security and IG risks to information, systems and networks supporting the operation of essential functions that arise as a result of dependencies on external suppliers. This includes ensuring that appropriate measures are employed where third party services are used.
B2.a	You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).
B4.d	You manage known vulnerabilities in your network and information systems to prevent adverse impact on your essential function(s).
C1.a	The data sources that you include in your monitoring allow for timely identification of security events which might affect the operation of your essential function(s).
D1.a	You have an up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of your essential function(s) and covers a range of incident scenarios.
E2.b	You have a good understanding of requirements around consent and privacy, including the common law duty of confidentiality, and use these to manage consent.
E3.a	You lawfully and appropriately use and share information for direct care.

Executive summary

The Trust was also required to choose four additional outcomes from the remaining 39, to be reviewed as part of the audit. The Trust has selected the following:

Four additional outcomes selected by Sherwood Forest Hospitals NHS Foundation Trust for this review
B3.c You have protected stored soft and hard copy data important to the operation of your essential function(s).
B3.e Before reuse and / or disposal you appropriately sanitise devices, equipment and removable media holding data important to the operation of your essential function(s).
B4.b You securely configure the network and information systems that support the operation of your essential function(s).
C1.b You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data within an agreed retention period, after which it should be deleted.

Limitations of scope: The scope of our work was limited to assessment of the evidence to support the 12 outcomes required to be assessed for this review, as detailed above. The review has not provided assurance that the entire DSPT return is accurate and complete. Our work has not included detailed testing of IT systems and has not covered the submission of the DSPT to NHSE.

As independent assessors, we have used our professional judgement when assessing compliance against each control objective. Where necessary, we may have recognised alternative ways to meet each of the control objectives, based on the specific controls in place, local context and reference to supplementary guidance, such as the Big Picture Guides.

Audit assessment

Our review followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHS England. We have reviewed 12 outcomes across the five objectives in the Cyber Assessment Framework. NHS England has mandated eight outcomes to be audited for 2024/2025; organisations were required to select a further four outcomes to be audited which should have been approved by Sherwood Forest Hospitals NHS Foundation Trust Board. The scope of the audit has been approved by Sherwood Forest Hospitals NHS Foundation Trust.

Executive summary

We produced this report as an output of this review. As a result of our evidence assessment and interviews with key stakeholders, we have delivered four low risk findings in total. All findings and associated management actions have been discussed and accepted by Sherwood Forest Hospitals NHS Foundation Trust.

Objective	Outcome	Minimum achievement level (as per the profile set for 24/25)	High	Medium	Low	Outcome result	Minimum achievement level met?	Overall Risk Assurance
A	A2.a	Partially achieved	-	-	PA#5	Partially achieved	Met	Low
	A4.a	Partially achieved	-	-	-	Partially achieved	Met	
B	B2.a	Partially achieved	-	-	-	Partially achieved	Met	
	B4.d	Partially achieved	-	-	-	Partially achieved	Met	
C	C1.a	Partially achieved	-	-	-	Partially achieved	Met	
D	D1.a	Partially achieved	-	-	PA#2, PA#5	Partially achieved	Met	
E	E2.b	Achieved	-	-	-	Achieved	Met	
	E3.a	Achieved	-	-	A#2 A#5 A#6	Achieved	Met	
B	B3.c	Partially achieved	-	-	-	Partially achieved	Met	
	B3.e	Partially achieved	-	-	-	Partially achieved	Met	
	B4.b	Partially achieved	-	-	-	Partially achieved	Met	
C	C1.b	Partially achieved	-	-	-	Partially achieved	Met	

Executive summary

Assessment outputs

	Overall risk assurance across all five CAF objectives	Confidence level of the Independent Assessment *
Independent auditor assessment	Low	High

*** Understanding your report ratings – Assurance level**

The risk assurance level for Sherwood Forest Hospitals NHS Foundation Trust (based on the overall risk across all five objectives) is Low.

This means that all 12 outcomes were rated as meeting minimum achievement levels.

Assessing the veracity of your DSPT self-assessment

We have assessed 12 outcomes, and found that, for all 12 outcomes, our rating aligned with the organisation's self-assessment, resulting in a Low level of deviation between the independent assessment and self-assessment. The confidence level in the veracity of the Toolkit self-assessment is therefore High.

