Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 6th August 2026**
Time: **09:00 – 13:00**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**	-	-
2.	09:00	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest**:-** Register of Interest | Sherwood Forest Hospitals *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.	09:00	**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.	09:05	**Introduction** Rukshana Kapasi, Trust Chair	Assurance	Verbal
5.	09:15	**Patient Experience – Website accessibility** Presentation by the Head of Communications	Assurance	Presentation
6.	09:25	**Staff Experience – Enhancing our Resident Doctors' Experience** Presentation by the Chief Medical Officer	Assurance	Presentation
7.	09:35	**Minutes of the meeting held on 4th June 2026** To be agreed as an accurate record	Agree	Enclosure 7
8.	09:40	**Action Tracker**	Update	Enclosure 8
9.	09:45	**Chair's Report**	Assurance	Enclosure 9
10.	09:55	**Chief Executive's Report**	Assurance	Enclosure 10
	Strategy			
11.	10:20	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Perinatal Quality and Safety** Report of the Chief Nurse and the Chief Medical Officer • **Perinatal Safety Champions Update** Report of the Chief Nurse and the Chief Medical Officer	Assurance Assurance	Enclosure 11.1 Enclosure 11.2
12.	11.00	**CQC Report outcome** Report of the Chief Nurse	Assurance	Enclosure 12
	11:10	**BREAK (10 mins)**		
	Operational			

	Time	Item	Status	Paper
13.	11:20	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 13
	Governance			
14.	12:20	**Fit and Proper Person Test compliance** Report of the Director of Corporate Affairs (DoCA)	Assurance	Enclosure 14
15.	12:30	**Assurance from Sub Committees**		
		• **Finance Committee** Report of the Committee Chair (last meeting)	Assurance	Enclosure 15.1
		• **Quality Committee** Report of the Committee Chair (last meeting)	Assurance	Enclosure 15.2
		• **Audit and Assurance Committee** Report of the Committee Chair (last meeting)	Assurance	Enclosure 15.3
		• **People Committee** Report of the Committee Chair (last meeting)	Assurance	Enclosure 15.4
		• **Charitable Funds** Report of the Committee Chair (last meeting)	Assurance	Enclosure 15.5
16.	12:40	**Data Security Protection Toolkit Submission** Report of the Senior Information Risk Owner / DoCA	Approval	Enclosure 16
17.	12:50	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
18.	13:00	**Any Other Business**	-	-
19.	-	**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be: **1st October 2026, Boardroom, King's Mill Hospital**		
20.	-	**Chair declares the meeting closed**		
21.	-	**Questions from members of the public present** (Pertaining to items specific to the agenda)		
22.	-	**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. 23	**Perinatal Safe Staffing**
Enc. 24	**Nursing Safe Staffing**
Enc. 25	**Regional Maternity Heatmap**
Enc. 26	**Board Assurance Framework**
Enc. 27	**Significant Risks Report**

	Sub-committee's approved minutes
Enc. 28	• **Finance and Performance Committee**
Enc. 29	• **Quality Committee**
Enc. 30	• **Audit and Assurance Committee**
Enc. 31	• **Extraordinary Audit and Assurance Committee**
Enc. 32	• **People Committee**
Enc. 33	• **Charitable Funds**

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ("THE TRUST")
UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON THURSDAY 4TH JUNE 2026 AT 09:00 IN THE BOARDROOM, KING'S MILL HOSPITAL

Present:	Steve Banks	Acting Chair	SB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Richard Cotton	Non-Executive Director	RC
	Manjeet Gill	Non-Executive Director	MG
	Barbara Brady	Non-Executive Director	BB
	Jon Melbourne	Chief Executive	JM
	Richard Mills	Chief Financial Officer	RM
	Rob Simcox	Chief People Officer	RS
	Simon Roe	Chief Medical Officer	SR
	Phil Bolton	Chief Nurse	PB
	Simon Illingworth	Chief Operating Officer	SI
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
In attendance:	Paula Shore	Divisional Director of Nursing	PS
	Laura Webster	Corporate Secretariat Team Leader (Minutes)	LW
	Caroline Kirk	Communications Specialist	CK
	Jess Baxter	Communications Specialist	JB
	Emma Dawkins	Speech and Language Therapy Service Lead	ED
	Lindsay Chapman	Divisional Director of Nursing	LC
	Mark Clymer	Assistant Chief Pharmacist	MC
Observers:	Rukshana Kapasi	Chair designate	
	Two members of the public		
Apologies:	Jonathan Van Tam	Associate Non-Executive Director	JVT

Item No.	Item	Action	Date
26/074	**WELCOME AND APOLOGIES FOR ABSENCE** Quoracy Check; Quoracy check: (s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)		
Length of Discussion; 1 minute	The meeting was held in person and live-streamed to enable public access. The agenda and papers were published on the Trust website, and members of the public were able to submit questions via a live Q&A function. It was CONFIRMED that apologies for absence had been received from Jonathan Van Tam, Associate Non-Executive Director. The meeting being quorate, SB declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.		
26/075	**DECLARATIONS OF INTEREST**		
Length of Discussion; 1 minute	It was CONFIRMED that there were no additional declarations of interest relating to items on the agenda.		
26/076	**PATIENT STORY – GOLD STANDARD PATIENT MEALTIMES**		
Length of Discussion; 15 minutes	LC and ED joined the meeting. PH introduced the patient story and advised that the presentation related to protected mealtimes and ongoing work taking place across the Trust. A video presentation was then played to the Board featuring members of the Dietetics and Language teams. The video outlined the purpose of protected mealtimes, including reducing non-urgent interruptions during meals, supporting patients with personal preparation prior to eating, ensuring bed spaces were suitable and clutter free, and encouraging patients to use dining areas where possible. The video further highlighted the support provided to patients requiring assistance with feeding, opening packaging, cutting food, and use of adaptive cutlery, alongside arrangements for monitoring nutrition and hydration for patients identified as nutritionally at risk. ED concluded the presentation by noting that the update demonstrated ongoing improvement work intended to strengthen patient experience, dignity, and nutritional outcomes. ED also advised the Board that Nutrition Champions were in place across wards to promote good nutritional practice and hydration awareness. NM queried whether the work relating to protected mealtimes had been formally fed back to the Council of Governors. In response, PH confirmed that feedback had been provided and that there had been engagement with Governors, including involvement from staff Governors in supporting aspects of the work. It was further noted that the patient story would be shared more widely with Governors to support visibility and ongoing assurance.		

	ED provided an update on improvements to the kitchen dashboard, noting that a key risk had been identified in the transfer of dietary information. It was confirmed that Charitable Funds had approved funding for ward-based iPads and cases, enabling each ward to access live data. This development would support real-time updating of the kitchen dashboard and improve the accuracy of dietary information. The change was expected to reduce the risk of patients receiving incorrect meals and enhance nutritional safety. LC and ED left the meeting.		
26/077	**MINUTES OF THE PREVIOUS MEETING HELD ON 2ND APRIL 2026**		
Length of Discussion; 1 minute	Following a review of the minutes of the Board of Directors held in Public on the 2nd April 2026, the Board of Directors APPROVED the minutes as a true and accurate record.		
26/078	**ACTION TRACKER AND MATTERS ARISING**		
Length of Discussion; 1 minute	The Board reviewed the action tracker and AGREED that actions 26/009.1, 26/038, 26/044.1, 26/044.2, 25/133, and 26/046 are COMPLETE and could be REMOVED from the action tracker.		
26/079	**CHAIR'S REPORT**		
Length of Discussion; 3 minutes	SB introduced the report and formally noted his recent appointment as Acting Chair. SB advised that a significant development since the previous meeting had been the appointment of RK as the Trust's substantive Chair, with a confirmed commencement date at the beginning of July. SB welcomed the appointment and noted the value of the experience and leadership RK would bring to the Organisation. SB also recognised the contribution of the outgoing Chair, Graham Ward (GW), acknowledging eleven years of service to the Trust, including his tenure as Chair. SB highlighted GW's patient-centred approach, leadership during periods of organisational challenge, and commitment to supporting colleagues. The Board concurred and formally acknowledged GW's contribution. The Board of Directors were ASSURED by the report. **Council of Governors Highlight Report** SB advised that the Council of Governors had met since the previous Public Board meeting. SB confirmed that the Council of Governors had approved the Trust Chair's appraisal as part of the formal process. SB also advised that the Council of Governors had escalated to the Board of Directors the approval of KPMG as the Trust's external auditors for a further three-year period. The Board of Directors was ASSURED by the report.		
26/080	**CHIEF EXECUTIVE'S REPORT**		
Length of Discussion; 5 minutes	JM introduced the report and reflected on the significant amount of activity that had taken place across the Trust since the previous Public Board meeting in April.		

	JM highlighted the opening of the new Community Diagnostic Centre at Mansfield Community Hospital and thanked everybody involved in the project, including Dr. James Thomas who had led the work as Deputy Chief Medical Officer. JM also advised that Nervecentre had now been implemented within the Emergency Department following implementation within the Urgent Treatment Centre earlier in the year, describing this as a significant milestone in the Trust's ongoing digital journey. JM updated the Board on performance improvements relating to elective recovery and waiting lists, advising that the Trust's overall waiting list was now at its lowest level since before the pandemic. JM acknowledged that further improvement was still required and stated that current levels remained below what the Organisation would ultimately accept, however the progress represented an important milestone for the wider team. JM also confirmed that Newark had been rated "Good" by the CQC and advised that additional CQC visits had taken place, with further updates expected at future Board meetings. JM described the Newark rating as a proud moment for the Organisation and praised colleagues involved within the service. JM additionally reflected on recent leadership changes, including the departure of GW as Chair, formally offering thanks for the contribution he made, and welcoming SB into the Acting position ahead of RK commencing in July 2026. JM advised that the Trust had refreshed its strategy, setting out a clear framework for delivering high-quality care, improving access, and ensuring the effective use of resources. It was emphasised that improvement must be driven through organisational change, including digital transformation, neighbourhood working, and adoption of best practice, supported by initiatives such as Getting It Right First Time. JM also highlighted the importance of being a good place to work, noting the strong link between staff experience, organisational culture, and patient outcomes. The strategic approach was described as ambitious, with a focus on using these priorities as a foundation for future development and continuous improvement. JM referred to the recent passing of Reverend Rodney Warden, acknowledging his longstanding contribution to the Trust and noting that he would be greatly missed. It was noted that a book of condolences had been made available for colleagues. JM also acknowledged the publication of the Lord Mann review that morning, confirming that the Trust would review the findings in detail and respond appropriately once fully considered. Finally, JM recognised National Volunteers' Week, thanking volunteers for their contribution and highlighting their importance to the organisation, including the scale and longevity of volunteer support across the Trust. The Board of Directors was ASSURED by the report.		

26/081	**MAKING TOMORROW BETTER – STRATEGY DELIVERY UPDATE**		
Length of Discussion; 11 minutes	CH joined the meeting. CH presented the six-monthly update on the Improving Lives Strategy, covering October 2025 to March 2026. It was noted that the report aggregated delivery across the Trust's strategies and that a midpoint refresh had refocused priorities on improving through change, driving best practice, and being a great place to work. These priorities, informed by stakeholder feedback, will guide delivery for the remainder of the strategy period. During the period, progress was made in new service models and digital delivery, including CDC pathway developments and Electronic Patient Record (EPR) implementation. Work to support colleagues also continued, including a refreshed Equality, Diversity, and Inclusion (EDI) Policy. Transformation programmes increasingly incorporated health inequalities data, supported by the mobile research unit to improve access and engagement. Investment across the estate continued, including Newark infrastructure, aseptic unit replacement, and development of the Mansfield Community Diagnostic Centre (CDC), supporting delivery of care closer to home through integrated neighbourhood working and partnership approaches. MG queried priorities in the context of performance and financial pressures. CH advised that the priority should remain on driving best practice, noting this would support improvements in patient outcomes, staff experience, and overall performance. CH also highlighted the importance of strengthening the Trust's strategic influence within the local system, including working proactively with partners and positioning the Trust as a key provider of local care. SR highlighted that urgent and emergency care remained a key challenge, noting that while programmes such as Getting It Right First Time (GIRFT) provided significant opportunity, their scale and complexity required clearer prioritisation, including both cross-cutting and specialty-specific actions. PB supported this, noting that pressures within urgent care impacted wider pathways and required clearer prioritisation and simplification. JM sought clarification on the extent to which patient flow was within the Trust's control. SI advised that this was shared between internal and system factors, with significant work required internally, particularly within ED and discharge processes. SI noted that although improvement plans were in place, progress in some areas, particularly discharge, had been slower than expected and required greater traction. NM sought CH's view on the organisation's overall appetite for change. CH advised there was strong appetite, though progress could be hindered by complexity, and emphasised practical, incremental steps to build momentum. ARB asked how Non-Executive Directors could provide additional support. CH advised that focused questioning was particularly helpful, especially in complex situations as it supported teams to identify next steps and progress delivery. The Board of Directors was ASSURED by the report.		

	CH left the meeting.		
26/082	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
Length of Discussion; 26 minutes	**Perinatal Quality and Safety** PB introduced the reports, noting that the integrated Perinatal Quality and Safety report was now in its third iteration and continued to develop as a tool to strengthen triangulation of quality, safety, and assurance. It was emphasised that the report provided improved Board visibility, supported early identification of risks, and enabled appropriate escalation. Improvements were noted in key clinical indicators, including third- and fourth-degree tears and obstetric haemorrhage, although further work was required, particularly in relation to stillbirth outcomes, which remained variable and subject to ongoing review and learning. It was confirmed that all baby losses are now fully reported and reviewed internally and externally, with no specific concerns identified within the reporting period. Ongoing work relating to reduced foetal movement and engagement with families and staff was also highlighted. Safety governance activity remained well established, including walkarounds and staff listening forums, with positive progress also noted in the neonatal unit following leadership changes. Improvements in vaccination uptake were also recognised, alongside forthcoming national reviews. BB raised a query on tobacco dependency compliance, noting a decline in performance and seeking assurance on the cause. PS confirmed that this related to audit and recording processes rather than clinical care, with overall compliance remaining above national standards and improvement ongoing. BB queried training compliance, particularly in relation to changes affecting maternity support workers. PS advised that compliance remained below target due to the increased complexity of national requirements, including additional staff groups; however, this remained a key focus with a trajectory to achieve year-end targets. NM highlighted the improvement in vaccination uptake, commending the impact of recent initiatives in supporting better outcomes for women and babies. The Board of Directors was ASSURED by the report. **Perinatal Safety Champions Update** This item was incorporated within the preceding agenda item. **Antimicrobial Resistance (AMR) – Annual Update** MC joined the meeting. MC introduced the report, noting it was presented in response to NHS England requirements for regular Board oversight of antimicrobial resistance. It was confirmed that established processes were in place, including monitoring of antibiotic usage, multidisciplinary working, and a coordinated approach to antimicrobial stewardship with microbiology and		

	infection control teams. Performance was noted to be broadly in line with national benchmarks and improving against some targets; however, prescribing remained complex, particularly in balancing timely treatment of sepsis with appropriate de escalation. Key areas of focus included strengthening antimicrobial stewardship, improving IV to oral switching, addressing variation in prescribing practice, and reducing C. difficile rates, which remained above target. A programme of improvement was outlined, including enhanced clinician engagement, education, and development of more granular specialty level data to support targeted interventions and clinical ownership. Board discussion highlighted: • The complex and data heavy nature of the report, with a need for clearer summary outputs. • The importance of strengthening antimicrobial stewardship, including improving IV to oral switching to support patient flow, cost efficiency, and patient experience. • The need for improved data and analytical capability, particularly to provide specialty level insight and support clinical teams. The Board noted the report as a useful first presentation and agreed that further development should continue through the Quality Committee, with the item returning annually. ***Action: Quality Committee to oversee further development of the AMR report, with updates provided to the Board via the annual work programme.*** The Board of Directors was ASSURED by the report. MC left the meeting.	**LM**	**06/08/26**
26/083	**STRATEGIC OBJECTIVE 3 - IMPROVE HEALTH AND WELLBEING WITHIN OUR COMMUNITIES**		
Length of Discussion; 11 minutes	**Health Inequalities Annual Statement** SR presented the Health Inequalities Annual Statement, noting this formed part of the Trust's annual requirement and would contribute to the Annual Report. It was confirmed that the report had been refreshed in line with updated NHS England guidance, with a focus on population need, access, experience, outcomes, and governance. Progress was noted in translating data into action, including development of the Health Inequalities Index and work to move from Trust-level reporting to more specialty-level delivery, supported by integrated neighbourhood working. The mobile research unit was also highlighted as improving access and participation for underrepresented groups. SR placed on record thanks to Dr Caroline Panto, Public Health Registrar, acknowledging her significant contribution to the development of this work during the year.		

	NM queried how the impact of this work is measured. SR advised this remains challenging, requiring a whole-system approach, with the Health Inequalities Index supporting progress. BB noted that current measures focus on access rather than outcomes, and that this is a broader NHS issue. MG highlighted the need for greater focus on demand analysis and targeted interventions, with further work required to embed this into specialties. SR acknowledged that this remained an area of ongoing development, with further work required to embed health inequalities thinking within specialties and move towards more targeted, integrated approaches. The Board of Directors APPROVED the Health Inequalities Annual Statement.		
26/084	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
Length of Discussion; 14 minutes	**Capital Expenditure Plan** RM presented the annual Capital Expenditure Plan, noting that it is brought to the Board each year for approval. The plan sets out the Trust's capital investment across infrastructure, medical equipment, and digital developments, with a total value of £21.7m for 2026/27. It was noted that the plan continues to prioritise high-risk infrastructure and operational requirements, including major schemes such as the MRI development, with investment in these areas limiting the ability to fund other schemes. Capital risks are monitored through the Board Assurance Framework and Risk Committee, with ongoing work to maximise access to external funding opportunities. RC queried the balance between replacement and innovation. RM advised that investment was primarily focused on essential replacement, with transformational schemes supported through external funding and targeted initiatives, including the CDC and EPR. LM queried whether sufficient capacity existed to access external funding. RM confirmed this was variable and not dedicated, with work underway to strengthen processes through the Capital Resources Group. MG queried whether increasing maintenance reflected an ageing equipment risk. RM advised that while monitoring arrangements were in place, there was no consistent metric to track emerging equipment risks, and further development was required. The Board also noted that capital constraints continue to impact business-as-usual delivery, with limited ability to address backlog pressures in the short term. RM highlighted recent delivery of major capital schemes, including the CDC, clinical research facility, aseptic unit improvements, MRI development, and EPR implementation. The Board of Directors APPROVED the Capital Expenditure Plan.		