Areas of good practice

The Trust has evidenced the indicators of good practice consistently across all of the outcomes reviewed and generally has shown good processes in place for reviewing and assessing the controls in place.

Summary findings/direction of travel

We identified a small number of areas where the Trust needs to strengthen the arrangements in place to ensure full, embedded and ongoing compliance with the requirements of the DSPT:

- A2.a – The Data Protection Impact Assessment Policy and associated procedures to be subject to review as they are now out of date.
- D1.a - The Trust's incident response plans to be updated to include data breach scenarios, the responsibilities required of a data controller in the event of a data breach and the requirement to contact system partners.
- E3.a (PA#2, PA#6) - The Information Sharing Policy to be updated to include scenarios where direct care information sharing decisions

are required to be escalated to the Information Governance Team.

- E3.a (A#5) - Data sharing agreements to be subject to regular review.

Further details on all risk areas identified are set out within the detailed report.

Summary of actions

	High	Medium	Low	Total
Proposed actions	0	0	4	4
Agreed	0	0	4	4

Follow up

Individual actions agreed in this report will be followed up via our online action tracking system, Pentana. Action owners are responsible for ensuring actions are completed by the agreed implementation dates and for providing relevant supporting evidence.

The expected evidence required to demonstrate implementation is included in the report. It is possible that alternative evidence may be provided by the Trust; we will assess whether alternative evidence addresses the risk identified.

Actions not completed by their agreed date are regularly reported to the Audit and Assurance Committee and impact on the organisation's Head of Internal Audit Opinion.

Key findings

The following sections of the report summarise the findings of our review. Our risk assessment process aligns with the ISO 31000 principles and generic guidelines on risk management. The risk matrix and scoring methodology used is prescribed by NHS England.

A2.a Your organisation has effective internal processes for managing risks to the security and governance of information, systems and networks related to the operation of your essential function(s) and communicating associated activities. This includes a process for data protection impact assessments.	**Findings**
	PA#5: You conduct risk assessments (including DPIAs) when significant events potentially affect the essential function(s), such as replacing a system, commencing new or changing high-risk data processing, or a change in the cyber security threat. The Data Protection Impact Assessment Policy is dated 30 January 2023 and was due for review on 30 January 2025. The Data Protection Impact Assessment Procedure is dated April 2023 and was due for review on April 2025. Both these documents are, therefore, out of date.
Risk rating **Low**	**Risk**
	If the Data Protection Impact Assessment Policy and Procedure are out of date, they may fail to address new risks introduced by changes in processing activities, technologies or legal requirements.
	Recommendations
	The Data Protection Impact Assessment Policy and Procedure to be reviewed and updated as necessary.
	Evidence to confirm implementation
	Updated Data Protection Impact Assessment Policy and Procedure.

		Responsible officer
		Jacqueline Widdowson, Head of Data Security & Privacy
		Target date
		31 December 2025

D1.a You have an up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of your essential function(s) and covers a range of incident scenarios.		**Findings** <u>PA#2: Your response plan comprehensively covers scenarios that are focused on likely impacts of known and well-understood attacks and incidents only</u>. We reviewed Incident Response Plans from the Trust and Nottinghamshire Health Informatics Service (NHIS), which appeared comprehensive. The Trust's Incident Response Plan includes various action cards which describe scenarios and the Trust's response to each, however, there is no reference to data breaches or cyber-attacks as required by the DSPT requirements. Business Continuity plans are in place at a divisional level and whilst these do include various scenarios such as loss of IT, loss of staff, denial of access (to physical location) and loss of utilities, they do not specifically reference cyber security and data breach scenarios. The NHIS Incident Response Plan includes a specific and detailed section on responding to cyber events. <u>PA#5: Your response plan covers your obligations as a controller or processor.</u> The Notts Cyber Resilience Plan included reference to the requirements to report data breach incidents to the Information Commissioner's Office and DSPT reporting line, but we could not find any reference to these requirements in the Trust or NHIS Incident Response Plans.

Risk rating	Risk
Low	If incident response and business continuity plans do not include data breach and cyber-attack scenarios, then there is a risk of delayed or inadequate action in response to such incidents, resulting in delayed recovery of essential functions.
	Recommendations
	The Trust to update its Incident Response Plan to include clear reference to its response to cyber security and data breach, which includes its responsibilities as a data controller.
	Evidence to confirm implementation
	Updated Incident Response Plan including action cards/run books.
	Responsible officer
	Lauren Ward, Emergency Planning Officer & Business Continuity Officer and Jacquie Widdowson, Head of Data Security & Privacy
	Target date
	28 February 2026

E3.a Using and sharing information for direct care	**Findings**
	E3.a (A#2) Information is used or shared for direct care when it is needed. E3.a (A#6) There are appropriate arrangements in place for information sharing for direct care. Our review of the Trust Information Sharing Policy identified that it does not include scenarios where direct care information sharing decisions are required to be escalated to the Information Governance Team.

Risk rating	Risk
Low	If details on information sharing are not clear, there is a risk that information could be shared in error, resulting in a data breach.
	Recommendations
	The Information Sharing Policy to be updated to include scenarios where direct care information sharing decisions are required to be escalated to the Information Governance Team.
	Evidence to confirm implementation
	Updated and approved Information Sharing Policy
	Responsible officer
	Jacquie Widdowson, Head of Data Security & Privacy
	Target date
	31 December 2025

E3.a Using and sharing information for direct care	Findings
	E3.a (A#5) Your organisation has a process in place to enable appropriate non-routine ad hoc data sharing for direct care purposes. A list of data sharing agreements is held by the Trust. A review of this list identified approximately 60 agreements that had not been reviewed in over three years.

Risk rating		Risk
Low		If data sharing agreements are not subject to regular review this could lead to unlawful sharing of data.
		Recommendations
		Data sharing agreements to be subject to regular review.
		Evidence to confirm implementation
		List of data sharing agreements showing recent review dates.
		Responsible officer
		Jacquie Widdowson, Head of Data Security & Privacy
		Target date
		31 March 2026

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

The tables below summarise the evidence items within scope, setting out your self-assessment and our risk assessment. This detailed assessment supports the overall audit assessment presented within the executive summary:

Agree	Understated	Overstated	Agree but insufficient
From the evidence available we are able to agree with the organisation's self-assessment as a reasonable assessment of current performance.	From the evidence provided it is our assessment that the organisation is performing at a level higher than recorded.	From the evidence available we are not able to agree the self-assessment as a reasonable assessment of current performance.	From the evidence provided it is our opinion the organisation has been accurate with its self-assessment, but it has not currently completed the mandatory outcomes as required by NHSE.

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A2.a	Your organisation has effective internal processes for managing risks to the security and governance of information, systems and networks related to the operation of your essential function(s) and communicating associated activities. This includes a process for data protection impact assessments (DPIAs).	PA#1	Partially Achieved	**Agree**	✓ Reviewed the risk management processes documentation.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Reviewed project documentation.	
		PA#3	Partially Achieved	**Agree**	✓ Reviewed completed risk management documentation.	
		PA#4	Partially Achieved	**Agree**	✓ Reviewed documentation showing that the Trust has established thresholds at which risks are monitored and reviewed.	
		PA#5	Partially Achieved	**Overstated**	✓ Reviewed the risk management processes documentation.	
		PA#6	Partially Achieved	**Agree**	✓ Reviewed procedural documents and the Risk Registers.	
		PA#7	Partially Achieved	**Agree**	✓ Reviewed the risk management processes documentation.	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A4.a	The organisation understands and manages security and IG risks to information, systems and networks supporting the operation of essential functions that arise as a result of dependencies on external suppliers. This includes ensuring that appropriate measures are employed where third party services are used.	PA#1	Partially Achieved	**Agree**	✓ Reviewed risk identification documentation.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Reviewed supplier lists and other documentation.	
		PA#3	Partially Achieved	**Agree**	✓ Verified that supplier contracts contain appropriate cyber security and data protection clauses.	
		PA#4	Partially Achieved	**Agree**	✓ Reviewed processes in place to identify all third party connections to Trust networks.	
		PA#5	Partially Achieved	**Agree**	✓ Reviewed incident management documentation.	
		PA#6	Partially Achieved	**Agree**	✓ Reviewed Data Protection Impact Assessments.	
		PA#7	Partially Achieved	**Agree**	✓ Reviewed assessment documents.	