26/085	**STRATEGIC OBJECTIVE 6 - WORK COLLABORATIVELY WITH PARTNERS IN THE COMMUNITY**		
Length of Discussion; 6 minutes	**Partnerships Annual Review** CH joined the meeting. CH presented the annual Partnerships Review, noting that partnership working had become increasingly critical, but also more complex, within a rapidly changing NHS landscape. It was reported that the review focused on strategic partnerships supporting delivery of the Trust's objectives and wider anchor responsibilities, rather than providing an exhaustive list of all relationships. The report provided assurance that the Trust's approach to partnerships was continuing to mature, with progress in delivering care despite significant changes across national policy, Integrated Care Boards, local government, and partner organisations. It was acknowledged that the partnership landscape remained dynamic and, at times, difficult to define; however, effective partnership working remained essential to achieving improved patient outcomes. CH outlined the future direction, noting that partnership development would be progressed across four key themes: system leadership and strategic partnerships; clinical collaboration and provider partnerships; population health, prevention, and neighbourhoods; and digital, data, and improvement partnerships. It was recommended that the Board note the report and that oversight continue through the Partnerships and Communities Committee, with further review of the approach planned via a forthcoming workshop. RS reflected on a recent People Committee discussion, highlighting the partnership with West Nottinghamshire College as a positive example of long-standing collaboration beginning to demonstrate tangible outcomes. RS suggested that showcasing such examples would help to better demonstrate the value of partnerships, particularly in public-facing Board discussions. CH welcomed this observation and agreed that there was a need to better highlight and celebrate successful partnership outcomes. It was confirmed that this would be incorporated into the forthcoming Committee workshop to support greater visibility of partnership impact. The Board of Directors was ASSURED by the report. CH left the meeting.		
26/086	**2026/2027 TO 2028/2029 PLANNING**		
Length of Discussion; 3 minutes	RM presented the Trust's Medium-Term Plan submitted in line with NHS England requirements, covering a three-year period and incorporating access, quality, finance, and workforce priorities. It was reported that the plan had been assessed as compliant with conditions, with a particular emphasis on achieving financial sustainability and break-even over the period. The plan included a focus on reducing elective and cancer waiting times, improving urgent and emergency care, and delivering efficiency through financial controls, service redesign, digital enablement, and workforce optimisation. It was noted that delivery remained dependent on effective		

	system-wide collaboration, particularly in managing ongoing risks within urgent care pathways. The Board of Directors was ASSURED by the report.		
26/087	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Length of Discussion; 23 minutes	The Board noted that performance across urgent and emergency care remained challenging, with ongoing delays, crowding, and impact on patient experience. Key concerns included C. difficile rates, infection prevention, and loss of decant capacity. NM queried the clarity of the stillbirth metric and requested alignment with statistical reporting methods. It was confirmed that IPR updates are in progress to address this. The Board also noted that workforce performance remained mixed, with ongoing challenges in vacancy rates, appraisal compliance, sickness absence, and variable pay, although improvements in sickness absence and prior reductions in agency usage were recognised. The Board noted that while there were areas of strong performance, it would be important to maintain momentum, particularly in areas such as mandatory training. It was also noted that national best practice guidance was available and would be considered through the People Committee to support further improvement. Operational performance showed continued improvement in elective pathways, with reductions in long waits and positive impact from increased activity, including at Newark. Cancer performance remained mixed, with the 62-day pathway below target but early signs of improvement. Diagnostic performance had been impacted by demand pressures, with recovery expected following additional capacity. The Board noted that the CDC had opened and was beginning to deliver planned activity, with expectations of further improvement as services scale. LM sought assurance on timelines and the quality of care for patients waiting. PB acknowledged that while patients continued to receive care and supervision, delays in assessment and treatment remained significant, particularly overnight. It was emphasised that reducing waiting times and ensuring patients are assessed in a timely manner remained a key area of focus, with recognition that further improvement was required. NM raised concerns regarding lack of improvement in medically fit for discharge patients. SI confirmed that this remained a system-wide issue, with ongoing engagement across partners including the ICB and local authority. Planned actions included further system collaboration, implementation of a discharge to assess model, and introduction of a trusted assessor pilot, with expectations that these would begin to improve flow over time. JM summarised the discussion, noting that key areas would be taken forward through the relevant sub-committees, including the impact of the SDEC move, delivery of CDC activity, and recovery of four-hour performance, with updates to be reported back to the Board. JM also highlighted the need to clarify and strengthen the Trust's asks of system partners, particularly in relation to improving patient flow and reducing		

	delays. It was agreed that this would be developed further and brought back to the Board for review. ***Action: Monitor the impact of the SDEC move, CDC activity delivery, and four-hour recovery, and clarify the Trust's asks of system partners, with updates reported to the Board.*** RM reported the financial position, including an in-month deficit driven by industrial action and income pressures. While the run rate had stabilised, delivery of efficiency plans remained below target, and cash flow pressures required a support request to NHS England. SB confirmed the proposed governance approach for approving the cash support request. RM advised the Board that the Finance and Performance Committee had recommended delegated authority to a small executive group, consisting of the Chief Financial Officer, Chief Executive, Trust Chair, and Chair of the Finance Committee, to act on behalf of the Board and submit the request on the 5th June 2026. The Board DELEGATED approval of the cash support request as outlined, authorising the named group to act on its behalf. The Board of Directors was ASSURED by the report.	**JM**	**06/08/26**
26/088	**IPR ANNUAL REVIEW**		
Length of Discussion; 2 minutes	SI introduced the annual review of the IPR, reminding the Board that this had previously been presented at a Board workshop. It was noted that the review reflected changes to national reporting requirements, including the addition of eleven indicators, removal of five, and amendment of three. The overall structure of the report remained unchanged, providing continuity in how performance information was presented. It was confirmed that where indicators had been removed from the national dataset, appropriate alternative arrangements were in place to ensure continued oversight through relevant governance forums. It was noted that the impact of these changes on the oversight framework was still to be fully understood, with further national data expected in the coming months. No concerns were raised by Board members, noting that the proposed changes had already been subject to prior discussion. The Board of Directors APPROVED the updated IPR framework.		
26/089	**POST WINTER PLAN DE-BRIEF**		
Length of Discussion; 2 minutes	SI advised that the update largely reflected the position presented in the previous meeting and was being brought to the Board formally. The Board took the report as READ. JM queried when the winter plan for the forthcoming year would be presented to the Board. SI confirmed that preparatory work was already underway, including recent engagement with divisional teams to begin planning for the next winter period. The Board of Directors was ASSURED by the report.		

26/090	**COMMITTEE GOVERNANCE HEALTH CHECK**		
Length of Discussion; 2 minutes	SBS presented the annual Committee Governance Health Check, summarising reviews undertaken across Board committees. It was noted that the process remained aligned to national guidance and provided assurance that committees continued to operate in line with their terms of reference. It was also confirmed that the exercise had been renamed from "Committee Effectiveness Review" to "Governance Health Check" to improve clarity, with no change to the underlying methodology. The report evidenced completion of outstanding actions from the previous year and identified a small number of areas for ongoing improvement. The Board of Directors was ASSURED by the report.		
26/091	**ASSURANCE FROM SUB-COMMITTEES INCLUDING ANNUAL REPORTS**		
Length of Discussion; 15 minutes	**Finance Committee** RC provided the following updates: • Delivery of the efficiency programme is below plan, with c.£17m identified against a £34.4m requirement, and further work required to close the gap. • Continued focus is required to ensure schemes are well-developed, targeted and deliverable. • Positive progress against the sustainability risk was noted, with a reduction in overall risk score; however, capital, and financial risks remain unchanged. • The Committee has transitioned to a Finance and Performance Committee, reflecting a more integrated approach to financial and operational oversight and avoiding gaps between domains. • Clarity has been established regarding the interface with Quality Committee, ensuring responsibilities remain aligned and that no issues fall between governance structures. • Encouraging progress was reported from GIRFT and improvement (WAVE) initiatives, supported by data insight. **Quality Committee** LM provided the following updates: • Capital constraints are impacting delivery of quality improvements and transformation, including risks relating to equipment and service development. • Specific concerns were discussed in relation to the stroke pathway and diagnostic risks, with ongoing work to address these. • Continued pressure across urgent and emergency care, including demand, capacity, medical bed pressures, and the use of non-standard clinical spaces, impacting patient experience and privacy. • Ongoing discharge constraints, including delays in care packages, with system-wide work underway to improve flow and reduce length of stay. • Further analysis of geographical demand patterns was available and would be shared with system partners to support planning and collaboration. • Positive progress was noted in areas such as GIRFT and improvement programmes, demonstrating improvement at specialty level. • The Committee continues to provide robust monthly oversight,		

supported by high-quality papers and constructive discussion.

Audit and Assurance Committee
MG provided the following updates:

- Overall positive assurance was provided across a range of areas and updates.
- A key focus was the need to maintain delivery of higher and medium risk internal audit actions in the context of organisational capacity pressures.
- Performance against internal audit actions was slightly below the 68% target, requiring continued focus and oversight.
- Corporate governance and support capacity was noted as stretched, impacting delivery.

MG left the meeting.

People Committee
SB provided the following updates:

- A request to strengthen oversight of the workforce impact of digital transformation, ensuring staffing implications are fully understood alongside programme delivery.
- A query regarding the deliverability of the business case for automated voice technology, with a request for further assurance through the relevant governance route.
- Ongoing consideration of the Board Assurance Framework risk relating to workforce capacity and capability, which remains high and has been in place for a prolonged period. Recognition that, while the risk remains significant, mitigation measures may be having effect, given it has not worsened despite ongoing pressures. Agreement to keep the risk under review, with further discussion planned at a future Committee meeting.

RS welcomed the report on the impact and contribution of volunteers, noting it was timely in light of National Volunteers' Week and was available within the Reading Room. RS suggested that the report would be valuable for consideration at Board level to further highlight the role of volunteers. SB supported this view and recommended that Board members review the report, noting it provided a strong reflection of the contribution of volunteers and the impact of charitable funds in supporting the organisation.

Charitable Funds Committee
ARB provided the following updates:

- Thanks were recorded for the significant contribution of volunteers.
- The importance of clinical engagement prior to equipment purchases was highlighted, with reference to a defibrillator-related decision requiring further clinical review.
- Approval of investment in new equipment funded through Charitable Funds, which was noted as being well received and supporting patient care .
- The need to increase promotion of the Charity Lottery, which had not yet broken even, to prevent a reduction in participation and income.
- A wider observation that Charitable Funds remain limited in scale, with ongoing consideration required around funding priorities and sustainability.

	• A reminder was provided regarding an upcoming abseil fundraising event, with encouragement for wider participation. **Partnerships and Communities Committee** BB provided the following updates: • The partnership landscape remains highly dynamic, particularly due to ongoing changes across the ICB and place-based working arrangements, with potential implications for the Trust. • There remains a level of uncertainty regarding roles, responsibilities, and resourcing within the evolving system, which could have a significant impact on delivery. • Work has been commissioned to assess the resource required to support the strategic partnership agenda, including health inequalities. • Consideration was given to the impact of changes in key personnel, recognising the importance of sustaining capability in this area. The Board of Directors was ASSURED by the reports from all sub-committees.		
26/092	**MARTYN'S LAW FRAMEWORK**		
Length of Discussion; 7 minutes	LW joined the meeting. LW presented the report, noting the Trust was ahead of schedule in implementation, including establishment of a working group, defined senior accountability, and completion of initial compliance assessments. It was confirmed that the Act will come into force in April 2027, with preparatory work underway, including mandatory counter-terrorism training for staff and a planned multi-agency exercise to test lockdown and evacuation procedures. LM queried whether the planned counter-terrorism exercise would be a table-top exercise or a full simulation and sought assurance regarding its scope. LW confirmed that the exercise would be primarily a table-top exercise but would include elements of simulated activity supported by Counter Terrorism Policing to test response processes. It was noted that this approach would allow a walkthrough of lockdown and evacuation procedures while mitigating the risk of causing concern to patients and the public. LM emphasised the importance of a multi-agency approach, noting that cross-organisation coordination was critical to effective response. LW also confirmed that funding had been secured for colleagues to complete Level 3 counter-terrorism training, which would support further development of vulnerability assessments and organisational preparedness. JM sought assurance that the Trust was on track and whether further support was required. LW confirmed confidence in achieving compliance, supported by Level 3 counter-terrorism training and ongoing national guidance. It was also highlighted that continued support from the Board and wider teams would be important, alongside expected additional national guidance as the legislation is further developed. ARB asked whether the counter-terrorism training would be mandatory for all staff or targeted to specific groups. LW confirmed that the training		

	would be mandatory for all staff, in line with the requirements of the legislation. The Board of Directors was ASSURED by the report. LW left the meeting.		
26/093	**CQC FINAL REPORT NEWARK END OF LIFE CARE**		
Length of Discussion; 3 minutes	PB presented the final CQC report following the Newark inspection, noting that it demonstrated significant improvement, with the service improving from Requires Improvement to Good and achieving an Outstanding rating in one area. Newark Hospital remains rated Good across all domains. It was noted that the report identified continued progress alongside areas for further improvement, with work ongoing to drive improvement. PB also advised that additional unannounced inspections had taken place, including end of life care and acute medicine, with feedback awaited or under review. Board members welcomed the positive outcome, noting that inspections should be viewed as an opportunity for learning and continuous improvement. The Board commended the teams involved, particularly in relation to the Outstanding rating in caring, and noted the Trust's positive and proactive approach to inspections. The Board of Directors was ASSURED by the report.		
26/094	**SPOTLIGHT ON – THE OPENING OF THE NEW MANSFIELD COMMUNITY DIAGNOSTIC CENTRE**		
Length of Discussion; 2 minutes	The Board received a spotlight update on the opening of the Mansfield CDC, noting it was a significant £27.5m investment and the largest expansion of diagnostic capacity undertaken by the Trust. The facility provides a wide range of diagnostic services, including imaging, endoscopy, cardio-respiratory testing, and outpatient services, supporting improved access and faster diagnosis for patients. It was highlighted that the Centre enables more care to be delivered closer to home, with improved accessibility and patient experience. The Board noted that the new service model supports streamlined patient pathways, including same-day diagnostics and treatment planning in some cases, significantly reducing waiting times. Positive early feedback from patients and staff was reported, alongside the expectation that the Centre will deliver up to 100,000 additional tests per year, contributing to reduced waiting times and improved outcomes. NM asked whether the update had been shared with the Council of Governors, noting that the topic had been raised previously. It was confirmed that this would be shared at a future Council of Governors meeting. ***Action: CDC spotlight video to be presented at a future Council of Governors meeting.***	**SB**	**06/08/26**

26/095	**COMMUNICATIONS TO WIDER ORGANISATION**		
Length of Discussion; 1 minutes	JM advised that there were no specific decisions requiring formal communication to the wider organisation arising from the meeting. However, it was noted that a number of updates, including financial matters and capital planning, would be shared through routine communication channels.		
26/096	**ANY OTHER BUSINESS**		
Length of Discussion; 1 minute	No other business was raised.		
26/097	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED that the next Board of Directors meeting in Public would be held on 6th August 2026 at 09:00. There being no further business the Chair declared the meeting closed at 12:00.		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. **Steve Banks** **Acting Chair** **Date**		

26/098	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
Length of Discussion; 1 minute	SB reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
26/099	**BOARD OF DIRECTOR'S RESOLUTION**		
Length of Discussion; 1 minute	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

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

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

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
26/082	04/06/2026	Quality Committee to oversee further development of the AMR report, with updates provided to the Board via the annual work programme.	Public Board of Directors	Quality Committee	06/08/2026	L Maclean	M Clymer		Amber
26/087	04/06/2026	Monitor the impact of the SDEC move, CDC activity delivery, and four-hour recovery, and clarify the Trust's asks of system partners, with updates reported to the Board.	Public Board of Directors	Relevant	06/08/2026	J Melbourne	S Illingworth	**Update 24/07/2026** These areas will be overseen by OPC and reported to Board via the access and FPC updates	Amber
26/094	04/06/2026	CDC spotlight video to be presented at a future Council of Governors meeting.	Public Board of Directors	Council of Governors	06/08/2026	S Banks		**Update 03/07/26** Notification sent to Emma Day to schedule onto a future CoG agenda.	Amber
26/012	05/02/2026	Target and tolerable levels of risk to be reviewed at a future Board of Directors workshop	Public Board of Directors	None	01/10/2026	J Melbourne		**Update 20/02/2026** Added to Board workshop schedule for September 2026	Grey
26/014	05/02/2026	Penny Dash Report (Patient Safety across the Health and Care Landscape in England) to be a topic for a future Board of Directors workshop	Public Board of Directors	None	01/10/2026	P Bolton		**Update 20/02/2026** Added to Board workshop schedule for September 2026	Grey

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Public Meeting of the Trust's Board of Directors - Cover Sheet

Subject:	Chair's report	**Date:**	30 July 2026
Prepared By:	Rich Brown, Head of Communications and Rukshana Kapasi OBE, Trust Chair		
Approved By:	Rukshana Kapasi OBE, Trust Chair		
Presented By:	Rukshana Kapasi OBE, Trust Chair		

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

Recommendation

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

ATTFE = Academy Transformation Trust Further Education
NEDs = Non-Executive Directors
NHS = National Health Service

Executive Summary

An update regarding some of the most noteworthy events and items from the past two months from the Chair's perspective, covering June and July 2026.

Personal introduction

I am delighted to have taken up my position as Chair of Sherwood Forest Hospitals, which has given me opportunity to be back in Mansfield where I grew up and have the opportunity to give back to the community that gave me so much. It has been a busy three weeks and I have thoroughly enjoyed meeting patients, families, colleagues, volunteers, governors, partners across the system and my fellow Board members.

As I have gone round various departments and services, I have really appreciated your warm welcome, encouragement and the feeling of *family* that Sherwood exudes.

Some of my highlights have been hearing about the innovation happening in our maternity services, such as the continuity of care in our pathways, the excellence in our neonatal services and the research we are innovating around data and equity. At a time when maternity services across the country have been under the spotlight and as a mother with experience of three maternity units, I know I would have benefited from some of the services and pathways we provide. So, it is important that we recognise and are proud about what we are doing well and the difference it is making to how patients access and experience our services and the outcomes they have.

I feel privileged to have met so many inspiring leaders at every level who have worked for Sherwood for so many years and still want to develop their services to a standard they would want to experience for themselves and their families. So, I will mention just a few:

- Mandy, the receptionist I met on Ward 36, who shared some brilliant ideas about avoiding duplication. This was during a '15 Steps' visit with the dynamic Marie Sissons (our Acting Divisional Director of Nursing Division of Surgery, Anaesthetics & Critical Care) whose person-centred approach, vibrancy, professionalism, and attention to detail was second to none.

- It was also a pleasure to meet Elizabeth Sansom, a Matron in End of Life Care, and Bruce Clayton, our Mortuary Technician, to see their proactive leadership in ensuring that all the mortuary pathways and services we provide are thoughtful and caring at such an important time in peoples' lives.

- My first three weeks would not have been complete without visiting theatres, who have faced some enduring challenges, so it was heartening to meet Trevor Hammond, Pete Pinnick and Helen Westwell.

- I was impressed by the progress this team of leaders have made on cultural change in a short space of time with a continuous improvement mindset and perseverance. They have taken our 'CARE' values, articulated what that requires in terms of behaviour and actions and, by building them into daily routines, they are encouraging people to live and breathe our values purposefully. This type of cultural change work around improving equity and inclusion to create an environment that everyone wants to work in is never easy, it requires long term follow through, so it was good to see transformational leadership in action.

Members of our Theatres team proudly showcase their Theatres team charter

As Chair, I know we have more to do to make our services more effective, efficient, high quality and person-centred and to improve the time patients are waiting, as we know this then affects their outcomes. This improvement work is so important as we know that people in the population we serve who experience more inequalities are more likely to have poorer access.

As a carer of elderly parents who have used our services over many years, I am bringing a personal commitment to enable Sherwood to be the best it can be. I am also committed to working with colleagues to do that, as I strongly believe in the words of an African proverb: 'If you want to go fast, go alone; if you want to go far, go together.'

As Chair, I have good reason to be hopeful and optimistic because I have every confidence in all of you and the values-based, dynamic leadership we have in Jon, our Chief Executive and the Executive team. This, together with the skills and capabilities we have among our Non-Executive Directors (NEDs) who collectively form our unitary Board at Sherwood, adds to the strength that I as Chair look forward to empowering to give us robust assurance as an organisation. What is clear to me as Chair is that, if we look at things differently, we are more likely to do things differently.

And finally, to colleagues working across the Trust: please do reach out to me. I would love to come and meet you and see the work you are doing to improve lives.

Recognising the difference made by our Trust Charity and Trust volunteers

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

In June and July alone, 383 Trust volunteers generously gave over 9,200 hours of their time to help make great patient care happen across the 27 services they have supported during the month.

Other notable developments from our brilliant Community Involvement team and our team of volunteers include:

- Emergency Department Consultant Andrew Jacklin ran the Derby half marathon and raised £1,000. Pictured right.
- Emily's Ice cream van at King's Mill Hospital donated a proportion of profits to the Trust Charity, with the first week's donation totalling £523.

Celebrating Volunteers' Week 2026

Volunteers' Week 2026 celebrated the fantastic contribution that our team of volunteers give to our hospitals. During the week, which ran between Monday 1 and Sunday 7 June 2026:

- Volunteers were given a "make the difference" pin badge by the Community Involvement Team and an individually wrapped cupcake kindly baked by Butterfly Bakes Community Ambassadors at ATTFE College.
- Appreciation stations were situated in the main entrances for staff, patients and visitors to offer words of thanks.
- Engagement events were held at King's Mill and Newark Hospitals which were very well-attended and appreciated by the volunteers.
- Members of the Executive Team showed their support by visiting volunteers throughout the week to thank them personally for their invaluable contribution.

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.

Sherwood hosts second King's Mill Charity Abseil

I was delighted to join the second King's Mill Charity Abseil event, which helped to raise essential funds for the Trust Charity.

As the incoming Chair, I'm very conscious of the trust that people place in us when they come into our care, and I know the vital role our charity plays in supporting both patients and staff. It was wonderful to do the abseil before I started in post to meet patients and volunteers who are supporting the abseil because they have received such compassionate and outstanding care, and staff who are scaling the heights because they are so passionate about the services we provide at Sherwood'.

I was just one of 48 people to take part in the abseil, with many of the participants really getting into the spirit by abseiling down in fancy dress.

It was fantastic to see a second abseil event arranged to bring so many people together in support of our hospitals. We are incredibly grateful to everyone who took part and to our amazing volunteers who supported on the day.

The event raised more than £13,000 for the Trust Charity.

Other Trust updates

Council of Governor elections update

Polls for this year's Trust Council of Governor elections closed on Wednesday 8 July, with the following results being declared following the election:

- For our Mansfield, Ashfield & surrounding areas public constituency: Tracy Burton and Pam Kirby were both re-elected, with serving governor John Dove losing his seat. Gurtej Sandhu was elected as a new governor.
- For our Newark, Sherwood and surrounding areas public constituency: Peter Gregory and Shane O'Neill were re-elected, with new governor Neil Fuller elected to the vacant seat in this constituency.
- In our Rest of England public constituency, Dean Wilson was re-elected unopposed.
- For our staff constituency, Samantha Musson was re-elected.

Thank you to everyone who took the time to vote in this year's Trust Council of Governor elections and for making your voice heard. You can view the results of this year's election here.

Outstanding Care,
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Public Meeting of the Trust's Board of Directors - Cover Sheet

Subject:	Chief Executive's report	**Date:**	30 July 2026
Prepared By:	Rich Brown, Head of Communications and Jon Melbourne, Chief Executive		
Approved By:	Jon Melbourne, Chief Executive		
Presented By:	Jon Melbourne, Chief Executive		

Purpose

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

Recommendation

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

BAF = Board Assurance Framework
CQC = Care Quality Commission
GIRFT = Getting It Right First Time
MRI = Magnetic Resonance Imaging
NHS = National Health Service
NOF = National Oversight Framework
OBE = Officer of the Order of the British Empire
PR = Principal Risk
UoN = University of Nottingham
VWNC = Vision West Nottinghamshire College

Executive Summary

An update regarding some of the most noteworthy events and items from the past two months from the Chief Executive's perspective, covering June and July 2026.

Introduction

I am pleased to share this latest report, which includes a number of updates from across the Trust. I would also like to formally welcome Rukshana Kapasi OBE to the Trust as Chair. I am excited to work with Rukshana to help Sherwood Forest Hospitals be everything it can be.

As we head into the summer, I hope that colleagues get some time to rest and recharge. Yet I recognise the pressures that we have every day mean that this can be difficult — including challenges presented by the heatwave and increasing demands on our services. I am so grateful for everyone's hard work during this time.

We have committed to driving best practice, improving through change, and being a great place to work – and doing these things helps us to achieve our goals, including high quality, compassionate and efficient care.

Our focus best practice can be seen in our recent CQC result, where we were proud to receive a 'Good' rating from the CQC in July. This is a testament to the hard work of colleagues across Sherwood. We will use this as a springboard to improve. We continue to do this in areas such as the National Getting It Right First Time (GIRFT) programme, who have visited us this month to help us make progress in priority areas such as Urgent and Emergency Care.

We are improving through change: for example our Nervecentre roll-out within our Emergency Department and Urgent Treatment Centre is supporting us to provide better, more digitally-enabled care. We have exciting future plans in digital, leading us towards an Electronic Patient Record which will continue our digital journey. After the opening our Community Diagnostic Centre earlier this year, we also have a new surgical sterilisation unit and MRI facility opening later in the year, as well as ongoing works in our Emergency Department.

This month, I am also delighted to welcome our new resident doctor cohort – 243 colleagues in total. As with all colleagues, we know that being a supportive, caring and compassionate place to work translates into high quality care.

I would also like to acknowledge the publication of Donna Ockenden's Independent Review of Maternity Services and the Amos Review since our last Board. The findings have significance for maternity care across the country. Our thoughts are with the families affected and we recognise the profound impact this will have had on them. As a Trust, we will carefully review the findings to ensure that we learn from the reviews and use that learning to strengthen our own services here at Sherwood Forest Hospitals. We are proud of our services and we can also strengthen through improvement.

Trust updates

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

We were pleased to report that King's Mill Hospital was rated 'Good' overall in a report issued by the independent regulators of health and adult social care services in England on Wednesday 15 July 2026.

The report shares the outcome of the inspection from the Care Quality Commission which took place on Monday 9 and Tuesday 10 March 2026, rating the hospital as 'Good' across five other domains of being Safe, Effective, Caring, Responsive and Well-led.

The ratings, which recognise that services are performing well and meeting expectations, were awarded following an inspection of the site's Medical Care and Urgent and Emergency Care services.

In their report, inspectors noted that hospital staff worked well together for the benefit of patients and their loved ones, working alongside other local NHS services to plan and deliver patients' care. Patients who

used services were involved in planning and making shared decisions about their care and treatment and it centred around them and their needs.

The report highlighted a number of strengths across the service, including the Trust's open and honest culture, person-centred approach, and commitment to ensuring patients were seen quickly and that they feel safe, cared for, listened to and fully informed of all treatment options. They also noted that staff worked well in collaboration with colleagues from other services external to the hospital.

After speaking to a number of patients and their carers, the Commission noted that patients and their families were positive about the staff and said they were "treated with warmth, kindness and provided with effective care and treatment". They did not feel anxious about raising concerns and experienced a non-judgmental and inclusive approach to their care.

We are delighted that the Care Quality Commission has recognised the quality of care provided by our teams with an overall 'Good' rating, which reflects the dedication, professionalism and compassion shown by our teams across our hospitals every day.

While recognising the challenges facing NHS services across the country right now, the report highlights our commitment to delivering safe and effective care and recognising the positive experiences of the patients, families and communities we serve.

We are proud of this achievement and remain committed to continuous improvement and building on the CQC's feedback to further enhance the care and experience we provide for our patients.

Trust's National Oversight Framework (NOF) position updated

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

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

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

For us here at Sherwood, the league tables see us ranked 82nd place in the country, placing us in the third of the four segments, recognising that any trust working in financial deficit cannot climb any higher than segment three.

Partnership updates

Hosting the Undergraduate Medical Education Conference

The Undergraduate Medical Education Conference is delivered annually in partnership with the University of Nottingham (UoN) and brings together educators and colleagues from NHS organisations across the East Midlands who are involved in undergraduate medical education.

This year was particularly significant as Sherwood Forest Hospitals became the first Trust outside Nottingham to host the conference, with approximately 130 delegates from across the region.

Hosting the conference provided an excellent opportunity to strengthen the Trust's partnership with the University and regional NHS organisations by sharing best practice, educational innovation and collaborative approaches to supporting medical students.

The event received excellent feedback from delegates, with 97.5% stating they would attend a future conference and the vast majority rating the day as excellent or good.

The success of the conference has also established a lasting legacy, with another regional Trust now planning to host the event in future. Sherwood will support them by sharing the knowledge and experience gained from hosting this year's conference, helping to strengthen collaboration across the region.

The conference showcased Sherwood's commitment to high-quality medical education and reinforced its reputation as a trusted partner in developing the future medical workforce.

By working collaboratively with the UoN and partner Trusts, Sherwood is helping to improve the educational experience for medical students, support the development of educators, and ultimately contribute to the delivery of high-quality patient care across the region.

Securing our future workforce, in partnership with Vision West Nottinghamshire College

The Trust continues to strengthen its strategic partnership with Vision West Nottinghamshire College (VWNC) as part of its commitment to securing a sustainable future workforce and creating opportunities for local people to access careers in healthcare. This partnership supports the Trust's ambitions to expand work experience, apprenticeships and widening participation initiatives, while ensuring local education pathways are aligned to future workforce requirements across both clinical and non-clinical professions.

During the period, the Trust successfully delivered its second VWNC Work Experience Takeover programme. This included interviewing A-Level students and arranging 20 bespoke work experience placements tailored to individual interests and career aspirations. To further enhance the experience provided, a dedicated simulation day was introduced within Operating Theatres, giving students valuable insight into healthcare careers and the realities of working within an acute hospital environment.

These activities were supported by a joint communications campaign with the College, helping to raise awareness of NHS career opportunities and strengthen engagement with prospective future employees.

Contributing to the Building Blocks of Health

The Board will be aware that the factors which most significantly influence health outcomes extend well beyond healthcare services and include wider determinants such as employment, housing, education, environment and community resilience.

As one of the largest employers in the area and an organisation with a long-standing presence in our communities, we recognise both our responsibility and its opportunity to contribute positively to these wider building blocks of health. Working alongside partners, Sherwood continues to use its influence to support healthier, more prosperous and sustainable communities across mid Nottinghamshire and beyond.

Over recent months, the Trust has continued to contribute to the development of the East Midlands Combined County Authority's Heartlands Economic Strategy, covering Ashfield, Mansfield, Newark and Sherwood.

Developed collaboratively by public and private sector partners and led by Vision West Nottinghamshire College, the strategy sets out a shared vision and priorities for economic growth across the area. Trust representatives have supported the development of the strategy through contributions to draft proposals and participation in a stakeholder workshop held in June to help finalise the document.

The Trust has also strengthened its work with local authority partners to explore opportunities to influence the wider determinants of health. Most recently, colleagues contributed to Ashfield District Council's Pride in Place grant decision-making process. The programme provides capital investment to improve community facilities, helping to ensure local assets remain safe, accessible and welcoming.

Such investment supports stronger communities and creates opportunities to bring social support, wellbeing initiatives and health-related activity closer to residents.

Sustainability partnerships

Supporting environmental sustainability remains an important element of the Trust's contribution to population health and the wider determinants of wellbeing.

During the period, the Trust organised a joint "Bioblitz" event at King's Mill Hospital with colleagues from Nottinghamshire Healthcare NHS Foundation Trust and support from the Centre for Sustainable Healthcare. Participants recorded approximately 100 observations of local flora and fauna within the hospital's wildlife and woodland areas, helping to enhance understanding of biodiversity across the site. Partners are now exploring further collaborative opportunities, including the potential development of a shared beehive project.

The Trust has also joined an Integrated Care Board sustainability leads network, bringing together representatives from acute, community and mental health providers across Derbyshire, Lincolnshire and Nottinghamshire. The forum provides an opportunity to share learning, exchange good practice and support progress against organisational and system-wide green plans. Through this collaboration, the Trust continues to strengthen its contribution to environmental sustainability and population health improvement.

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.

Following changes in risk management personnel and the appointment of a new Head of Risk, the Board Assurance Framework reporting schedule has been revised:

- The June report has been deferred to August and is presented later in the agenda.
- Four-monthly reporting to the Board of Directors will now resume, with the next scheduled report due in October 2026.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Director Meeting in Public - Cover Sheet and report

Subject:	Perinatal Services Quality and Safety – May and June 2026 data.	**Date:**	6 August 2026
Prepared By:	Sarah Ayre, Head of Perinatal Services and Lisa Butler, Deputy Head of Midwifery		
Approved By:	Philip Bolton, Executive Chief Nurse, Neil McDonald, Non-Executive Director and Paula Shore, Director of Midwifery and DDN W&C		
Presented By:	Sarah Ayre, Head of Perinatal Services		

Purpose

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

Recommendation

The Board of Directors are asked to:

- **Receive assurance** that effective governance arrangements remain in place to oversee maternity and neonatal quality, safety and organisational risk.
- **Note** the key areas of operational pressure, particularly within Maternity Triage, together with the actions being taken to strengthen workforce resilience, patient flow and escalation.
- **Endorse** the ongoing development of the integrated Perinatal Quality Oversight Model (PQOM) report as the Trust's principal ward-to-board assurance mechanism for maternity and neonatal services.

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

- Nursing and Midwifery AHP Committee
- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Service Line
- Divisional Performance Review

- Perinatal Forum (formally Maternity Forum)
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

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

Executive Summary

This report provides the Board of Directors with an integrated overview of maternity and neonatal safety, quality and governance for May and June 2026, aligned to the NHS England Perinatal Quality Oversight Model (PQOM). It brings together statistical process control (SPC) data, patient safety investigations, mortality reviews, national safety programmes, training compliance, operational performance and organisational risk to provide a comprehensive ward-to-board assessment of service quality and safety.

Overall, the report provides assurance that maternity and neonatal services continue to deliver safe care, with no evidence of sustained deterioration or unrecognised harm across the key quality indicators reviewed. SPC analysis demonstrates predominantly common cause variation, whilst mortality surveillance, patient safety investigations, MNSI learning and NHS Resolution intelligence continue to be actively monitored through established governance arrangements.

The report highlights sustained operational pressures within Maternity Triage, with activity increasing significantly during May and June 2026. Whilst this has impacted performance against the 15-minute initial assessment standard during periods of peak demand, there is no evidence that patient safety has been compromised. Operational review has identified workforce abstraction, rapid surges in attendance and increasing clinical acuity as the principal contributory factors. Improvement work continues to strengthen workforce resilience, patient flow and escalation arrangements.

Key quality indicators remain reassuring. Delivery activity and major obstetric haemorrhage rates remain stable; overall term neonatal admissions remain below the national benchmark despite a single-month increase during June 2026; there were no intrapartum stillbirths, no neonatal deaths during the reporting period, and no new MOSS safety signals or Coroner's Prevention of Future Death reports requiring escalation. Learning from PMRT, MNSI and PSII investigations continues to be translated into measurable quality improvement actions across the service.

During this reporting period, the service has also reviewed maternity service diversions following implementation of the revised Escalation Policy in January 2026. Whilst diversions continue to be clinically led and predominantly driven by acuity, the review has identified opportunities to strengthen out-of-hours operational leadership and improve consistency in application of the escalation process. These findings are informing the revised Escalation Policy and associated options appraisal presented separately to PAC.

The report also assures preparation for new national requirements, including implementation of the NHS England Maternity Outcomes Signal System (MOSS). An annual MOSS Critical Safety Check (Annex 9) drill will be undertaken before the October 2026 PAC meeting to test organisational readiness to respond to a Level 2 safety signal and ensure compliance with national requirements.

Overall, this report assures that the Trust continues to maintain effective oversight of perinatal safety, with robust governance arrangements in place to identify emerging risks, respond to operational pressures and translate learning into continuous improvement. Areas requiring continued focus include maternity triage resilience, workforce sustainability, escalation processes and delivery of improvement actions arising from national safety programmes.

Sherwood Forest Hospitals
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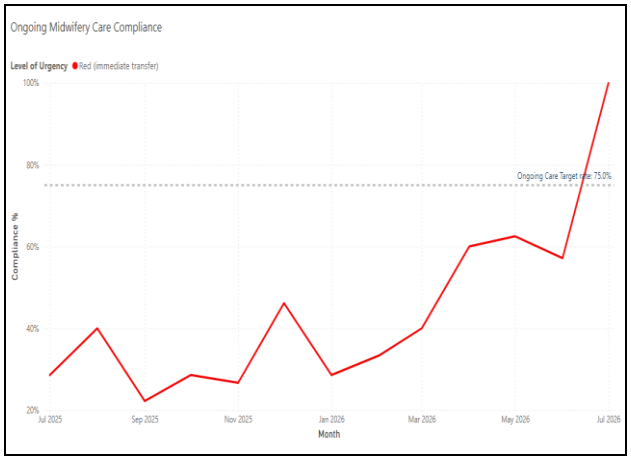
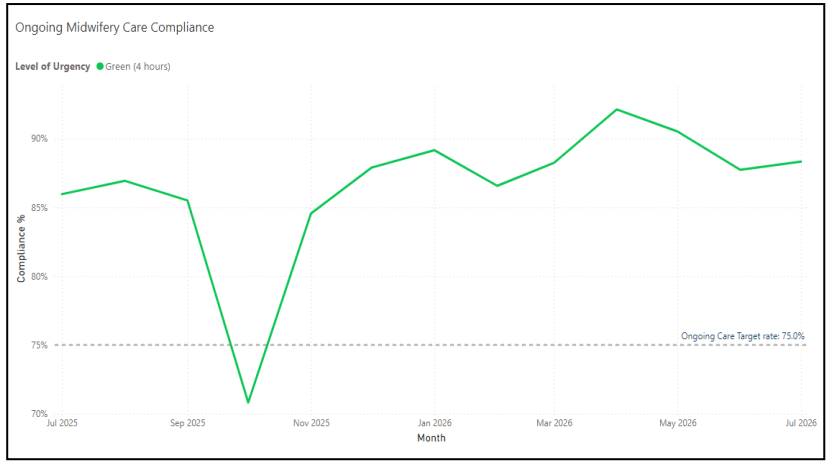
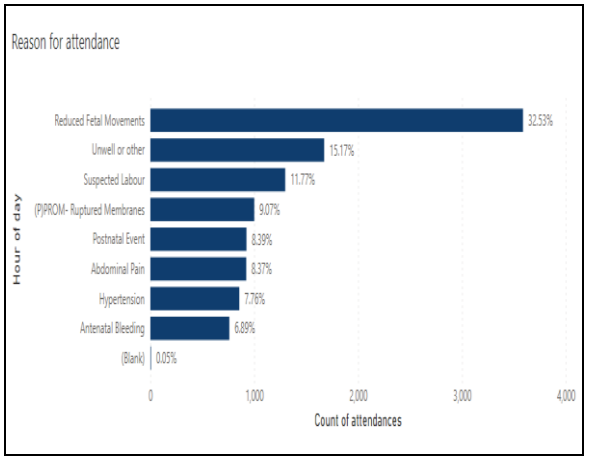
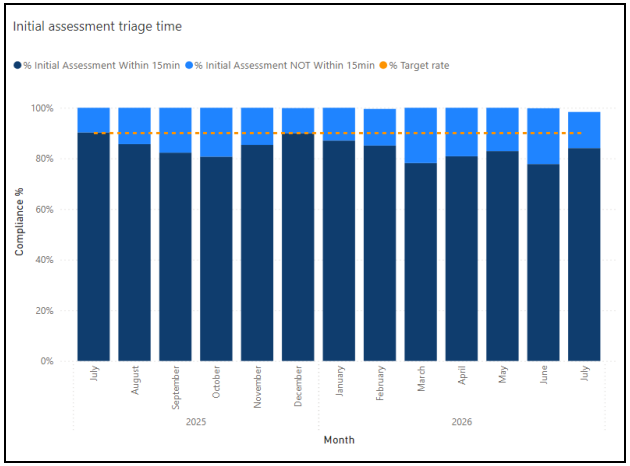
PERINATAL QUALITY SURVELLIANCE DATA – SPC DATA

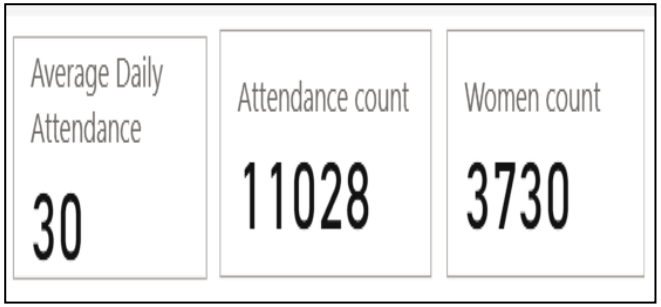
Maternity Triage Data: July 2025-July 2026