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B2.a	You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).	PA#1	Partially Achieved	**Agree**	✓ Verified that appropriate processes are in place to verify substantive and temporary staff identity prior to being given access to systems and data.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Reviewed documentation in place to establish a procedure for ensuring authentication is robust.	
		PA#3	Partially Achieved	**Agree**	✓ Verified that policy is in place to ensure access levels are appropriate.	
		PA#4	Partially Achieved	**Agree**	✓ Reviewed documentation to determine whether additional verification methods are required for elevated permission accounts.	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
		PA#5	Partially Achieved	Agree	✓ Confirm implementation of secure remote access being in place, via screensharing.	
		PA#6	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether processes are in place to ensure user access is appropriate.	
		PA#7	Partially Achieved	Agree	✓ Tested authentication practices against best practice.	

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B4.d	You manage known vulnerabilities in your network and information systems to prevent adverse impact on your essential function(s).	PA#1	Partially Achieved	Agree	✓ Reviewed documentation provided to show how the Trust gathers and cross-checks threat intelligence.	**Agree**
		PA#2	Partially Achieved	Agree	✓ Reviewed documentation provided to receive, track, analyse, prioritise and address announced vulnerabilities.	
		PA#3	Partially Achieved	Agree	✓ Reviewed documentation provided to mitigate vulnerabilities that cannot be promptly addressed.	
		PA#4	Partially Achieved	Agree	✓ Checked that systems becoming end of life or out of support have appropriate plans in place to migrate or mitigate.	
		PA#5	Partially Achieved	Agree	✓ Reviewed documentation provided to show how the Trust gathers and cross-checks threat intelligence.	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
C1.a	The data sources that you include in your monitoring allow for timely identification of security events which might affect the operation of your essential function(s).	PA#1	Partially Achieved	**Agree**	✓ Reviewed the policies provided to ensure appropriateness.	Agree
		PA#2	Partially Achieved	**Agree**	✓ Reviewed information from SIEM/MDE to ensure appropriate processes in place to detect Indicators of Compromise.	
		PA#3	Partially Achieved	**Agree**	✓ Reviewed evidence that suitable user monitoring is undertaken.	
		PA#4	Partially Achieved	**Agree**	✓ Reviewed evidence that suitable network boundary monitoring is undertaken.	

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D1.a	You have an up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of your essential function(s) and covers a range of incident scenarios.	PA#1	Partially Achieved	**Agree**	✓ Reviewed documentation provided to confirm whether essential functions have been considered within response plans.	**Agree**
		PA#2	Partially Achieved	**Overstated**	✓ Reviewed documentation provided to determine whether plans contain scenarios for known attacks ('play books').	
		PA#3	Partially Achieved	**Agree**	✓ Reviewed documentation provided to determine whether plans outline roles and responsibilities of staff members.	
		PA#4	Partially Achieved	**Agree**	✓ Reviewed documentation provided to determine whether the plan had been shared with relevant stakeholders.	
		PA#5	Partially Achieved	**Overstated**	✓ Reviewed documentation provided to determine whether plans contain details regarding how the Trust meets its obligations as a data controller/processor during an incident situation.	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
		PA#6	Partially Achieved	Agree	✓ Reviewed documentation provided to determine whether plans identify the need to inform system partners of an incident and contain contact details to facilitate this.	

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E2.b	You have a good understanding of requirements around consent and privacy, including the common law duty of confidentiality, and use these to manage consent.	A#1	Achieved	Agree	✓ Reviewed training documentation and guidance provided in respect of ensuring consent processes are in place.	**Agree**
		A#2	Achieved	Agree	✓ Reviewed policies in place in respect of consent to ensure appropriateness.	
		A#3	Achieved	Agree	✓ Reviewed documentation provided in respect of transparency to ensure appropriateness.	

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E3.a	You lawfully and appropriately use and share information for direct care.	A#1	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	**Agree**
		A#2	Achieved	Overstated	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	
		A#3	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SFH Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
		A#4	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	
		A#5	Achieved	Overstated	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	
		A#6	Achieved	Overstated	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	

Appendix B: Summary of work undertaken and risks reviewed – Discretionary outcomes

Req. #	Description	IGP#	SFH Assessment	360 Assurance Assessment	Comment	Overall Assessment
B3.c	You have protected stored soft and hard copy data important to the operation of your essential function(s).	A#1	Achieved	**Agree**	✓ Reviewed documentation in relation to the storage and security of data.	**Agree**
		A#2	Achieved	**Agree**	✓ Reviewed physical and technical controls in place to protect stored data.	
		A#3	Achieved	**Agree**	✓ Reviewed if cryptographic protections are used for data and if they have been technically and procedurally applied in a suitable way to protect the data.	
		A#4	Achieved	**Agree**	✓ Reviewed documentation in relation backups of data which allow the operation of essential functions to continue should the original data not be available.	
		A#5	Achieved	**Agree**	✓ Reviewed evidence of historic or archive data is stored, and whether suitable security measures are implemented.	