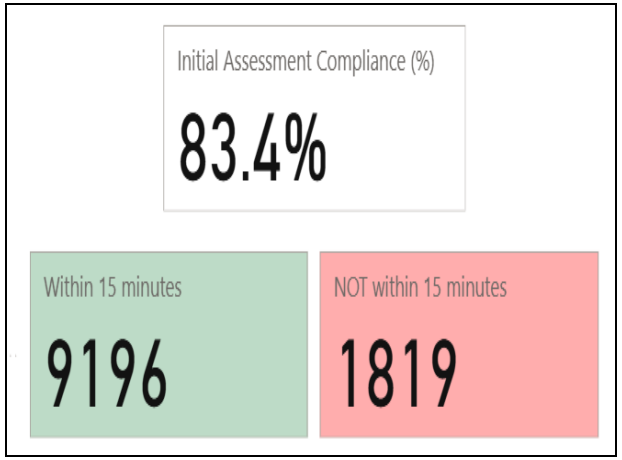












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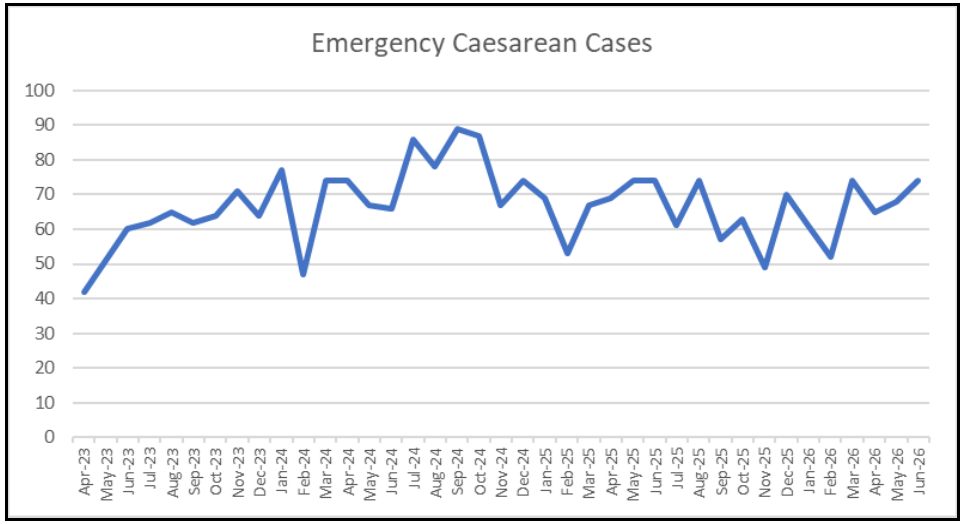
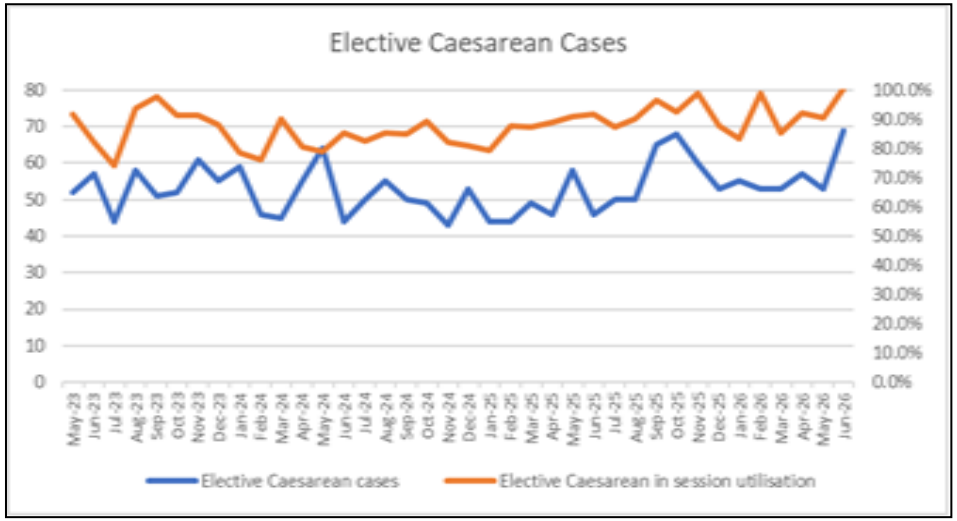
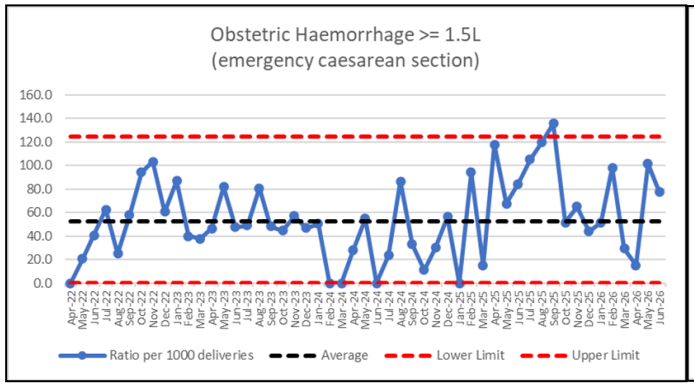
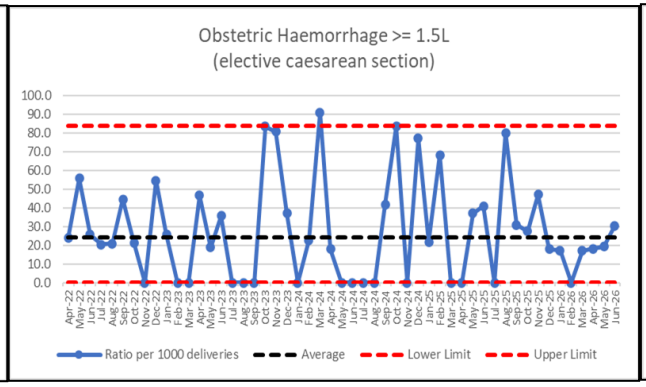
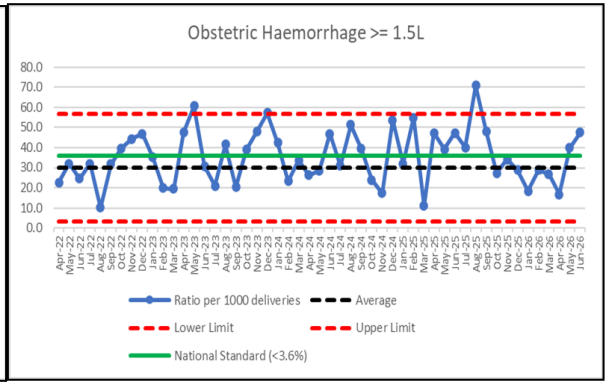
PERINATAL QUALITY SURVELLIANCE DATA – SPC DATA











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Report Overview

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

1.0 SPC Data Overview

This PQOM report uses SPC to provide robust, consistent and meaningful interpretation of maternity and neonatal safety data. SPC enables the Trust to distinguish between expected variation and true change in performance, supporting early identification of emerging risk and timely, proportionate escalation. Across all SPC measures, performance demonstrates predominantly common cause variation with no evidence of sustained deterioration or unrecognised harm. The SPC methodology assures that the service remains stable while enabling early identification of emerging risks should statistically significant change occur.

1.1 Maternity Triage Activity and Performance

Maternity Triage activity has remained consistently high over the last 12 months, with attendances increasing from 852 in December 2025 to over 1,000 attendances per month between April and June 2026, equating to an average of 35 attendances per day. Reduced fetal movements (RFM) continued to be the most common reason for attendance, accounting for approximately one-third of all presentations, alongside sustained demand relating to suspected labour, hypertension and women and birthing individuals presenting as 'unwell.'

The sustained increase in activity has been associated with a reduction in the proportion of women and birthing individuals receiving an initial assessment within 15 minutes, decreasing from 89.9% in December 2025 to 77.8% in June 2026. Review of operational data identified that performance is influenced by periods of rapidly escalating demand, increasing clinical acuity and workforce pressures, particularly when multiple women and birthing individuals present simultaneously requiring urgent assessment. In response, maternity triage performance continues to be closely monitored through operational and governance processes. Learning from periods of peak demand is informing ongoing work to strengthen workforce resilience, optimise patient flow and support timely assessment, ensuring women, birthing individuals and babies continue to receive safe, responsive and personalised care.

Operational data from 27 March 2026 provides a representative example of the challenges experienced during periods of peak demand within Maternity Triage. Within 90 minutes, nine women attended the department, including four arrivals within just 11 minutes. At the peak of activity, ten women were present in triage simultaneously, with five awaiting initial clinical assessment. During this period, workforce pressures were compounded by the redeployment of a triage midwife to support activity elsewhere within the service, resulting in a single midwife managing the increasing demand. Established escalation processes were implemented, including notification of Bronze escalation; however, only 66.7% of women were assessed within the 15-minute standard that day. This example demonstrates the impact that rapid surges in activity, combined with workforce abstraction and increasing clinical acuity, can have on operational performance, despite appropriate escalation and proactive operational management. Learning from these events continues to inform ongoing work to strengthen maternity triage resilience, workforce planning and patient flow.

1.2 Delivery Activity and Obstetric Haemorrhage

Delivery activity has remained stable throughout the reporting period, with no evidence of sustained variation in emergency or elective caesarean section activity. Emergency caesarean birth numbers continue to fluctuate within the expected range for a service of this size and complexity, reflecting normal variation in case mix rather than a change in clinical practice. Elective caesarean section activity has similarly remained consistent, with theatre utilisation maintained at approximately 80–90%, demonstrating effective planning and use of dedicated elective capacity. The introduction of the five-day elective caesarean service continues to support predictable patient flow whilst maintaining high utilisation of available theatre sessions.

The obstetric haemorrhage SPC charts provide further assurance that quality outcomes remain stable. Haemorrhage rates following both emergency and elective caesarean birth demonstrate expected month-to-month variation, with no sustained signals indicating deterioration in clinical performance. Whilst individual months exceed the upper control limit, these represent isolated events rather than evidence of systemic change and are consistent with common cause variation seen within low-frequency outcome measures. Of note, the overall obstetric haemorrhage rate (≥1.5 L) demonstrates a gradual improvement across the reporting period, with recent performance moving closer to, and in several months below, the national benchmark. This suggests that the quality improvement work undertaken across the maternity service, including the implementation of multidisciplinary simulation training and strengthened governance oversight, is becoming embedded within clinical practice.

Overall, these measures assure that, despite increasing operational pressures elsewhere within the maternity pathway, intrapartum activity and key maternal safety outcomes have remained stable. There is no SPC evidence of special cause variation or deterioration in performance, and current trends indicate sustained delivery of safe care alongside continued improvement in the management of obstetric haemorrhage.

2.0 Perinatal Mortality Rate

2.1 Summary

Cases of Stillbirths and Late fetal losses			
Ref No.	**Incident Category**	**Outcome**	**Immediate actions**
May 2026			
103985	IUFD	24+5 attended for planned USS 24+2 – no FH (RIP). Baby born 30/05/26	None identified
June 2026			
104119	IUFD	25+3 IUFD confirmed birthed at 26+0- no signs of life (RIP)	1 Identified
Cases of Neonatal and Postnatal death			
Ref No.	**Incident Category**	**Outcome**	**Immediate actions**
May 2026			
No cases within this period			
June 2026			
No cases within this period			

2.2 Learning from PMRT reviews

Issue		Action	By Who	By When
2025-26 – completed actions				
Q3	Learning update disseminated to ED and SBU staff regarding the CDOP and reporting process.	CDRT to provide learning on annual training regarding usual CDOP processes and correct reporting process.	CDRT Lead Midwife	January 2026
	Reminder to junior Dr's during teaching regarding exploring other avenues with UTI symptoms	Teaching update	Consultant Obstetrician	January 2026
	Update required regarding need for repeat bloods.	Plan to contact patient and repeat bloods as required if consents.	Consultant Obstetrician	January 2026
	Incomplete plans regarding fetal monitoring	Shared learning through an after action review.	Clinical governance midwife	March 2026
	Declined GTT - No HBA1c offered	To discuss Diabetic Specialist MW to clarify if a patient is declining GTT, if any investigations should occur in place.	Clinical governance midwife	December 2025 Discussed – currently unable to offer an alternative – Gold standard is GTT – as per NICE
	Deranged urinalysis not actioned	Individual discussions with MW and Reg regarding management	Clinical governance midwife	December 2025
2025-26 – completed actions				
Q4	Lack of documentation	Discussed with MW at the time of the incident – Retrospective account completed.	Clinical governance midwife	February 2026

	Prescribed Iron BD instead of iron infusion	Learning to staff regarding iron dosage and iron infusion	Clinical governance midwife	March 2026
	No Mifepristone given to commence regime	For discussion with consultant – shared learning.	Consultant Obstetrician	March 2026
	Poor documentation around decision for birth	Individual discussions with staff	Consultant Obstetrician	March 2026
	Incorrect VTE assessment	Individual feedback to Community Midwife	Quality and Safety Lead	March 2026
	UtAD on USS not performed.	Review of CRIS shows that the UtAD was booked however the patient DNAd	Consultant Obstetrician	March 2026
2026-27 – completed actions				
Q1	Missed FGR risk	S2S completed as patient receiving OOA CMW care	RDH	31/07/2026

3.0 The Maternity and Newborn Safety Investigation Programme (MNSI)

3.1 Investigation progress update

(Two open MNSI cases underway within the investigation process.)

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

3.2 Learning from MNSI reviews

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

3.3 Maternity Patient Safety Incident Investigation (PSII)

Ref No.	Incident category	Summary/ Update
DW222256	HIE	Investigation completed, external input received from GP services and EMAS to support completion. The family have received the report and have several outstanding queries. As of June 2026, Consultant Midwife Sam Todd is now leading the completion of this report and plans to meet directly with the family to discuss their concerns.

3.4 Incident tracker for ongoing investigations

	STEIS	PSII	MNSI	Thematic review	Rapid review	AAR	SHOT	TOTAL
Maternity	4	1	2	0	2	2	6	19

4.0 Coroners' report

4.1 Outstanding reports due

	Date Listed	Summary
Nothing to report		

4.2 Regulation 28 report issued

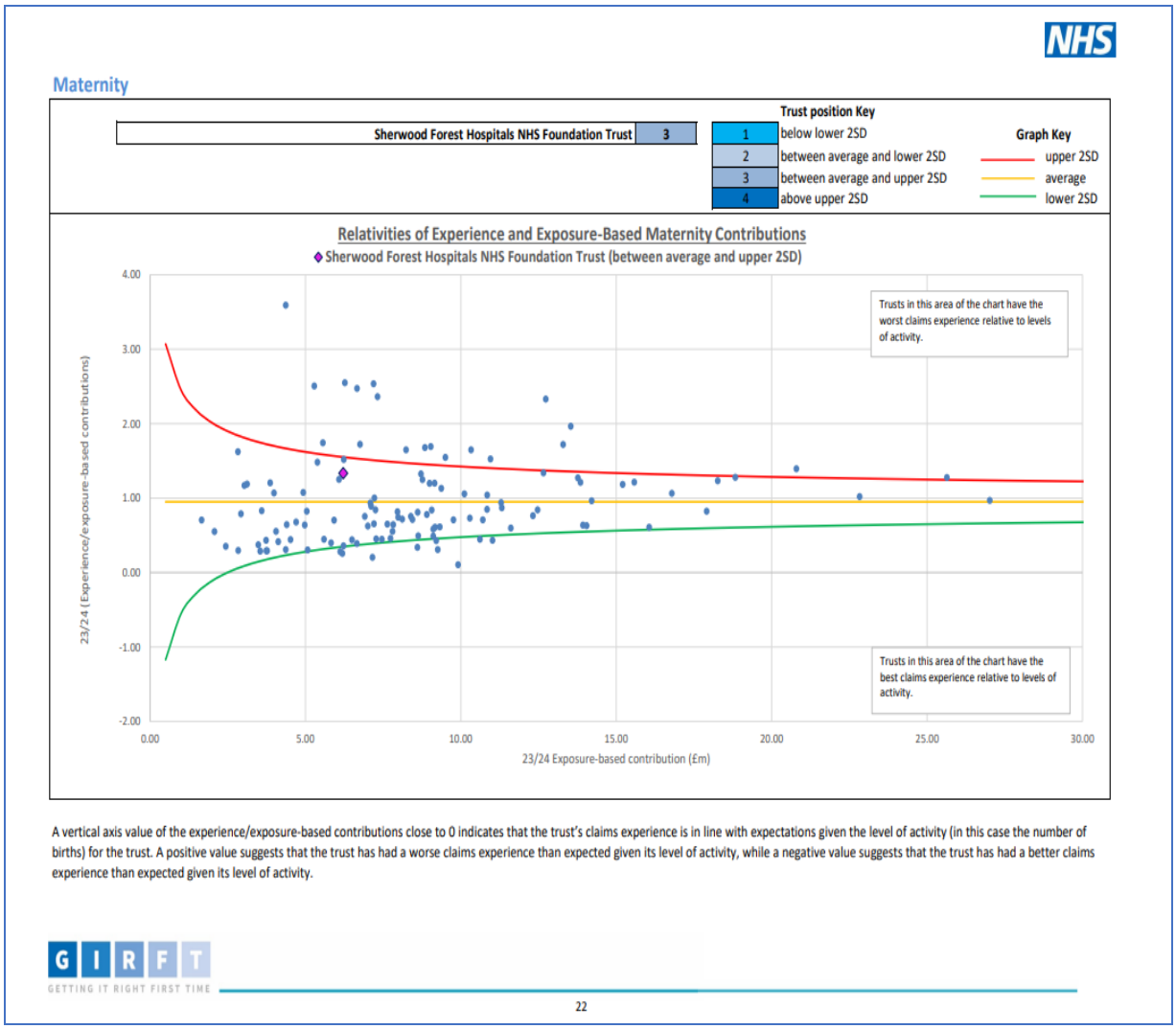
Identifier	Action required	Progress	Responsible role	By when
Nothing to report				

5.0 Review of NHS Resolution Scorecard

Nothing additional to report in May and June 2026.

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

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



6.0 Maternity Outcomes Safety Signals System (MOSS)

MOSS signal received by Trust 2026/2027	
Q1	No Signal received during this quarter

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

NHS England MOSS Critical Safety Check (Annex 9): NHS England requires all maternity services to complete an annual MOSS Critical Safety Check (Annex 9) drill to test organisational readiness to respond to a Level 2 Maternity Outcomes Signal System (MOSS) alert.

The exercise is designed to assure that the Trust can rapidly assess key safety processes, identify any immediate risks and complete the required executive assurance within the national eight-working-day timeframe.

The Perinatal Leadership Team will meet in August 2026 to agree the multidisciplinary task and finish group, governance arrangements and timescales for completion of the annual drill. The exercise will be completed in advance of the October 2026 Perinatal Assurance Committee, with a summary of the findings, learning and any actions arising presented to PAC for assurance.

Maternity Outcomes Signal - Cumulative sum (CUSUM) - Sherwood Forest Hospitals NHS Foundation Trust

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days.

The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

Chart guidance can be found using the "I" icon.

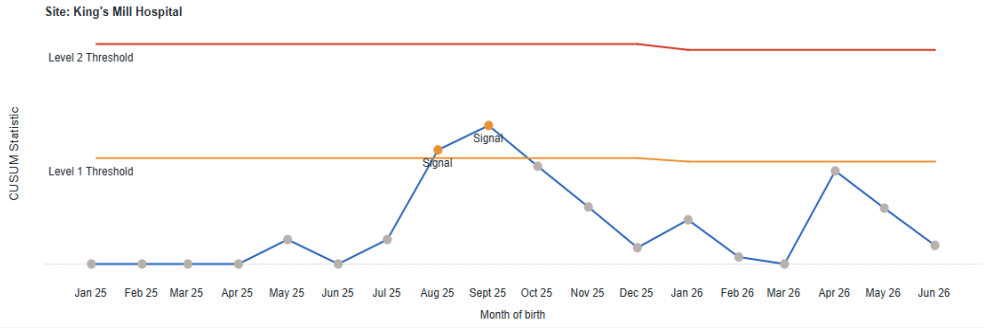


Table of Events - Trust: Sherwood Forest Hospitals NHS Foundation Trust

Date of term birth	Events (term only)	Site name
19 Apr 26	1 Term Stillbirth(s)	King's Mill Hospital
10 Apr 26	1 Term Stillbirth(s)	King's Mill Hospital
06 Jan 26	1 Term Stillbirth(s)	King's Mill Hospital
30 Sept 25	1 Term Stillbirth(s)	King's Mill Hospital
30 Aug 25	1 Term Stillbirth(s)	King's Mill Hospital
12 Aug 25	1 Term Stillbirth(s)	King's Mill Hospital

7.0 Performance Metrics

7.1 Maternity Service Diversions

A review of maternity service diversions has been undertaken to provide assurance regarding the implementation of the revised Maternity Escalation Policy and to better understand the operational factors contributing to service diversion. The review demonstrates an increase in the number of diversions during 2025/26 compared with the previous year, with activity during the first quarter of 2026/27 continuing at a similar trajectory: April 2 diverts, May 3 diverts, and June 2 diverts.