Req. #	Description	IGP#	Trust's Assessment	360 Assurance Assessment	Comment	Overall Assessment
B3.e	Before reuse and/or disposal you appropriately sanitise devices, equipment and removable media holding data important to the operation of your essential function(s).	A#1	Achieved	**Agree**	✓ Reviewed documentation around the removal of data from all devices, equipment and removable media before reuse and/or disposed.	Agree
		A#2	Achieved	**Agree**	✓ Reviewed evidence of the use of an assured product or service for media sanitisation.	

Appendix B: Summary of work undertaken and risks reviewed – Discretionary outcomes

Req. #	Description	IGP#	Trust's Assessment	360 Assurance Assessment	Comment	Overall Assessment
B4.b	You securely configure the network and information systems that support the operation of your essential function(s).	PA#1	Partially Achieved	**Agree**	✓ Reviewed documentation provided to ensure that devices requiring a standard build have been identified.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Reviewed documentation to confirm that the Trust has defined and documented a collection of secure baseline builds for devices across its estate and rolled these out.	
		PA#3	Partially Achieved	**Agree**	✓ Reviewed documentation to verify that the standard builds are documented and have been appropriately rolled out.	
		PA#4	Partially Achieved	**Agree**	✓ Reviewed documentation provided to ensure that the standard baseline builds have been appropriately approved.	
		PA#5	Partially Achieved	**Agree**	✓ Reviewed documentation provided to show that software is approved prior to being rolled out.	
		PA#3	Partially Achieved	**Agree**	✓ Reviewed documentation in relation to the identification of generic, shared, default name and built-in accounts used across its systems and networks.	

Req. #	Description	IGP#	Trust's Assessment	360 Assurance Assessment	Comment	Overall Assessment
C1.b	You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete	PA#1	Partially Achieved	**Agree**	✓ Reviewed documentation in relation to log access controls.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Reviewed lists held of authorised users and systems	

	master copies of log data within an agreed retention period, after which it should be deleted.	PA#3	Partially Achieved	**Agree**	✓ Reviewed documentation and procedures for monitoring access and actions to log data.	

Appendix C: Risk assurance rating and confidence level methodology

Risk assurance ratings

How to determine the indicator of good practice achievement level

The CAF-aligned DSPT Independent Assessor must assess the achievement level for each in-scope DSPT indicator of good practice assessed as part of their DSPT review. The Independent Assessor leverages knowledge and subject matter expertise alongside observations made during the assessment to evaluate each indicator of good practice against the Not Achieved, Partially Achieved or Achieved statements of the Cyber Assessment Framework. These statements are used to assign an achievement level to each indicator of good practice.

This achievement level reflects the maturity of the organisation in being able to meet the expected outcomes through implementation of controls and processes.

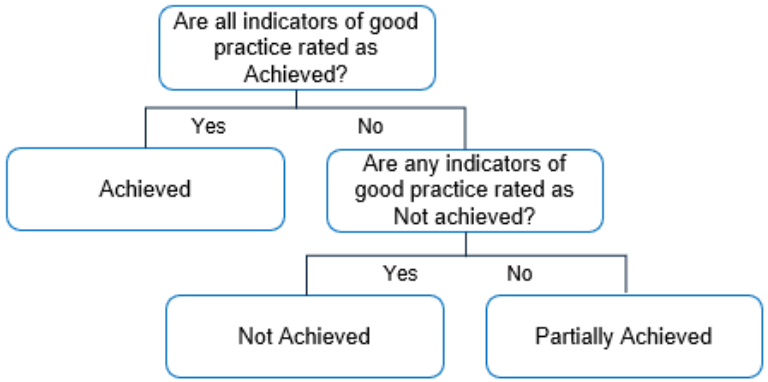
How to determine the outcome level achievement level

The DSPT Independent Assessor must then follow the CAF requirements to assign an achievement level at the outcome level. The CAF states that an outcome will be rated as Achieved if every underlying indicator of good practice is rated as Achieved. An outcome with be rated as Not Achieved if one or more underlying indicator of good practice is rated as Not Achieved. Finally, an outcome will be rated as Partially Achieved if no indicator of good practice is rated as Not Achieved, but not all indicators of good practice are rated as Achieved.

How to determine the overall risk rating for the organisation

The DSPT Independent Assessor then uses the table on the right-hand side to assign an overall risk rating to the organisation.

How to determine the outcome level of the achievement level



Overall Risk Rating across all tested outcomes	
Very High	More than four outcomes are rated as not meeting minimum achievement levels required and/or the organisation cannot comply with mandatory policy requirements.
High	Between two and four outcomes are rated as not meeting minimum achievement levels required.
Moderate	No more than one outcome is rated as not meeting minimum achievement levels required.
Low	All minimum achievement levels have been met.
Very Low	All minimum achievement levels have been met and achievement levels have been exceeded for at least one outcome.

Appendix C: Risk assurance rating and confidence level methodology

Overall Confidence and Risk Levels

The confidence-level in the veracity of the organisation's DSPT self-assessment submission has been determined by comparing our assessment findings against the self-assessment made by the organisation. The following NHS England definitions were used for aiding the decision of applying a confidence-level.

Level of deviation between self and independent assessment	Confidence level
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" (meeting the expected achievement levels across all outcomes) but the independent assessment has found multiple outcomes as not meeting minimum levels of achievement.	Low
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment. For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a non-trivial deviation or discord between the two.	Medium
Low level or no deviation - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	High

Appendix D: 360 Assurance standing information

Contact details

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Audit and Assurance Committee Chair's Highlight Report to Board

Subject:	Audit and Assurance Committee	**Date:**	17th July 2025
Prepared By:	Andrew Rose-Britton – Chair of Audit and Assurance Committee		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose:			
To provide an overview of the key discussion items from the Audit and Assurance Committee meeting held on 17th July 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
A concern was noted in relation to the action from the Capital Schemes Internal Audit around evidencing the approval of Capital business cases by the appropriate forum and in accordance with the Trust's Scheme of Delegation that will be referred to the Finance Committee for its consideration.	• External Audit tender. • Continued work on declarations of interests compliance. • Head of Procurement to review the contract for equipment provided by Hologic UK to ascertain whether the service can be provided safely using a lower priced alternative. • A general Contract Management Report to be brought to the next meeting including new developments.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Assurance received from the Counter Fraud Progress Report, noting the changes in legislation from September 2025. Internal Audit Progress Report. The Fire Safety Internal Audit Reports provided Limited Assurance, however it was acknowledged that significant progress had been made in response to the 19 actions, noting ten had been completed before the report was issued and the remainder are on course for completion on time.	Losses and Special Payments approved, noting that the largest value item related to the long-term care of mental health patients from 2023 in respect of which a settlement had now been reached with the Council. ED practises had been changed to mitigate the likelihood of this recurring. Fifteen single tender waivers with a cumulative value of £1,040,152 had been approved in the reporting period, one of which is to be reviewed (see quadrant above).

Good assurance received from the remaining Internal Audit reports submitted to other Board Sub-Committees. External Audit Progress Report and confirmation that the Financial Statements 2024/25 had been submitted according to the required time schedules with one post-approval adjustment necessary regarding impairment on buildings. Good progress made with outstanding Internal Audit Actions. The submission of the Data Security and Protection Toolkit and its assessment as “standards met” was noted. Four low level actions are in progress. Risk Committee Report including progress with actions. Clinical Audit Planning Process and Current Year Progress Report, (greater participation of staff needs to be encouraged). Register of Interests report showing good progress on declarations. Non-Clinical Policies Report and progress with renewals/approvals (25 in Q1). Board Assurance Framework Report provided assurance on the process. Purchase order v No-Purchase order update, noting the progress made towards every order having a PO in place prior to a commitment being made.	

Comments on effectiveness of the meeting
Good challenge and debate as to the items under consideration (Governor feedback). From the STW paper it looks like there's a lot of financial abuse and ripping off and low morals about charges going on (Governor feedback).
Items recommended for consideration by other Committees
Finance Committee: action from the Capital Schemes Internal Audit (see top left of the quadrant) and one single tender waiver (Hologic UK – see top right) to be followed up.
Progress with Actions
Number of actions considered at the meeting - 7 Number of actions closed at the meeting – 5 Number of actions carried forward - 1 Any concerns with progress of actions – The Stock Policy has been amended in line with proposals and is awaiting Procurement review. It was felt that further clarity on the progress and timescales would support assurance and oversight. Action to remain open. Update to be provided at the next meeting in September.