Since implementation of the revised escalation policy in January 2026, there have been a total of 12 episodes of service diversion, providing an opportunity to evaluate both operational decision-making and policy compliance.

Analysis demonstrates that clinical acuity remains the primary driver for diversion, with all episodes occurring in response to periods of increased clinical demand. Whilst workforce and capacity contributed to some events, these were secondary factors rather than the principal reason for diversion, assuring that decisions to divert services continue to be clinically led and centred on maintaining patient safety.

A significant finding from the review is that three-quarters of diversions occurred outside normal working hours, when senior operational support available within the hospital is reduced. During these periods, the maternity coordinator has reduced access to senior midwifery leadership, specialist clinical teams and wider operational support, requiring decisions to be made within a more challenging operational environment. This highlights the importance of ensuring robust and responsive senior leadership arrangements are consistently available seven days a week, particularly during evenings, nights and weekends.

The review also evaluated compliance with the revised escalation process. Whilst the policy was followed appropriately in 50% of diversion episodes, opportunities for improvement were identified in the remaining cases. Themes included delayed engagement of Gold On-Call, variation in ownership of diversion decisions, delays whilst seeking additional confirmation prior to diversion and inconsistent adherence to the agreed escalation process. These findings do not suggest that inappropriate diversion decisions were made; rather, they identify variation in the operational application of the policy during periods of heightened pressure.

These findings have directly informed the proposed review of the Maternity Escalation Policy and the options appraisal presented separately to PAC. The review supports strengthening operational leadership, clarifying decision-making responsibilities and streamlining escalation processes to enable timely, consistent and clinically led diversion decisions during periods of exceptional demand.

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

Term admission to the Neonatal Unit (ATAIN) remains a key national quality indicator, assuring the effectiveness of intrapartum care, immediate postnatal management and the utilisation of Transitional Care services. The national benchmark is to maintain term neonatal admissions below **6%** of all term births.

All term neonatal admissions continue to be subject to multidisciplinary clinical review to determine the appropriateness of admission and identify any emerging trends or opportunities for improvement. Review of admissions during this reporting period has identified no concerns regarding the clinical appropriateness of admissions, with all babies admitted for recognised clinical indications and in accordance with local and national guidance. No recurrent themes or avoidable factors have been identified.

The increase observed during June will continue to be monitored through established governance processes to determine whether this represents normal month-to-month variation or an emerging trend.

Comprehensive case reviews and thematic analysis will be incorporated within the annual ATAIN report, alongside evaluation of opportunities to further strengthen Transitional Care pathways and reduce avoidable neonatal admissions where clinically appropriate.

	March 2026	April 2026	May 2026	June 2026	YTD total
Term admission to NICU as a % of term births **National target <6%**	4.00%	2.46%	4.53%	6.38%	4.45%
Primary reason for admission	Under review; no concerns raised on the appropriateness of admissions.				
Findings upon review	The annual report will include comprehensive case reviews and an assessment of the appropriateness of all admissions.				

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

	Midwives	Obstetricians (Consultant)	MSWs	Anaesthetists	Neonatalogists (Consultants)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle	83%	92%	91%	**N/A**	**N/A**	**N/A**
Fetal monitoring and surveillance	97%	92%	**N/A**	**N/A**	**N/A**	**N/A**
Maternity Emergencies and multi-professional training	90%	100%	82%	100%	**N/A**	**N/A**
Equality/ equity and personalised care (3-Year programme)	90%	100%	82%	**N/A**	**N/A**	**N/A**
Care during labour and immediate postnatal period (3-Year programme)	90%	100%	82%	**100%**	**N/A**	**N/A**
Neonatal Life Support training	87%	**N/A**	**N/A**	**N/A**	100%	92%
Mandatory & Stat training	92%	81%	93%	82%	89%	93%
Qualified in specialty	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	

9.0 Saving Babies' Lives V3.2 (Submission 12 -Quarter 4)

	Compliance/ progress/ action	Responsible lead	Compliance required	Current compliance
Element 1	**REF 1.1** Booking CO reading **REF 1.3** Smoking	LF/JG	90%	**87%** ↓ **70.9%** ↑

	status at 36/40 **REF 1.6** Percentage of smokers who are referred into an inhouse tobacco dependence treatment service who set a quit date	LF/JG LF/JG	80% 40%	**33.7%**↑
Element 2	**REF 2.19** Percentage of pregnancies where an SGA fetus is antenatally detected	NA/SS	70%	**65.7%**↑
Element 3	Fully compliant	YJ	100%	100%
Element 4	Fully compliant	NP	100%	100%
Element 5	Fully compliant	BL	100%	100%
Element 6	Fully compliant	RW	100%	100%

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

Action plans requested from responsible leads for elements below compliance threshold.

NB:

There has been no communication as yet to confirm the plan / timeframes moving forward for oversight from the LMNS for SBLCB as previously. Whilst awaiting clarity we will continue to utilise the support of the LMNS and the next planned meeting will be in August for Quarter 1 submission. This will be brought to next PAC meeting.

10.0 NHS Resolution Maternity Incentive Scheme – Year 8 Overview

NHS Resolution Maternity (Perinatal) Incentive Scheme (MIS) Year 8 core standards published 31 March 2026.

Key changes for Year 8: MIS Year 8 streamlines the scheme from multiple actions to six focused core areas, reducing administrative burden while maintaining robust assurance:

A). Workforce and capacity
B). Training
C). Learning from reviews & investigations
D). Service-user voice and equity
E). Care bundles
F). Board oversight, governance, culture and leadership

11.0 Risk Register Assurance

11.1 Existing Risks ≥12

Risk ID	Risk / Description	Current Score	Current Position / Assurance	Lead
3081	Delay in securing neonatal airway in emergencies, increasing risk of hypoxic injury, morbidity or mortality	12	Trying to secure ARNI course training, trying to improve LISA techniques/data, but the risk around airways is long term. Due review by Lead 06.08.26	Alison Davies
1481	Abduction from the Maternity ward	12	On going actions include relocating staff desk/office to improve oversight of door onto Ward Baby Tagging Business Case - action 7346 Review of Staff Receptionist hours given impact of relocating MTC to clinic 12 Due review by Lead 25.09.26	Sarah Ayre

11.2 Emerging Risks

Emerging Risk	Current Position	Status
Maternity Pharmacy Provision	Business case and supporting risk assessment in development to ensure sustainable pharmacy support for Perinatal Services.	In Progress
National Epidural Supply	Risk assessment completed and scheduled for review through Perinatal Governance to support local contingency planning.	Monitoring
MNVP Collaboration	Following changes to the strategic operating model for the Maternity and Neonatal Voices Partnership (MNVP), there has been a noticeable reduction in the frequency of engagement and the level of service user feedback available to inform Trust governance and assurance processes.	Under review

PAC Assurance

The Perinatal Risk Register continues to be actively monitored through established governance arrangements. Existing risks remain under regular review by named risk owners, with mitigation plans in place and oversight provided through Perinatal Governance. Emerging risks relating to maternity pharmacy provision and the national epidural supply have been identified proactively, with risk assessments and mitigating actions underway to maintain patient safety and service resilience.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet and report

Subject:	PQOM Bi-monthly Perinatal Safety Champion update report	**Date:**	6 August 2026
Prepared By:	Sarah Ayre, Head of Perinatal Services		
Approved By:	Paula Shore, Director of Midwifery/Deputy Chief Nurse, Philip Bolton, Executive Chief Nurse, Neil McDonald, Non-Executive Director		
Presented By:	Sarah Ayre, Head of Perinatal Services		

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

Recommendation

The Board of Directors are asked to:

1. Receive assurance that Perinatal Services continue to operate within a robust governance framework, maintaining safe and effective care through strong leadership oversight, multidisciplinary working, and active quality improvement programmes.
2. Note the positive progress made across Perinatal Services during Quarter 1 2026/27, including planning for the implementation of the Maternity Care Bundle, benchmarking against the original Ockenden Immediate and Essential Actions, improvements in infant feeding outcomes and clinically led service improvements.
3. Receive assurance regarding workforce sustainability through the introduction of the NMAHP Workforce Assurance Scorecard and the continued focus on recruitment, retention, staff wellbeing, and attendance management.
4. Note the financial efficiencies and quality improvements achieved through clinical leadership initiatives, including equipment standardisation and review of translation services.
5. Support the continued delivery of the improvement priorities outlined within this report.

Strategic Objectives

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

Identify which Principal Risk this report relates to:

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

Committees/groups where this item has been presented before

- Senior Management Team (SMT) (Divisional weekly meeting)
- Perinatal Quality Surveillance Group (LMNS)
- Perinatal Governance Meeting

Acronyms

BFI	Baby Friendly Initiative
EMNODN	East Midlands Neonatal Operational Delivery Network
HoM	Head of Midwifery
ICB	Integrated Care Board
LMNS	Local Maternity and Neonatal System
MCB	Maternity Care Bundle
MIS	Maternity Incentive Scheme
MNSI	Maternity and Neonatal Safety Improvement
MNVP	Maternity and Neonatal Voices Partnership
MTC	Maternity Triage Centre
NHS	National Health Service
NICU	Neonatal Intensive Care Unit
PEADP	Perinatal Equity and Anti-Discrimination Programme
PQOM	Perinatal Quality Oversight Model
PSF	Perinatal Services Forum
SBU	Sherwood Birthing Unit
SFH	Sherwood Forest Hospitals NHS Trust
TC	Transitional Care

Executive Summary

This report provides bi-monthly assurance to the Board of Directors regarding the safety, quality, workforce, and operational performance of Perinatal Services during May and June 2026. Overall, Perinatal Services continues to deliver safe, compassionate, and evidence-based care within a robust governance framework, supported by visible leadership, multidisciplinary collaboration, and a strong culture of continuous improvement.

During the reporting period, significant progress has been made across several strategic priorities. This includes continued implementation of the NHS Maternity Care Bundle, benchmarking against the original Ockenden Immediate and Essential Actions, preparation for the Perinatal Equity and Anti-Discrimination Programme (PEADP), delivery of quality improvement initiatives and participation in the Women's and Children's Divisional Planning process, ensuring alignment with the Trust's strategic objectives and future direction.

The service also welcomed a positive East Midlands Neonatal Operational Delivery Network Peer Review, providing external assurance of the progress being made through the integrated Perinatal Services leadership model and the strengthening of neonatal leadership. Quality improvement has continued to deliver measurable benefits for women, birthing individuals, babies, and families. Highlights include improved infant feeding outcomes through the Baby Friendly Initiative, continued development of the Enhanced Midwifery Continuity of Carer Strategy, implementation of the Position for Progress programme, improvements to the antenatal clinic environment, and clinically led initiatives that have improved standardisation, reduced variation and delivered financial efficiencies.

Developing and supporting our workforce has remained a key priority. Progress has continued through implementation of the Staff Survey Action Plan, investment in leadership development, recognition of our workforce through national celebration events, and strengthening workforce assurance through the introduction of the Perinatal Workforce Assurance Scorecard. Workforce pressures relating to sickness absence, parental leave, recruitment and increasing clinical acuity continue to be actively managed through proactive workforce planning, strengthened operational

escalation arrangements, and enhanced leadership oversight. Overall, this report assures that Perinatal Services continues to make sustained progress against local and national priorities whilst maintaining a clear focus on patient safety, workforce sustainability, quality improvement, and organisational culture. Separate deep-dive reports presented to this meeting provide further assurance in relation to the Maternity Care Bundle (MCB), Maternity Incentive Scheme (MIS), workforce sustainability, and the Silver On-Call escalation model.

This report reflects a period of continued service maturity following the implementation of the integrated Perinatal Services leadership model, demonstrating sustained progress across safety, quality, workforce, culture, and operational resilience while maintaining a clear focus on delivering the Trust's strategic priorities.

1.0 Perinatal Services Safety Champions

In 2018, Professor Jacqueline Dunkley-Bent, National Maternity Safety Champion, and Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health, launched the NHS Maternity Safety Champions programme to strengthen safety leadership across maternity services. The programme established Board-level obstetric and midwifery safety champions to promote a strong safety culture, improve communication from "floor to board", champion learning from incidents and national reviews, and provide visible leadership to support continuous improvement in the quality and safety of maternity care.

At Sherwood Forest Hospitals, the Safety Champion framework continues to support regular engagement with staff and service users through safety walkarounds, providing assurance that safety intelligence is identified, escalated, and acted upon through established governance processes.

****AWAITING NEW PHOTOGRAPHS***

1.1 NHS England & ICB Showcase Visit (Safety Champion Walkaround – May 2026)

On 18 May 2026, in place of the planned Safety Champion Walkaround, Perinatal Services welcomed Michelle Bateman, NHS England Deputy Chief Nursing Officer, and Rosa Waddingham, Chief Nursing Officer for the Nottingham and Nottinghamshire Integrated Care Board (ICB), for a Perinatal Services showcase visit. The visit provided an opportunity to demonstrate the progress being made across maternity and neonatal services, highlighting improvements in patient safety, quality, workforce development, innovation, and partnership working.

The visit enabled frontline staff to engage directly with regional nursing leaders, showcasing examples of good practice and sharing learning from ongoing quality improvement programmes. Discussions focused on clinically led innovation, workforce wellbeing, reducing health inequalities, strengthening system collaboration, and enhancing the experience and outcomes of women, birthing individuals, babies, and their families.

Feedback from both NHS England and ICB colleagues was overwhelmingly positive, recognising the professionalism, enthusiasm and commitment demonstrated by teams across Perinatal Services. The visit provided valuable external assurance of the progress being made. Further, it strengthened relationships with system partners, reinforcing SFH commitment to delivering safe, personalised and continuously improving perinatal care.

1.2 Perinatal Services Safety Champion Walk Around – 5 June 2026

The June Safety Champion Walkaround assured that, despite periods of increased clinical activity, teams across Perinatal Services felt well supported and demonstrated a proactive approach to managing operational pressures. Maternity teams discussed anticipated increases in elective

caesarean section activity and outlined plans to maximise capacity through additional operating lists where appropriate.

Workforce sustainability remained a key focus, with ongoing recruitment activity and consideration of innovative approaches to attract newly qualified midwives.

Staff also reflected openly on the anticipated publication of the Ockenden and Amos reports, acknowledging the potential impact on both colleagues and women, birthing individuals and families accessing services. Safety Champions reinforced the support available to staff and encouraged the continued use of established escalation processes to ensure any emerging concerns could be identified and addressed promptly.

Within Neonatal Services, teams spoke positively about the impact of the revised leadership arrangements, recognising improvements in leadership visibility, team engagement, and service development. Staff expressed confidence in the preparations underway for the forthcoming Neonatal Network Peer Review, reflecting a positive culture of assurance, continuous improvement, and readiness for external review.

2.0 Perinatal Services Forum (PSF)

The Perinatal Services Forum (PSF) is a key component of the Perinatal Services governance framework, providing a regular multidisciplinary forum for staff to share operational updates, raise concerns, celebrate good practice, and contribute to service improvement.

Attended by executive leaders, senior clinicians and multidisciplinary colleagues, the forum strengthens communication between frontline teams and Trust leadership, ensuring staff feedback, emerging risks and improvement opportunities are heard, acted upon, and embedded within operational decision-making. The PSF continues to promote openness, transparency, and collaborative working, assuring that staff voice remains central to the ongoing development of safe, high-quality, and compassionate perinatal care.

2.1 PSF 14 May 2026 (Chaired by Chief Nurse)

The May Perinatal Services Forum focused on strategic leadership, service assurance, and workforce engagement across Perinatal Services. Updates were provided on leadership arrangements following the appointment of the Director of Midwifery to her new executive role, together with assurance regarding the continued operational leadership of Perinatal Services. The forum also highlighted ongoing progress in workforce sustainability, leadership development, staff engagement, and quality improvement, including strengthening the service user voice, advancing health inequalities work and embedding learning through established governance processes. Discussions reinforced the importance of visible leadership, open communication, and multidisciplinary collaboration in supporting the continued delivery of safe, compassionate, and high-quality perinatal care

2.2 PSF 12 June 2026 (Chaired by Director of Midwifery)

The June Perinatal Services Forum provided a multidisciplinary update on key quality improvement, workforce, and service transformation programmes across maternity and neonatal services. Positive progress was reported across several areas, including improvements in fetal surveillance and uterine artery Doppler compliance, infant feeding, vaccination uptake, research activity, workforce recruitment, and clinical governance. The forum also recognised the continued development of clinically led quality improvement initiatives and regional recognition for innovative practice, including national conference presentations and research participation.

Discussions identified ongoing priorities relating to information governance, operational resilience, and preparation for the implementation of national maternity recommendations, ensuring that emerging risks and opportunities continue to be proactively managed through established governance arrangements.

Overall, the forum continues to demonstrate strong multidisciplinary engagement, open discussion, and active leadership support for service improvement across perinatal services.

3.0 Key Strategic Developments

3.1 Maternity Care Bundle

Implementation of the NHS Maternity Care Bundle continues to progress in line with national requirements, strengthening the delivery of evidence-based care across Perinatal Services.

3.2 Ockenden Benchmarking

Benchmarking against the original Ockenden Immediate and Essential Actions has been completed by Consultant Midwife Sam Todd (ST), assuring that Perinatal Services continues to monitor compliance and identify opportunities for continuous improvement.

3.3 Perinatal Equity and Anti-Discrimination Programme (PEADP)

SFH has been confirmed as part of the third national cohort of the NHS England PEADP commencing in September 2026. The programme will support the Trust to strengthen equitable, personalised maternity and neonatal care, reduce inequalities in outcomes and experience, and further develop an inclusive culture for both service users and staff. Local programme leads have been identified, and preparatory work is underway to support implementation, ensuring alignment with existing health inequalities and quality improvement programmes across Perinatal Services. A detailed update will be brought to PAC in November 2026 once the programme formally commences in September and local actions are underway.

3.4 Baroness Amos Independent Investigation – National Response

Following publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England on 30 June 2026, Perinatal Services has reviewed the national 10 Point Plan and commenced work to align local priorities with the urgent actions identified by NHS England. The recommendations reinforce many of the improvement programmes already underway within the Trust, including the implementation of the Maternity Care Bundle, strengthening patient and staff engagement, addressing health inequalities, enhancing maternity triage, improving workforce resilience, and embedding compassionate, trauma-informed approaches to safety and learning.

To support delivery, Director of Midwifery (DoM) Paula Shore has established several initial action groups to coordinate the Trust's response, oversee implementation and ensure progress is monitored through existing governance arrangements. A comprehensive update outlining progress against each of the national recommendations, together with evidence of local implementation and assurance, will be presented to the PAC in September 2026.

3.5 MIS Year 8

Perinatal Services continues to deliver against the NHS England Maternity Incentive Scheme (MIS) Year 8 requirements, assuring compliance with national maternity safety standards

4.0 Research and Innovation

Research continues to be embedded within routine maternity care, supporting women and birthing individuals to access opportunities to participate in nationally recognised studies. During the reporting period, Consultant Midwife Sam Todd has continued to promote the PANDA Study across community services, encouraging research discussions at booking appointments and strengthening collaboration with the Trust Research Team. Referral activity remained encouraging

within the Sherwood and Newark Community Midwifery Teams, with 21 referrals made during June 2026. Two participants were successfully recruited during the month, representing the highest monthly recruitment since the study opened at SFH. Work is continuing with all community teams to improve consistency of referrals and further strengthen research participation across the service. These developments demonstrate the Trust's commitment to supporting research, improving evidence-based practice, and ensuring women and birthing individuals have equitable access to research opportunities.

5.0 Quality Improvements

5.1 Baby Friendly Initiative (BFI)

Positive progress continues across the Baby Friendly Initiative work programme. Focused activity has supported improvements in infant feeding education, workforce development, and family-centred care. Work will continue throughout 2026 to maintain momentum and support future accreditation requirements. Newly published national infant feeding data demonstrated a significant improvement in local breastfeeding and chestfeeding rates at 6–8 weeks, reflecting the impact of sustained Baby Friendly Initiative improvement work across the perinatal pathway.

5.2 Improving the Environment

The antenatal clinic quiet room has undergone significant enhancement through the addition of soft furnishings, artwork and environmental improvements funded through charitable donations, volunteer fundraising and was led by staff members. The project was developed to provide a more supportive and compassionate environment for women, birthing individuals and families receiving difficult news or requiring privacy and emotional support during their care journey. This initiative demonstrates the continued commitment of staff and volunteers to improving the care experience.

5.*3 Avoiding Brain Injury in Childbirth (ABC) Programme – Intrapartum Fetal Deterioration (IFD)*

During this reporting period, we commenced implementation planning for the second phase of the regional Avoiding Brain Injury in Childbirth (ABC) Programme, focusing on the detection and response to suspected intrapartum fetal deterioration. Initial discussions have been held with Health Innovation East Midlands to assess organisational readiness, including digital capability,

fetal monitoring practice, workforce preparedness, and governance arrangements. This work will support implementation of the Intrapartum Track and Trigger Tool and ensure the Trust is well positioned to adopt the programme in line with regional expectations. A further update will be shared with PAC in October 2026.

5.4 Consultant Midwife-Led Quality Improvement

Under the leadership of Sam Todd, Consultant Midwife, a portfolio of clinically led quality improvement programmes has continued to deliver measurable benefits across Perinatal Services. Collectively, these initiatives are improving patient safety, enhancing the experience of women, birthing individuals, and families, reducing unwarranted variation, supporting health equity, and delivering better value through evidence-based clinical practice.

Improvement Programme	**Progress and Impact**
Blood Pressure Monitoring Equipment	A review of blood pressure cuff provision, undertaken in line with *Saving Babies' Lives* recommendations, has standardised equipment across Perinatal Services, improving clinical consistency, supporting patient safety, and delivering recurrent financial efficiencies.
Translation Services	A review of translation and communication support resources enabled Perinatal Services to transition from CardMedic to an alternative Trust-wide solution, maintaining equitable access to communication support whilst reducing duplication and delivering recurrent financial savings.
Enhanced Midwifery Continuity of Carer (EMCoC)	Q1 data provides positive assurance that the principles of the EMCoC Strategy continue to be embedded across Perinatal Services. Performance remains strong across continuity of antenatal and postnatal care, antenatal care planning, and continuity recording, with consistently high levels of ethnicity data capture supporting the Trust's equity ambitions. Opportunities to strengthen completion of intrapartum personalised care plans have been identified and are being progressed through existing community governance arrangements.
Position for Progress	The *Position for Progress* programme continues to promote physiological birth through the use of peanut balls and sacrum-free positioning. Staff feedback has demonstrated benefits including improved labour progress, enhanced maternal comfort and increased opportunities to avoid unnecessary intervention. Ongoing work includes investment in specialist training, additional equipment, patient information resources, and collaboration with the Maternity and Neonatal Voices Partnership (MNVP) to further improve outcomes and experiences.

Collectively, these Consultant Midwife-led improvement programmes demonstrate how clinical leadership continues to drive measurable improvements in patient safety, personalised care, workforce engagement, operational efficiency, and value for money across Perinatal Services.

6.0 Improving Culture

6.1 Staff Survey 2025 Action Group

As part of the next phase of this programme, the focus will be on supporting the Staff Survey Action Group, ensuring that the priority actions arising from the three agreed staff survey themes are embedded across the division. This will support sustained cultural improvement, strengthen staff engagement, and ensure that learning from the staff survey translates into visible, practical improvements for teams across Perinatal Services. Investment in leadership development remains

a key priority. During this reporting period, opportunities have been promoted for Band 7 and Band 8 nurses and midwives to apply for Florence Nightingale Foundation scholarships, supporting the development of future clinical leaders and strengthening leadership capacity across Perinatal Services. This work aligns with the wider workforce strategy and commitment to succession planning.

6.2 Celebrating our Workforce

During the reporting period, Perinatal Services marked several national and local workforce celebration events, including International Day of the Midwife (5 May 2026), International Nurses Day (12 May 2026), and Midwifery Students' Day (15 June 2026).

These events recognised the dedication, professionalism and compassion of our midwives, neonatal nurses, nursing associates, and student midwives, celebrating their invaluable contribution to delivering safe, personalised, and compassionate care. Activities included visible leadership, staff recognition, and wellbeing initiatives such as the *Positivi-Tea* trolley. Collectively, these initiatives reinforce our commitment to creating a positive, inclusive, and supportive working environment where colleagues feel recognised, valued and connected to the wider Perinatal Services vision, supporting our ambition to make Perinatal Services the best place to work.

7.0 Heads and Directors of Midwifery and Clinical Directors Away Day – 20 May 2026

On 20 May 2026, SFH was proud to host the regional Heads of Midwifery, Directors of Midwifery and Clinical Directors Away Day, bringing together senior maternity and neonatal leaders from across the Midlands. Led by Gaynor Armstrong, Regional Chief Midwifery Officer, the event provided an opportunity to share learning, explore national priorities, and strengthen collaboration across organisations in support of continuous improvement in maternity and neonatal services.

A particular highlight of the day was a keynote presentation from SFH's Lead Advocate, Sarah Seddon, showcasing the Trust's innovative approach to staff advocacy, culture and speaking up. The presentation was exceptionally well received, generating significant interest from colleagues across the region, with several organisations expressing a desire to understand how the role has been established and how a similar model could be embedded within their own services. The presentation has subsequently been shared by NHS England as an example of emerging good practice across the Midlands.

Hosting the event provided an opportunity to showcase the progress being made across Perinatal Services and highlighted SFH's growing contribution to regional maternity leadership, innovation, and the sharing of best practice.

Feedback from the Regional Chief Midwifery Officer recognised both the quality of the programme and the hospitality provided by the Trust, reflecting positively on the organisation and the wider Perinatal Services team.

8.0 Women's and Children's Divisional Planning 2026/27

During the reporting period, Perinatal Services participated in the Women's and Children's Divisional Planning Away Day (1st June 2026) bringing together clinical leaders, operational leaders, business unit leads and corporate colleagues from across the Women's and Children's and Urgent and Emergency Care (UEC) Divisions. The collaborative event provided an opportunity to reflect on current performance, identify shared challenges and opportunities, and collectively shape the priorities that will support delivery of the Trust's strategic ambitions over the coming years.

Working alongside colleagues from UEC, the group identified areas where integrated working and shared approaches could accelerate improvement across the organisation, particularly in relation to workforce sustainability, patient flow, quality improvement, operational resilience, digital transformation, and staff experience. For Perinatal Services, four strategic priorities were agreed: creating the best place to work; improving outcomes and reducing health inequalities; financial sustainability and productivity; and workforce planning and sustainability.

The outputs from the Away Day have informed the Trust's wider corporate planning process and have been incorporated into the Divisional Delivery Plan for 2026/27. Progress against these priorities will be monitored through established divisional governance arrangements and reported regularly to the Perinatal Assurance Committee, providing ongoing assurance of delivery against both divisional and Trust-wide strategic objectives.

9.0 MNSI Quality, Risk and Maternity Improvement Visit – 12th May 2026

In May 2026, Perinatal Services welcomed the Maternity and Neonatal Safety Improvement (MNSI) Team for a service review and showcase visit. The visit was attended by the Perinatal Services Senior Leadership Team, alongside the Perinatal Lead Advocate and representatives from the Maternity and Neonatal Voices Partnership (MNVP), providing an opportunity to demonstrate the progress being made across maternity and neonatal services and to discuss our ongoing quality improvement journey.

The presentation highlighted the significant progress achieved within Neonatal and Transitional Care following the introduction of the integrated Perinatal Services leadership model, including strengthened clinical leadership, enhanced workforce capability, improved communication and engagement, quality improvement initiatives, and a renewed focus on staff wellbeing. The visit provided positive external engagement and an opportunity to showcase the collaborative, clinically

led improvements being delivered across Perinatal Services, supporting the continued development of safe, compassionate, and high-quality care.

10.0 Neonatal Network Peer Review – 22 June 2026

On 22 June 2026, SFH hosted the East Midlands Neonatal Operational Delivery Network (EMNODN) Peer Review. The peer review process provides external assurance against regional and national standards, assessing the quality and safety of neonatal services across key domains including parent and family involvement, capacity and activity, workforce, education, medical staffing, governance, quality monitoring, and quality improvement. The visit included a tour of maternity and neonatal services, review of evidence and action plans, and discussions with multidisciplinary teams and system partners.

Initial verbal feedback from the review team was overwhelmingly positive, recognising the professionalism, commitment and teamwork demonstrated across the neonatal and wider perinatal teams. Reviewers acknowledged the significant progress made within the service and the strong culture of collaboration and continuous improvement. The feedback also reflected the positive impact of the Perinatal Services leadership model, introduced in November 2025, bringing maternity and neonatal services under a single leadership structure. The new Neonatal Matron and Ward Leader have provided greater leadership visibility, consistency, and operational stability, supporting the continued development of an integrated perinatal service. The Trust now awaits the formal peer review report, which will be used to inform the next phase of quality improvement and ongoing assurance.

11.0 Workforce Sustainability and Safe Staffing

Workforce sustainability remains a strategic priority for Perinatal Services. Throughout the reporting period, continued focus has been placed on recruitment, retention, attendance management, workforce wellbeing, and establishment optimisation to ensure the delivery of safe and effective care. The Perinatal Workforce Assurance Scorecard has now been finalised and will be presented through the NMAHP Board from Quarter 2 2026/27, providing enhanced oversight of workforce indicators, including vacancies, sickness absence, temporary staffing, compliance, and workforce risk. This will strengthen assurance and support proactive workforce planning across Perinatal Services.

12.0 Escalation and Operational Resilience

The revised Silver On-Call model has now been fully embedded across Perinatal Services and continues to strengthen operational resilience during periods of increased demand, patient acuity, and workforce pressure. Since its implementation in January 2026, the enhanced escalation framework has supported timely operational decision-making, strengthened multidisciplinary oversight, and maintained patient safety through improved leadership visibility and coordinated responses to operational pressures. A formal review of the model has been completed to evaluate

its effectiveness, operational impact, and future sustainability. The review has identified opportunities to further strengthen escalation arrangements while maintaining robust governance and executive oversight.

13.0 Conclusion

This reporting period demonstrates the continued maturity of the integrated Perinatal Services model, with strengthening leadership, improved governance, and increasing evidence that service improvements are translating into better outcomes for women, birthing individuals, their babies, families, and staff.

This report assures that Perinatal Services continues to deliver safe, compassionate, and high-quality care within a robust governance framework, whilst maintaining a strong focus on continuous improvement, workforce sustainability, and service transformation. During this reporting period, positive progress has been made across several strategic priorities, including planning for the implementation of the NHS Maternity Care Bundle, strengthening workforce assurance through the NMAHP Workforce Assurance Scorecard, clinically led quality improvement initiatives, investment in leadership development, improvements in infant feeding outcomes and the establishment of a clear divisional delivery plan for 2026/27.

Whilst workforce challenges, increasing acuity and operational pressures continue to present risks across maternity and neonatal services, these are being actively managed through strengthened escalation arrangements, visible clinical leadership, proactive workforce planning, and established governance processes.

The service continues to demonstrate a culture of learning, collaboration, and continuous improvement, ensuring that risks are identified early, mitigated appropriately, and monitored through robust assurance mechanisms.

Looking ahead, the focus will be on embedding the agreed divisional priorities, delivering the Staff Survey Action Plan, strengthening workforce resilience, progressing pathway transformation and digital innovation, and continuing to evidence measurable improvements in safety, quality, experience and outcomes for women, birthing individuals, babies, families, and our workforce.

The Board of Directors are asked to receive assurance that Perinatal Services continues to deliver safe, compassionate, and evidence-based care through strong governance, visible leadership and a clear programme of continuous improvement aligned to both Trust and national priorities.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet and report

Subject:	CQC inspection of Medical Care and Urgent and Emergency Care King's Mill Hospital	**Date:**	6 August 2026
Prepared By:	Candice Smith Director of Nursing Quality & Governance		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Philip Bolton, Executive Chief Nurse		

Purpose		
The purpose of this paper is to provide an update on the CQC findings following their inspection of Medical Care and Urgent and Emergency Care at King's Mill Hospital	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Recommendation

The Board of Directors are asked to note the paper which provides an update on the CQC findings following their inspection of Medical Care and Urgent and Emergency Care at King's Mill Hospital.

Members are asked to take assurance from the next steps described.

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

N/A

Acronyms

CQC – Care Quality Commission

Executive Summary

The CQC undertook an unannounced inspection of Medical Care and Urgent and Emergency Care services and pathways at King's Mill Hospital on 9th and 10th March 2026 as part of the national winter system pressures inspection programme.

The inspection found that Medical Care and Urgent & Emergency Care at King's Mill Hospital were delivering good, safe, and compassionate care, with staff consistently described as kind, inclusive, and committed to patient wellbeing. Inspectors highlighted strong adherence to evidence-based practice, effective teamwork, and a positive safety culture where concerns were raised and learning shared.

The report also noted areas for improvement, including privacy and dignity, paediatric oversight, and medication labelling, while recognising visible and engaged leadership.
Follow-up meetings with divisional triumvirates were held virtually to complete lines of enquiry and provide further assurance.

The final report was published on 15th July 2026 and is attached as Appendix 1.

CQC Inspection of Medical Care and Urgent and Emergency Care Services at King's Mill Hospital

Background:
The CQC undertook an unannounced inspection of Medical Care and Urgent and Emergency Care services and pathways at King's Mill Hospital on 9th and 10th March 2026 as part of the national winter system pressures inspection programme. They focused on the full suite of quality statements under the Safe, Effective, Caring, Responsive and Well-Led domains, with particular emphasis on safety culture, patient flow, evidence-based practice, and patient experience.

Three inspectors and one specialist advisor assessed Medical Care Services, and a further three inspectors and one specialist advisor assessed Urgent and Emergency Care.
During the inspection, the team visited ED, EAU, Short Stay Unit, Medical Day Case Unit, SDEC and inpatient wards (including 21, 35, 36, 43, 54), speaking with staff across all disciplines, as well as patients and families.

Key leaders were interviewed during the on-site inspection, with follow-up meetings held virtually with the divisional triumvirates to provide further assurance and clarify outstanding points.
The final report was published on 15 July 2026.

Overview of report findings:
King's Mill Hospital has maintained its overall CQC rating of Good, with all five domains, Safe, Effective, Caring, Responsive and Well-led, remaining unchanged and rated as good. The services continue to demonstrate strong performance, delivering consistent standards of care, positive patient experience, reliable access to services, and robust leadership and governance arrangements.
Medical Care Services were recognised for strong safety culture, high-quality evidence-based care, and excellent patient experience, with good teamwork and visible leadership underpinning this.
Areas for improvement included discharge documentation and medicines management

In UEC, inspectors noted a strong learning culture, effective joint working with system partners and consistently positive patient feedback, set against sustained demand and whole-hospital flow pressures that continue to impact timeliness of care. The CQC highlighted strong collaboration between ED staff and colleagues from external services.
Areas for improvement included privacy and dignity within the ED environment, oversight of the paediatric area from both nursing and medical perspectives and labelling of time
sensitive medication.

Overall, the report highlights committed staff, positive culture and clear areas for further strengthening, which are being incorporated into ongoing improvement plans.

Next Steps:
Divisions are developing comprehensive action plans addressing all inspection findings. Delivery of these actions will be monitored through the Patient Safety Committee (PSC), with formal assurance and progress reporting to the Quality Committee (QC).

The findings have been shared with staff, and teams have been thanked for their hard work, professionalism and engagement throughout the inspection process.

LAP assessment report

King's Mill Hospital

LAP Assessment Report ID : LAP-02477

Inspection visit date(s): 9 and 10 March 2026

Table of contents

King's Mill Hospital
Location findings

Ratings for this location

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Overall location summary

Date of inspection: 9 to 10 March 2026. Kings Mill Hospital provides a range of NHS hospital services. This inspection looked at medical and urgent and emergency care services as part of our winter system pressure inspections. We rated both services as good. The ratings of medical and urgent and emergency care services has been combined with the ratings of the other services from the last inspections. See our previous reports to get a full picture of all the other services at Kings Mill Hospital. The rating of Kings Mill Hospital has changed to good. In our inspection of medical services, we found that there was a positive and proactive culture of openness and honesty about safety. Concerns were fully investigated and lessons were learnt. The service delivered evidence based care and monitored outcomes. They treated people with kindness and compassion. Staff morale was mixed with some feeling supported and others feeling their views were not listened too and they were not always included in decisions made. In urgent and emergency care services we found that there was a positive learning safety culture where events were investigated, and learning was shared and embedded to promote good practice. Patients could not always access care and treatment in the department in a timely manner due to multiple issues including flow issues throughout the hospital. However, the

service was aware of system pressures and sought to develop services that met the changing needs of patients.

Safe

Rating Good

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question good. At this inspection the service has remained as good across all services apart from Maternity which is rated as requires improvement.

Effective

Rating Good

Effective - this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. At our last inspection we rated this key question good. At this inspection the rating has not changed.

Caring

Rating Good

Caring – this means we looked for evidence that the provider supported staff and treated patients with compassion, kindness, dignity and respect. At our last inspection we rated this key question good. At this inspection the service has not changed.

Responsive

Rating Good

Responsive - this means we looked for evidence that the service met people's needs. At our last inspection we rated this key question good. At this inspection the rating has not changed.

Well-led

Rating Good

Location findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At our last inspection we rated this key question good. At this inspection the service remained good.

Medical care (Including older people's care)

Medical care (Including older people's care)

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Our view of the service

We carried out this inspection as part of our winter pressures assessment; it had last been inspected in August 2018.

We assessed most quality statements across the safe, effective, caring, responsive and well-led key questions and have combined the scores for these areas to give an overall rating.

We identified a breach of the regulation due to lack of patients monitoring and observation following administration of sedation medication.

People's experience of the service

Patients and family or carers with them were positive about the staff. They said staff treated them with warmth and kindness and provided effective care and treatment. We spoke with 20 patients and relatives who told us they did not feel anxious about raising concerns. They said they were seen quickly

and told us they felt cared for, listened to, and fully informed of the treatment options. They felt staff were available if they needed them for help or support

We reviewed 17 sets of records that showed patients were seen promptly, and information was documented about care treatment and risk assessment from nursing, medical and allied professional staff.

Staff worked collaboratively with patients assessing risk and developing personalised care and treatment approaches. Patients experienced a non-judgmental approach to their care and were treated in an inclusive and equitable manner.

Safe

Rating Good

Leaders had created a positive and proactive culture of openness and honesty about safety. Concerns about safety were fully investigated. The managers' ensured lessons were learnt to identify and embed good practices. There was a positive learning culture with staff managing incidents and safeguarding patients well. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. There were processes to ensure the service had enough staff with the right training, skills and qualifications to keep patients safe.

This key question has been rated good. This meant patients were safe and protected from avoidable harm.

Learning culture

Score

3. Evidence shows a good standard of care

The service had a proactive and positive culture of safety, based on openness and honesty. Staff knew how to raise incidents and concerns, which were reported on an electronic system and managers were alerted immediately. Incidents and complaints were reviewed daily at staff

meetings and fully investigated. Lessons were learnt to continually identify and embed good practice.

Patients experienced care based on the latest updates and learning which followed national updates and safety incidents. Patients and staff were encouraged and supported to raise concerns. They felt confident they would be treated with compassion and understanding and would not be blamed or treated negatively if they did so.

Leaders put the NHS Patient Safety Incident Framework (PSIRF) in place so the team could respond to patient safety incidents, learn from them, and make improvements. Incidents were fully investigated, and leaders clearly analysed the data and trends, comparing them with previous reporting periods. Leaders discussed incidents at the divisional clinical governance meetings, to review trends and lessons learnt. The team quickly reviewed any incidents that needed immediate investigation.

The PSIRF Oversight Group provided opportunity for shared learning and for the division to present their improvement plans. There was regular cross divisional learning. Themes and actions were routinely triangulated, enabling showing how learning was embedded and how improvements were progressing.

Staff had access to a newsletter which shared learning from incidents. Local leaders made sure important topics were discussed at daily huddles.