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

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Finance Committee Chair's Highlight Report to Board of Directors

Subject:	Finance Committee Meeting (Core Meeting and Deep Dive)	**Date:**	7th August 2025
Prepared By:	Richard Cotton, Finance Committee Chair		
Approved By:	Rich Mills, Chief Financial Officer		
Presented By:	Richard Cotton, Finance Committee Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee (Core Meeting & Deep Dive) meeting of 24th June 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Although the reported Month 2 position is aligned to plan (£1.6m deficit) there are risks associated, including £1.9m recognition of income ahead of plan. • Progress and risks relating to the Financial Efficiency Programme, noting in Month 2 there is a £1.5m shortfall.	• Timeline for workforce trajectories and associated pay costs to be presented to the Board of Directors on 3rd July. • Independent review of PFI accounting treatment commissioned, to be undertaken over the summer. • Capital and Revenue Business Case process currently being updated in line with recommendations from the Capital Schemes Internal Audit. Paper to be shared at July Finance Committee for approval.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• The Committee received a detailed presentation on Productivity metrics and how these will be applied nationally and by the Trust going forward. • The Committee received a presentation on the new contracting arrangements and welcomed the establishment of a Contract Executive Board with the Nottinghamshire ICB. • The financial risk relating to the MRI programme has reduced from £1.0m to £0.3m (compared to the original business case). • A presentation received at the national NHSE CFOs Forum was shared with the Committee.	• Ensure that the market testing relating to the Soft FM Contract is underway. Update to be provided to the next Committee in line with the Workplan. • Highlight report from CDC Steering Group to be shared with the Committee for information. • The Committee APPROVED for recommendation to the Board of Directors a five-year contract for supplies to support the Respiratory Physiology service, taking into account the cost mitigations and risks. • Approval to pay the annual CQC subscription. • The BAF was reviewed and it was agreed to maintain the risk

• The Committee welcomed the revised Contract Forward View reporting. • An update on the conclusion of the external audit of the 2024/25 financial accounts was received.	scores for PR4 (Finance) at 20 and for PR8 (Sustainability) at 12.

Comments on effectiveness of the meeting

Items recommended for consideration by other Committees

- Timeline for workforce consultation process to be considered by the People Committee following conclusion of MARS.
- Actions taken in response to recommendations from Capital Scheme Internal Audit to be shared with Audit and Assurance Committee.

Progress with Actions

Please answer the following regarding progress on actions:

Number of actions considered at the meeting – 6 (all other actions not yet due)
Number of actions closed at the meeting – 4
Number of actions carried forward - 2
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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Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	**Monday 2nd July 2025**
Prepared By:	Esther Smith, PA to Deputy Chief Nurse & Director of Nursing Quality & Governance		
Approved By:	Barbara Brady, 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
- **Concerns noted around cancer metrics within the IPR for Timely Care, specifically around Histopathology delays and breast capacity issues. Recovery plans and new equipment and funding is in place and improvements will take time.** - **Limited assurance taken from the update for MCA and DoLS noting this has been a persistent issue. A Working Group has been established, and regular updates will continue to be provided alongside the Safeguarding Committee Report.** - **A Patient Safety Incident Investigation (PSII) was commissioned and is in progress relating to the 'Never Event', attributed to issues with positive patient identification. The Committee will receive the learning from this on completion of the investigation.**	- Following the introduction of the Quality Strategy, a set of Key Performance Indicators (KPI's) are being agreed with links to other Trust Strategies. Progress against these will be reported to QC per the workplan. - An external peer review has been commissioned for IPC, including table top and on-site reviews with focus on antimicrobial prescribing and environmental cleaning.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Progress noted with the Quality Dashboard with aim to have 30% of requested metrics by the end of August. Further progress and the link to the Dashboard will be shared with the Quality Committee quarterly. - Positive assurance taken from the Patient Experience Committee highlight report with the Annual Report expected in September.	- The Committee APPROVED the Quality Committee Terms of Reference. - The Committee APPROVED the Quality Committee annual workplan pending addition of Quality Dashboard Updates and Patient Experience Annual Report, in addition to title change for Chief Medical Officer.