There had been 435 incidents reported in December 2025, 467 in January 2026 and 474 in February 2026. Most of these incidents resulted in no harm. Themes included falls, staffing issues, treatment and care and medication issues. All incidents were investigated and actions taken, including additional training, increase communication and support from pharmacy teams.

Staff understood the duty of candour and applied this wherever necessary.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always manage or monitor people's safety, for example patients did not have call bells in the Same Day Emergency Care (SDEC) seated waiting room. However, they worked well with people and healthcare partners to establish and maintain safe systems of care. They did make sure there was continuity of care, including when people moved between different services.

Staff told us the SDEC had been moved to share a space with the medical day case unit, they felt isolated from the emergency department which had resulted in a reduction of patients using the department.

As a result of the move in SDEC, new patients and returning outpatients used the same area with no separation. Although patients had initially been assessed in the emergency department, there was no regular or planned oversight of patients in the seated waiting area. We saw 10 patients waiting in the carpeted reception area, 1 patient had a vomit bowl in this area which did not meet infection prevention and control standards. We saw 1 patient with chest pain waiting for a medical review for 5 hours in this area, it was unclear if they had regular reviews during this time. Patients would have initial observations taken in the reception area which did not maintain privacy, dignity or confidentiality. There were no call bells to alert staff if patient needed help, they relied upon the reception staff to alert clinical staff if any patients required attention. We raised these concerns with senior leaders during our inspection. The trust took immediate action and the following day call bells were placed in the reception area and provided for patients. Dedicated healthcare assistants were responsible for overseeing the reception area and carrying out observations. A dedicated room was identified to carry out any observations. The standard operating procedure for flow of patients was reviewed to ensure that only outpatient or suitable patients waiting for results would wait in the waiting area.

Some wards had more than one extra patient in a bay. Bays that were designed for 4 or 5 beds had an additional bed to help with support the high number of patients admitted. We saw that

ward 43 had 3 additional beds, 1 in each bay. Additional beds in bays on wards helped prevent patients having care in corridors, especially in the emergency department. We saw extra curtain rails had been installed to ensure privacy and dignity. There was a policy to ensure patients placed in additional beds were clinically appropriate and did not require high dependency of care.

There were processes and pathways for patients transferred between wards, and collaborative arrangements with other local services to ensure safety and continuity of care. Leaders and staff worked closely with healthcare partners to ensure people were cared for at home.

There were some medical patients placed on surgical and gynaecology wards (medical outliers) due to bed capacity. At the time of our inspection there were 33 medical outliers. We reviewed 4 medical outliers and 2 of the patients had up to 4 ward moves during their admission. Staff told us it was unclear which medical team had overall responsibility for the patients care and nursing staff struggled to contact relevant teams. The 4 notes reviewed showed that patients had been seen by medical staff but did not have a clear discharge plan.

The medical day case unit had reduced capacity due to SDEC recently moving and sharing facilities. We saw mixed sex breaches during our inspection. A mixed sex breach is when patients of the opposite sex are placed in the same area. We saw 2 female patients in gowns opposite a male patient also in a gown in the same bay. We raised this with staff who were unaware that this was a mixed sex breach. The toilets were also unisex and used by SDEC patients. We raised these concerns with senior leaders during our inspection. The trust took immediate action and the following day the matron had completed a walkaround of the unit and carried out a risk assessment. This included a daily review of admission and separating male and female where possible. Physical dividers and placements of patients were implemented to prevent further mixed sex breaches and single sex bathrooms were identified. This had been added to the Trust's risk register.

The leaders from SDEC and the emergency department met fortnightly to review patient pathways.

The virtual ward team offered support and treatment to patients in their own homes, this was assessed and planned in advance of discharge. The Same Day Emergency Care (SDEC) service and virtual ward aimed to prevent hospital admissions. The aim was to care and monitor

patients in their own homes and enable early discharges. Such as patients requiring infusions, medication, oxygen and monitoring.

Staff saw patients from the emergency department, GP's and community referrals to assess and treat patients to allow them to return home. Patients could return for ongoing treatment to prevent admissions. The service was open from 7am to midnight 7 days a week. Staff had good working relationships with the emergency department. This meant staff in SDEC were able to take appropriate patients from ED.

The discharge lounge accepted patients from all wards once they had a planned discharge. The electronic system showed how many bed spaces and sit up chairs were available to allow staff to transfer patients waiting for discharges. The discharge lounge staff arranged medicines to take home and transport for patients. Staff also liaised with families and discharge location such as a care home. The discharge lounge had overnight beds for those patients whose discharge was the following day or delayed. There was access to bathroom facilities and meals to cater for patients' needs whilst on the discharge lounge.

The trust reported delayed discharges monthly. For October and November 2025 there were 86 delayed discharges. Each delayed discharge was reviewed and actions taken. Common themes for delayed discharges were awaiting transfer to another hospital, packages of care and placements. Delayed discharges were discussed at the trust flow meetings, staff handovers and board meetings.

Patient assessment processes included the use of recognised tools such as ReSPECT forms. This is a personalised document for individuals with complex health needs. Staff completed falls assessments. There was an Amber care bundle used for patients' to improve the quality of care for people whose recovery and prognosis was uncertain.

Staff had handovers at the beginning of each shift. These included details of patient ongoing care and treatment, any interventions required, risk assessment and medication. Staff were engaged in the process and shared information to ensure patient safety. Medical, nursing and allied health professionals attended board rounds on the wards and emergency assessment unit (EAU). Staff attending discussed the ongoing care and treatment of patients, interventions required and plans for discharges or moves to other wards. All staff had the opportunity to engage and shared information and ask questions. However, medical staff on EAU told us that locum medical staff did not always receive adequate handovers and skill sets were not always

checked.

Safeguarding

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. Staff concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

Staff understood their safeguarding responsibilities and knew how to take appropriate action when necessary. The trust had a clear safeguarding policy which was available for staff to access.

All staff were trained to level 2 safeguarding adults and level 2 children, with some senior staff trained to level 3 and 4. The trust had safeguarding leads that staff could contact for advice. In March 2026, 97% of staff in the medical division were up to date with safeguarding training.

Patients were supported to understand their rights, including their human rights, rights under acute services, the Mental Capacity Act 2005 and their rights under the Equality Act 2010. Staff understood the importance of supporting equality and diversity and ensured care and treatment was in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

Safety was a priority that involved everyone, including staff as well as people using the service. Staff made sure that people understood the care and treatment that was being provided.

We saw risk assessments such as venous thromboembolism (clots in the leg or lungs), falls assessments and skin integrity were completed and documented in line with national guidelines. These were completed by staff caring for patients. Staff closely monitored patients so they could respond quickly if their health deteriorated. They used a National Early Warning Score (NEWS 2) to record patient vital observation and identify deteriorating patients. Observations were entered onto an electronic system and all staff had access to review patients' observations. Any patient with high scores would be alerted to senior staff to review. Critical care outreach team would visit patients with a NEWS score of 7, ward staff were able to refer patient direct for support and advice.

Allied health professionals, such as physiotherapists and dietitians who visited the patients were provided with written and verbal information to ensure that all staff involved in patient care were fully informed of patients' condition and care needs.

Safe environments

Score

3. Evidence shows a good standard of care

The service detected and controlled potential risks in the care environment. Staff on the wards, EAU and discharge lounge made sure equipment, facilities and technology supported the delivery of safe care.

We visited the EAU, the SDEC, medical day case unit, the discharge lounge, virtual ward and 7 medical wards. All wards and areas visited had suitable facilities to safely meet the needs of patients.

All areas visited were visibly clean and tidy with appropriate equipment available to maintain safe levels of care. Competent staff tested medical equipment within required timeframes. Staff stored sterile equipment off the floor on appropriate shelving, we looked at 10 pieces of equipment, and all were in date. Staff had access to sharps bins and labelled these correctly when opening a new one.

Fire extinguishers had within date service checks and there were signs pointing out fire exits throughout the hospital.

Staff carried out daily safety checks of specialist equipment, such as the resuscitation trolley. Resuscitation equipment was easily accessible and located in each area. Resuscitation equipment had been checked daily and an up-to-date checklist confirmed all equipment was ready for use.

There was a process to manage the safety, maintenance and repair of facilities, premises and equipment.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

Managers made sure there were enough qualified, skilled and experienced staff, who received thorough support, supervision and strong development opportunities. Staff worked together well to provide safe care that met people’s individual needs.

The service had enough staff to keep patients safe. All staff had a period of induction and had supervision before commencing work. Where shifts had gaps, managers booked bank and agency staff. Bank staff told us they have an induction into the area they would work in and support from staff on the ward.

Every morning, staff could raise concerns about staffing levels and any support they required. Staff from other wards would move to work on areas that where short staffed required

additional support. Staffing levels and staffing requirements were discussed at the trusts daily flow meetings, this included any gaps in staffing levels and patients 1 to 1 care needs.

Ward Manager's told us there were additional beds in bays, but staffing levels had not increased to meet this demand. They sometimes felt there was not adequate staffing levels. Ward manager would work supervisory, this allowed them to be included in the numbers if there were any short-notice staffing gaps to maintain safer staffing levels. Sisters and ward manager's would often be required to be allocated a group of patients to look after due to staff shortages. Staff told us this sometimes meant that management duties and coordination of patients care may be delayed.

There were link champions such as tissue viability, infection prevention and control and dementia on the wards, who attended meetings and training. They provide peer support and updates to staff on the wards. They can impact on patient outcomes by ensuring safety protocols and implemented and improve overall compliance with care such as hand hygiene and wound care.

Nursing staff had completed their Nursing and Midwifery Council re-validation checks and updates to develop their competencies.

Staff received training appropriate and relevant to their role. Staff had additional competencies for their roles such as cannulation and catheterisation. All staff had an induction, and staff were provided with supervision as needed. Training compliance data showed 92% of all staff had completed their mandatory training.

Infection prevention and control

Score

3. Evidence shows a good standard of care

Staff assessed and managed the risk of infection. Staff detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

All areas visited and wards were visibly clean, tidy and well-maintained.

Dedicated cleaning staff were responsible for keeping the environment clean. They had enough equipment and followed a daily checklist to ensure they had completed all tasks. Staff on the wards also carried out daily cleaning of the equipment and environment. We saw cleaning and alcohol wipes were available throughout the hospital.

Staff followed infection control principles including the use personal protective equipment (PPE). Hand-washing and sanitising facilities were available for staff and visitors. We observed staff using PPE and hand sanitising gel appropriately during the inspection.

Infection prevention and control audits were carried weekly out as part of the matrons' checks. Environmental audits for the medical wards in March 2026 were generally over 96% compliant. Any concerns would be raised directly with the staff at the time.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always make sure that medicines and treatments were safe and met people's needs, capacities, and preferences. Staff involved people in planning, including when changes happened.

Staff mainly followed systems and processes to prescribe and administer medicines safely. We reviewed 10 medication charts and found patients' medicines were appropriately prescribed, supplied and mainly administered in line with the relevant legislation, current national guidance or best available evidence. Patients received the right choice of medicine, at the right time, to achieve the best possible health outcomes.

However, we saw patients that were administered medication for anxiety or as a sedative were not always closely monitored post administration, which did not follow national guidelines. Guidelines state that monitoring required close observation of respiratory function, blood

pressure, and heart rate. We found patients on ward 43 that had been administered the medication, had not had the required monitoring. We raised this during our inspection. Following our inspection the trust informed us of 4 similar incidents that they were reviewing and completing an internal Patient Safety Incident Investigation (PSII). The PSII resulted in actions taken including additional training, a review of prescribing and safeguards when prescribing, with support from pharmacy and the dementia team.

Staff did not always document information consistently on drug charts. We saw on ward 44 and 43 that height and weight was not always recorded, some medication did not have an indication for its use and antibiotics did not always have a review date.

Processes were in place for managing medicines and safe storage. Staff on the ward completed regular checks of medications and controlled drugs (CDs) in line with the policy. Medications were stored in locked cupboards in locked rooms. Controlled drugs are drugs that are subject to high levels of regulation because of government decisions about those drugs that are especially addictive and harmful. We saw staff checked CD cupboards and drugs at each shift change over and were correct. However, we did see liquid drugs open on ward 44 and 43 that did not have a date they had been opened. We raised this with the nurse in charge during our inspection.

Staff monitored fridge temperatures and checked to ensure these were within the required range. These were monitored and recorded daily. However, on the EAU and the virtual ward area, we saw medication fridges were not locked. Staff told us the keys for the fridges on EAU were missing and they were waiting for new fridges. Staff on the virtual ward area were unsure of the location of the keys. We raised this with senior staff during our inspection and the EAU fridge keys were located.

Staff wore red tabards to identify that they were carrying out drugs round and should not be disturbed. Drug trolleys were locked, clean and tidy and kept outside the bays with specific medication for the bays in the bays. However, we did see drug trolleys were left open and unattended during drug rounds on ward 44 and EAU. We did raise this at the time of the inspection and immediate action was taken to close the trolley and remind the staff.

Effective

Rating Good

We looked for evidence that patients and communities had the best possible outcomes because their needs were assessed. We checked that patients' care, support and treatment reflected their needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

This key question has been rated as good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. Staff did this in line with legislation and current evidence-based good practice and standards.

Policies we reviewed were up to date and had been approved by the appropriate governance processes. Staff assessed patients in line with national and best practice guidelines.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service followed National Institute for Health and Care Excellence (NICE) guidelines such as Acute Respiratory Infections (NG237), which focusses on initial assessments, antibiotic and diagnosis. It also followed the management of pneumonia (NG250). These standardised care and ensured staff followed national guidelines.

They used effective tools for screening malnutrition and dehydration and acted on any indicators of concern. Patients with special dietary needs were catered for. Snacks and drink were available on all the wards, EAU, SDEC and discharge lounge.

They used effective tools for screening and monitoring pain. We saw this was included in the daily risk assessments and documented in patients care plans. Patient were offered analgesia

as required.

We reviewed 5 care plans and found Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and do not attempt cardiopulmonary resuscitation (DNACPR) forms were completed in line with national guidance. ReSPECT forms records clinical care, treatment preferences and emergency decisions.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

There was good teamwork between medical, nursing and allied professional staff. During board rounds and handovers, staff shared patient information and discussed progress, interventions and future plans. A board round is when doctors, nurses, and other staff stand around a board that shows every patient on the ward. They talk about each patient to check how they are doing and what they need next. We observed staff sharing information from EAU to ward staff to handover a patients care.

Staff had good working relationships within the hospital to manage flow through the hospital. There were board rounds at regular intervals throughout the day to ensure that patients could be admitted or discharged in a timely manner. The trust had flow meetings throughout the day to have full oversight of the whole hospital and for senior leaders to assess any areas of concern. Flow meetings review capacity and patient movements in and out of the hospital. Each department shared information on line with regards to bed status, patient numbers and planned discharges.

Staff from SDEC would visit the emergency department (ED) daily to pull patient out of ED into SDEC for care and treatment.

Staff had access to the information they needed to appropriately assess, plan and deliver patients' care, treatment and support. Patients had one set of notes that would move with them throughout their hospital stay to share information.

Staff from the virtual ward and SDEC assessed patients' needs at home and could contact social services and community services for ongoing support.

The discharge lounge accepted patients that had planned discharges from all wards. The electronic system showed how many bed spaces and fit to sit chairs were available to allow staff to transfer patients waiting for discharges. The discharge lounge staff arranged medication to take home and transportation for patients.They liaised with the families, ambulance staff, care homes, community services and discharge location.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

The service routinely monitored people's care and treatment to continuously improve it. Staff ensured that outcomes were mainly positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

We found that people who used the service experienced positive outcomes as set out in legislation, standards, and evidence-based clinical guidance such as National Institute Clinical Excellence (NICE). Patients had access to 7 days a week diagnostic and support services. Medical staff we spoke with said that there was good access to services to support patient treatment and care.

Matrons carried out weekly and monthly audits including, cleanliness, nursing records, medicines management and risk assessments. We saw medical records audits for March 2026 showed a compliance of 96%, environmental audits were 96% compliance. Audit results were shared with staff directly and presented to the divisional governance meetings.

The trust participated in relevant local and national clinical audits at both service and organisational levels. The hospital monitored the compliance with the sepsis bundle and carried out weekly sepsis screening audits. In December 2025 compliance was 100%. This meant patients at risk of sepsis were treated quickly to prevent them becoming more unwell.

In December 2025, the percentage of people waiting less than 18 weeks for treatment was 59% compared to the national value of 61%. In December 2025, the unplanned reattendances rate was 9.2%, which was less than the England percentage of 9.5%.

The published Summary Hospital-level Mortality Indicator (SHMI) was within the expected range for observed deaths at the trust between October 2024 to September 2025, with a value of 1.04.

The hospital's Sentinel Stroke National Audit Programme (SSNAP) used combined total key indicator levels. The test gives each hospital a score from A to E, where A is the best and E is the lowest. From July to September 2025, this hospital scored a D. Across the whole country, 40% of hospitals also scored a D, which was the most common score during that time.

The national respiratory audit checked how well the trust cared for patients. The most recent results from 2024 showed that 31% of patients got the right care when they left hospital. This was lower than the national average of 49%. However, 75% of patients were seen by a respiratory specialist within 24 hours. This was better than the national average of 48%.

The most recent Adult Inpatient Survey for 2024, showed that the trust performed 'much better than expected' compared with other trusts, for questions regarding the hospital and ward.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment. Patients understood their rights around consent to the

care and treatment they were offered.

There were systems and practices to ensure patients understood the care and treatment being recommended. This helped them make an informed decision.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Patients received information about care and treatment in a way they could understand and had appropriate support and time to make decisions.

Staff mainly understood the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Although staff were aware of which patients had a MCA and DoLs in place, we saw some forms were completed and some were partially completed and staff knowledge of who completed them was mixed, especially on wards 43 and 21. We raised this on our inspection and following our inspection the trust developed an action plan to address our concerns. The action plan included a review of training, documentation, handover process and audits, additional support from MCA and safeguarding specialist teams and engaging with all staff on the wards.

Caring

Rating Good

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported, mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service always treated people with kindness, empathy and compassion and respected their privacy and dignity.

Staff were discreet and responsive when caring for patients. Staff took the time to understand the needs of the patients and interact with patients and those close to them in a respectful and considerate way.

People were assured that information about them was treated confidentially, and they knew that staff respected their privacy. Staff made sure conversations were not overheard, all conversation were behind curtains round the bed space or closed doors. We observed interactions between patients and staff where staff ensured patients' dignity was maintained.

We observed staff introducing themselves and informing patients of what they were going to do, such as carrying out observations.

We observed staff talking calmly to a patient with mental health symptoms on EAU and reassured other patients in the same bay. Staff were supportive to each other and offering help with the patient's behaviours.

Staff on EAU and the wards told us they would find a quite space to share difficult news with patient and relatives in a sensitive way and ensure they had time to ask questions.

Patients said staff treated them well and with kindness. We observed staff speaking politely and with respect to patients and relatives. One patient on the discharge lounge told us, 'staff are simply wonderful they are so helpful'. Another patient on ward 51 told us, 'staff are pleasant they do everything, nothing seems too much trouble, they listen to you'. A patient on ward 44 told us, 'everyone is really helpful, they have explained everything to me, when I press the buzzer, they come really quickly and help with my pain'.

Responding to people’s immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people’s needs, views and wishes. Staff responded to people’s needs in the moment and acted to minimise any discomfort, concern or distress. We saw staff supporting patient to mobilise and making them comfortable. We saw staff in EAU reassuring a patient with mental health symptoms and giving them time to talk.

Patients and relatives told us they could speak with doctors and nurses and were aware of the plans for their care. We saw staff had arranged a family meeting to support a family whose relative was reaching the end of their life to discuss care, treatments and options.

Visiting hours for relatives were flexible for patients receiving end of life care, families could stay overnight when required.

Patients with learning disabilities, special characteristics and dementia could have carers and family members stay with them throughout their hospital admission. Staff on the ward told us they had access to reclining chairs for visitors to stay overnight if required.

We heard conversations with medical, nursing and physiotherapy staff about immediate changes to patients care and how these would be implemented.

Staff from the virtual ward told us that when they visit patient in their own homes, they would often refer patients to other services and charities that could offer support with cleaning, shopping and access to furniture to support their needs.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centered care.