- Positive assurance against the IPR reports for Timely & Quality Care. - Positive assurance taken from the Patient Safety Committee Report. - Positive assurance taken from the Cancer Services Annual Report. Future annual reports will explicitly link back to previous years recommendations and progress. - Positive assurance and feedback noted against the final NMAHP Strategy.	- The Committee APPROVED the Board Assurance Framework with no changes to risk score for Principal Risks 1,2 and 5.

Comments on effectiveness of the meeting

The new monthly meeting frequency was supported with several members stating it allows for timely follow up's and is appropriate with the current pressures being faced. This will be kept under review going forward. No concerns were raised, and it was felt the meeting was completed efficiently with good pace and focussed discussion.

Items recommended for consideration by other Committees

NA

Progress with Actions

Number of actions considered at the meeting - 4
Number of actions closed at the meeting – 4
Number of actions carried forward - 2
Any concerns with progress of actions – No
If Yes, please describe –

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People Committee Chair's Highlight Report to Board

Subject:	Chair's Report	**Date:**	29th July, 2025
Prepared By:	Steve Banks Non-Executive Director		
Approved By:	Steve Banks Non-Executive Director		
Presented By:	Andrew Rose-Britton Non-Executive Director		
Purpose:			
For Assurance			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Impact of financial challenges for 25/26 on staff and patient care, compounded by Industrial action. • Risk of missing WTE targets, particularly due to Agency spend.	• Workforce transformation detailed tracking and planning • Review of bands 4-9 Nursing and Midwifery National profiles
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
There was much positive assurance provided including: • Trust approach to Violence Prevention showcased at NHS Confederation EXPO • Medical Job planning approach and annual medical workforce staffing report • WRES and WDES reports • Occupational Health Annual report • Health and Safety update • Freedom to Speak Up Guardian update, including noting completion of Well Led review actions	• BAF discussed; actions up to date and risks and assurance levels remain as is, but assurances and mitigations updated • Updated People Committee Workplan approved

Comments on effectiveness of the meeting
Good to welcome a new Governor observer. Hot topics section working well and committee encouraged to request items for discussion; papers were of good quality, as was the debate; presenters summaries are more concise leading us to the right debates and having more time for debate.
Items recommended for consideration by other Committees
Finance Committee: Workforce numbers and the risk of national re-banding referenced above inflating costs. Quality Committee: Quality Impact Assessments of staffing changes and the potential impact of the change in NHSE approach to provision of service during strikes presenting a patient safety risk.
Progress with Actions
Number of actions considered at the meeting - 1 Number of actions closed at the meeting – 1 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

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

Outstanding Care,
Compassionate People,
Healthier Communities

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Partnership and Communities Chair's Highlight Report to Trust Board

Subject:	Partnership and Communities Committee	**Date:**	7th August 2025
Prepared By:	Barbara Brady, Non-Executive Director/Chair		
Approved By:	Barbara Brady, Non-Executive Director/Chair		
Presented By:	Richard Cotton, Non-Executive Director/Committee member		
Purpose:			
To provide a brief overview of the key discussions from the committee meeting on the 21st July 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Capacity to develop the partnership agenda on behalf of SFHT • Ability of SFHT to engage with and shape discussions with Primary care regarding the future of neighbourhood services • Ongoing concern regarding the visibility of QIAs undertaken by partners with the system where a direct or indirect impact on SFHT might occur	• Review of the sub groups which support this committee • As a result of the changing footprint of the ICB for our area (now to include Lincs.), there is a need to develop working relationships with new partners
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• Good alignment between new 10-year plan and SFHT strategy. Although this will need to be reviewed as and when further detail regarding implementation emerges. • Application underway to join pilot 'National Neighbourhood Health Improvement Program'. The footprint of this is yet to be agreed locally, at a minimum it will include Mid Nottinghamshire with a possibility that Bassetlaw is involved also. If successful this will require a dedicated project manager. • Good progress against partnership and Anchor plans for 2025/26 • Memorandum of Understanding signed with Nottingham Trent University to cover 5 workstreams.	• BAF minor changes approved with overall scores remaining unchanged

Comments on effectiveness of the meeting
Good meeting enabled by good quality papers and effective engagement by committee members
Items recommended for consideration by other Committees
Progress with Actions
Number of actions considered at the meeting 3 Number of actions closed at the meeting – 2 Number of actions carried forward - 1 Any concerns with progress of actions –No If Yes, please describe –

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