Most staff reported a culture of kindness and respect between colleagues. Most staff told us they felt respected, listened too and able to raise concerns and suggestions to their direct line managers. Some staff felt senior leaders in the organisation did not listen or support their wellbeing. They were not always involved in decisions about working environments and changes. One ward manager told us they felt micromanaged and were not always listened too when raising concerns.

Staff morale was mixed, staff on the medical wards and EAU told us they felt supported by their immediate leaders and senior managers. They could raise concerns and were listened to. Staff told us they had good peer support, and positive working relations with physiotherapy staff and medical staff. Staff felt supported by the matrons who visited the wards daily. During the ward handover staff discussed how everyone was feeling about the tasks allocated and workload. We saw staff supporting each other, offering help and discussing how they were feeling.

However, staff morale was low on SDEC. Staff felt they had not been involved in decisions taken to move the SDEC and were unsure of any reviews or potential moves back to the emergency department environment. We raised this with senior leaders at the time of our inspection. Following our inspection leaders told us they had met with staff and would ensure they were involved and kept up to date with decisions.

Staff said they could provide high standards of care and treatment. Staff told us they were able to attend the face to face training or complete this online. We spoke with student nurses and newly qualified nurses who told us staff were supportive of their training and learning needs. Training days were organised multiple times a year in focused relevant areas. Leaders told us they did not organise mandatory training during winter months due to increase in capacity to prevent cancellation of training days and felt this had worked well this winter.

Staff told us they had an annual appraisal and could raise any issues or learning needs or opportunities with their line manager. In the last 12 months, 88% of staff working in the medical division had received an appraisal and 92% of medical staff had completed an appraisal. There were a variety of online learning platforms that staff could use to develop their skills and

experience to enhance their development.

Staff survey results showed mostly positive feedback. The response rate was 63%. Staff rated morale at 6.31 out of 10 and engagement at 7.13 out of 10. Just over 63% felt the trust supported their health and wellbeing. Most staff, 89% felt their work made a difference to patients. With 90% felt trusted to do their job. The survey results were discussed at divisional and board meetings. Key areas to improve included retaining staff, making sure they have the right equipment, and celebrating staff achievements.

A monthly divisional newsletter was available. Managers recognised staff for their achievements such as completing courses and winning awards. Managers held events where staff were presented with certificates and badges to recognise services. Staff told us they appreciated being recognised for their achievements.

The trust had a Working Together Strategy 2025-26 to ensure all staff felt well informed and supported. This included staff survey, exit interviews, staff well being and enabled staff to present any projects.

Responsive

Rating Good

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

This key question has been rated good. This meant people’s needs were met through good organisation and delivery.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

Patients who used services were involved in planning and making shared decisions about their care and treatment, so it is centred around them and their needs.

Staff monitored patients' personal needs including mobility, pain and dietary requirements. We reviewed 17 patient records, care plans reflected physical, mental, emotional, and social needs of patients including those related to protected characteristics under the Equality Act. Staff undertook risk assessments to identify specific needs such as nutrition, hydration, mobility, falls risk and frailty score. Staff made reasonable adjustments to help patients access services. Staff updated patient records daily about ward rounds, medication, patients' care and treatment. We saw positive interactions between staff and patients. Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff used personalised documents to provide tailored care. We saw a learning disability care plan completed for a patient that included 'my usual self' assessment. This included information on general appearance, facial expressions, body language, vocal sounds, behaviour and things that relax me. This had been completed with the patient and their family. The patient had been reviewed by the trust's disability nurse and safeguarding team.

Patients with learning disabilities, special characteristics and dementia could have carers and a family members stay with them throughout their hospital admission. Staff had access to specialist nurse for support and advice for patients living with learning disabilities, dementia and mental health symptoms.

Patients told us they had enough food and drink and a choice of meals. Patients' dietary requirements were taken into consideration in meal choices.

Patients' communication needs were assessed and met to maximise the effectiveness of their care and treatment. Translation services were available for people whose first language was not English. Staff knew how to access this service.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

People had access to information and advice that was accurate, up-to-date and provided in a way they could understand and met their communication needs.

Patients could access various leaflets such as about the virtual ward, frailty ward, outpatient antibiotic therapy, the stroke unit and the discharge lounge. All contained information about what to expect and contact numbers.

We saw a variety of posters and information for staff, patients and visitors displayed on the wards including, infection control guidance, dementia, falls and sepsis.

Translation services were available for people whose first language was not English. Staff knew how to access this service.

Listening to and involving people

Score

3. Evidence shows a good standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about

their care, treatment and support. Staff involved people in decisions about their care and told them what had changed as a result.

Patients knew how to give feedback about their experiences of care and support including how to raise any concerns or issues.

The trust collected friends and family feedback, via a variety of routes including paper, online and text messages, with an average response rate of between 93-96%. The data between December 2025 and January 2026 for the medical division showed 93% of patients rated their care as very good and good.

Staff had access to an online trust complaints policy. Managers and ward staff discussed complaints at daily meetings. Between April to October 2025 there had been 72 complaints within the medical division. Themes included clinical treatment and delays in treatments. All complaints were responded to and action plans developed. Actions included improving communication with patients and relatives and revitalised 'intentional hourly rounding' to ensure that patient needs were consistently addressed and any concerns identified and managed promptly. Leaders discussed complaints at divisional meetings, patient experience meetings and benchmarked with other local trusts.

Equity in access

Score

3. Evidence shows a good standard of care

The service made sure that people could access the care, support and treatment they needed when they needed it.

Patients could expect their care, treatment and support to be accessible and timely. It was delivered in line with best practice, quality standards and legal requirements. People could always access care, treatment and support when they needed to and in a way that worked for them.

The hospital had wheelchairs and lifts available to access all areas of the hospital. Staff were available at the entrance of the hospital to support and direct people to the correct areas. Wards were clearly sign posted and had swipe card access.

Staff told us patients with mental health symptoms would be given 1 to1 care. Patients with learning disabilities and dementia could have carers or family members with them during their stay.

People could access the inpatient service when they needed. Medical wards were open 24 hours a day all year round. Patient had access to other services within the hospital such as pharmacy, x-ray, and imaging.

SDEC was open 7am to midnight. The virtual ward worked 7 days a week. The service worked with other healthcare professionals to provide a timely service for different healthcare needs including mental health services, community services and GPs.

The multidisciplinary team were involved in the discharge planning for all patients. This commenced early in the patients pathway to ensure a safe transition from hospital to home or another care facility. The trust reported delayed discharged monthly. For October and November 2025 there were 86 delayed discharges. Each delayed discharge was reviewed and actions taken. Delayed discharges were discussed at the trust flow meetings, staff handovers and board meetings.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Patients and families were supported to make informed choices about their care and treatment. Patients we spoke with felt the information they were given was clear and accurate

and provided in a way they could understand. Patients were supported to make informed choices about their care and plan for the future. Patients told us they could ask questions and were aware of the plans in place.

We saw ReSPECT forms which also included information on DNAR, were completed and staff were aware of which patients had these in place. We saw these were discussed at staff handover and board rounds and clearly documented.

We saw staff had arranged a family meeting to support a family whose relative was reaching the end of their life to discuss care, treatments and options.

Well-led

Rating Good

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

At the last inspection this was rated as good at this inspection it remains good. This meant there was good leadership and a culture that created high-quality care.

Shared direction and culture

Score

3. Evidence shows a good standard of care

The service had a shared vision, strategy, and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

Divisional leaders told us the medical strategy interlinked with the trust strategy. Main workstreams were admission avoidance, improving patient flow and discharge and to digitise

and integrate data to improve efficiency.

The Trust actively promoted a zero-tolerance stance against discrimination, championing an inclusive working environment. They had a No Place For Racism strategy. They have a multicultural workforce representing over 100 countries. Flags reflecting colleagues' countries of birth were displayed in the hospital to support inclusivity and a welcoming environment.

The trust had access to community hospitals which allowed them to increase the flow through the hospital, especially for stroke patients. There was a shared direction and services in the community had been developed to support people in their own homes, such as virtual ward, SDEC and medical day case unit.

There was a shared culture of learning and improving to enhance the patient experience. The senior leaders were passionate about getting services right for patients and gave us several examples of changes to services including the stroke pathway and links with GPs for respiratory patients to prevent admissions.

Staff told us they were proud to work at the hospital and most staff enjoyed their work and felt supported by each other and their direct leaders. They told us about working together as a team and sharing information with other departments to support the flow of patients throughout the hospital. However, some staff felt senior leaders in the organisation did not listen or support them and they were not always involved in or information was shared about decisions, working environments and changes.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.

Most staff felt supported by all levels of their leadership team. Staff spoke positively about the immediate managers and matrons and the way they supported them. Matrons and senior leaders spoke with emotion about how proud they were of their teams, their dedication and compassion to deliver good care. Staff knew who the executive leaders were and told us they sometimes visited the ward.

The leaders were available when they were needed and led by example. They were knowledgeable about the issues and priorities in the medical service. The were keen to harness the improvement and suggestions made by staff. They focused on staff wellbeing and ensured a culture promoting good practice, good quality, and safe care and treatment.

Matrons and senior leaders told how proud they were of their teams, their dedication and compassion to deliver good care.

All staff had opportunities to develop, including for future leadership roles. There was inclusive recruitment and succession planning for the future. The trust had effective recruitment processes and ongoing checks to ensure all staff met the legal requirements to work in the trust. The service was aware of the challenges they faced in recruitment and the areas which required further support.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The service fostered a positive culture where people felt they could speak up and their voice would be heard.

The hospital had a Freedom to Speak Up Guardian (FTSUG) and Freedom to Speak Up champions. A FTSUG is a named person in every trust who can provide independent support and advice to staff that want to speak up. Staff told us they were aware of the champions and would access them if required.

Managers supported an open and honest culture. Most staff we spoke with felt supported,

respected, and valued. The culture encouraged openness and honesty at all levels within the organisation. Most staff told us they felt able to raise concerns and they were listened to by the leaders of the service. Staff described a 'no-blame culture' which empowered them to raise any concerns.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

The service had a shared vision, strategy, and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

Divisional leaders told us the medical strategy interlinked with the trust strategy. Main workstreams were admission avoidance, improving patient flow and discharge and to digitise and integrate data to improve efficiency.

Some wards had more than one extra patient in a bay. Bays that were designed for 4 or 5 beds had an additional bed to help with support the high number of patients admitted. Additional beds in bays on wards helped prevent patients having care in corridors, especially in the emergency department. There was a policy to ensure patients placed in additional beds were clinically appropriate and did not require high dependency of care. Some managers told us that staffing levels hadn't increased to accommodate the additional beds and they often worked clinical shifts to support capacity.

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examples of changes to services including the stroke pathway and links with GPs for respiratory patients to prevent admissions.

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The Trust actively promoted a zero-tolerance stance against discrimination, championing an inclusive working environment. They had a No Place For Racism strategy. They have a multicultural workforce representing over 100 countries. Flags reflecting colleagues' countries of birth were displayed in the hospital to support inclusivity and a welcoming environment.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff share information and learning with partners and collaborate for improvement.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the people and communities. Examples including working with the local authorities to support the homeless community and health inequalities and daily reviews with the community and ambulance services to review capacity and flow.

Feedback from external partners described the relationship with the hospital as strong, positive, and collaborative, with effective communication. They actively participate in quality improvement work and a review of any patients incidents involving both organisations. They

have a good working relationship with the trust.

The Patient Experience Team launched a new Coffee and Connect initiative welcoming stakeholders to discuss shared goals, challenges and opportunities for service improvement. The aim was to strengthen relationships and enhancing engagement with stakeholders.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement across the organisation and local system. Staff encouraged creative ways of delivering equality of experience, outcome and quality of life for people. Staff actively contribute to safe, effective practice and research.

Staff told us they were committed to learning and improving. There was a strong focus on developing the skills of staff to promote their professional growth within the hospital.

A monthly divisional newsletter was available to all staff which includes, information on incidents, complaints, lessons learnt and staff celebrations.

The trust had implemented a variety of learning and improvements including implementing voice recognition for consultation and note writing. The developments of a pathway for young adults with diabetes had resulted in a reduction in hospital admissions.

The dementia team presented a patient’s story outlining changes from feedback. This was shared with the wider community for learning. A review of the stroke pathways resulted in some patients moving to the community hospital for rehabilitation and group sessions.

The trust had developed links with GPs for respiratory patients to improve the overall care and treatment to prevent admissions. They told us this had been successful and were looking at rolling out a similar project for frailty patients.

Urgent and emergency services

Urgent and emergency services

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Our view of the service

The emergency department (ED) at King's Mill Hospital provides a 24-hour, seven-day a week service to the local population. The consultant led service is a member of the East Midlands trauma network and is a designated trauma unit. The ED consisted of 32 'majors' treatment trolleys, 10 'minors' treatment trolleys, a 15 bedded resuscitation area. The paediatric area consists of a paediatric resuscitation bay, and a paediatric emergency unit consisting of three trolleys and a high dependency unit space. There was also 3 triage rooms used for initial tests while patients wait for admission into the ED department. There is a same day emergency care (SDEC) unit to support patients experiencing acute medical conditions. Patients in SDEC are ideally assessed, diagnosed, and treated in a hospital on the same day of their arrival, allowing them to return home rather than being admitted for an overnight ward stay. There is a designated emergency department for children and young people. This unit opened 24 hours a day in December 2025. There is a co located urgent treatment centre which is run by a different provider. We did not inspect the urgent treatment centre.

On Monday 9 and Tuesday 10 March 2026 CQC carried out an assessment at King's Mill Hospital. We last

inspected urgent and emergency care (UEC) in 2024 and Medical Care services in 2018 when we rated both as good. At this assessment the ratings stayed the same.

We assessed 25 quality statements across the safe, effective, caring, responsive and well-led key questions. We have combined the scores for these areas with scores from the last assessment to give the rating.

We spoke with 12 patients and 6 relatives/carers. We reviewed 12 adult patient records and 6 records of children and young people. We spoke with more than 52 staff which included: consultants, resident doctors, nurses, senior leaders, healthcare assistants, administration staff, chief pharmacist, deputy chief pharmacist, pharmacy technician, housekeeping staff and volunteers.

People's experience of the service

Most patients, families and carers we spoke with were mostly positive about the staff, who treated them with warmth and kindness and provided effective care and treatment. Comments from patients, families and carers included: staff were “helpful, friendly and kind”. Patients said communication with them was generally good although most patients were not given any indication of how long they would have to wait for treatment past the initial meeting with the doctor.

Patients said they were seen quickly by trained nursing staff when they arrived and were asked appropriate questions to find out more about why they had attended the ED. Records we reviewed showed they were given the tests they needed usually promptly. We observed staff interacting with patients in a sensitive and kind manner. Most patients said that they were offered food and fluids whilst waiting.

Safe

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained the same.

This meant people were safe and protected from avoidable harm.

Learning culture

Score

3. Evidence shows a good standard of care

The service had a proactive and positive culture of safety, based on openness and honesty. Managers listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually identify and embed good practice.

Staff and leaders encouraged and supported to raise concerns, and felt confident that they would not be blamed, or treated negatively if they did so. Staff were aware of NHS England best practice guidance: Learn from Patient Safety Events (LFPSE). Some staff reported receiving feedback following an incident they had reported. Staff were supported by leaders following a distressing incident.

All staff described the ways in which information from incidents was shared within the department. This included the use of a private encrypted messaging group chat, emails, through a monthly newsletter and at handover. Most staff used emails or the messaging group to make themselves aware of changes to practice following incidents. Staff described that “hot” debriefs were in place, which happened as soon as practicable following an incident. This discussion of those involved and the investigation team allowed learning and actions to be undertaken soon after the incident. Leaders checked on the wellbeing of staff following these incidents.

Staff were aware of the duty of candour and enacted this at a patient level when aware of a complaint or incident. The service used the learning from complaints and concerns as an opportunity for improvement. Senior members of staff and leaders were involved in reviewing complaints and incidents at a daily review. For example, we heard about an issue of extending expiry dates on liquid medications which was not in line with best practice. In response to discussion around this issue several ideas were discussed for potential highlighting and resolving the issue. Following agreement on an action the leaders fed back to their own teams.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They made sure there was continuity of care, including when people moved between different services.

The department worked collaboratively with internal colleagues and external partners to maintain patients' safety. Continuity of care was maintained by effective handover of patients and communicating their individual needs. All patients entering the department on foot were required to check in at the reception desk. This would initiate streaming by the 24 hour receptionist and a nurse who was present between 10am and 10pm. The patient would then be sent to the most appropriate pathway. These pathways included: majors' area, resuscitation, minors' area, fit to sit area or to the primary care provider. The major's area saw patients who require more intensive care. Resuscitation is an area where the most seriously ill patients go for treatment. Minors and fit to sit areas are for patients that have less serious conditions.

Receptionists at the front desk explained the process of streaming and triage to patients. The department had different coloured chairs for triage and streaming. However, patients were unaware of this and sat wherever and waited for their name to be called. Triage patients we followed were seen within 15 minutes in 1 of the 3 triage rooms in operation. Initial observations were recorded, and tests were performed and then appropriate patients were returned to the waiting room to await being seen by a clinician. Some patients would be sent directly to other areas in the department. Children were sent through to the paediatric waiting area from reception. The waiting room was monitored by the nurse in reception who undertook observations on patients as necessary. We saw that when a patient fainted, staff saw this and gave treatment quickly.

Patients were called by clinicians from the waiting room to the appropriate area for assessment and treatment. We saw a mixture of paper and electronic records in place for patients. On paper records we noted that risk assessments were completed but sepsis screening was undertaken

on the electronic patient record. Staff used a dual system of recording patient information. However, they were looking forward to having one electronic patient record system which was about to be implemented following our inspection. Having one electronic patient record ensures that all patient information is in one place and this increases the safety of that patient.

Staff knew about the pathways of care for specific patients. For example, staff knew that trauma patients requiring secondary transfer, patients who required neurosurgery, patients with burns and severely ill children would all be transferred to different hospitals. There were good communications systems in place to ensure a robust handover was given and patients received timely care on arrival. Staff reported good working relationships with the hospitals that they regularly transferred patients too.

The department had a clear pathway for patients with mental health needs. When people with mental health needs arrived in the department, triage nurses or the reception nurse completed an initial assessment. They referred the patient to a third-party mental health trust who could stream patients with mental health needs directly to other services.

Mental health trained security staff supported clinical staff when a there was a risk of violence and aggression. We saw that they responded quickly but did not provide support and restraint unless advised by care staff. Staff completed an emergency department adult mental health triage safety and observational tool designed to assist staff to the recognise the needs of the patient. This form was designed following a member of staff identifying a need to support patients with a mental health condition and nursing staff. It also assisted with referral to the mental health team as appropriate.

Safeguarding

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. They concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination,

avoidable harm and neglect. The service shared concerns quickly and appropriately.

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. Patients we spoke with told us they felt safe and that if they had any concerns or issues, they would feel comfortable to tell someone.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm. Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies such as police and local authority safeguarding teams, to protect them. We saw that children who left the department without being seen by a doctor were flagged for follow up by the social worker liaison team.

Staff had training on how to recognise and report abuse, and they knew how to apply it. Data provided to us by the trust showed that compliance with all safeguarding training were over the trusts target of 90% within both the nursing staff and medical staff. Safeguarding children level 1, 2 and 3 training were all above 95% compliance for staff. Adults safeguarding training at all levels were above 96% compliance.

Staff had access to safeguarding policies, which referenced appropriate legislation and best practice guidance. Safeguarding information was displayed throughout the department. Staff told us they were confident in raising safeguarding concerns and the process for referrals on electronic patient record system and was easy to complete. Staff were able to tell us when they recently completed referrals. Staff told us there were safeguarding nurses who provided support and advice when needed. We heard that feedback from investigations was shared with the department.

The service shared concerns quickly and appropriately. Where applicable doctors completed Mental Capacity Assessments (MCA) for best interest's restrictions. The trust had delivered training courses on the Mental Capacity Act. Staff told us that they found the training helpful. Staff considered patient's capacity when assessing them. Staff recorded an assessment of capacity in one of the records we reviewed.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

The department had effective processes and tools for assessing patients when they first presented to the department and monitored patients for signs of deterioration when they were taken into the department. Patients we spoke with told us their wait for triage had been timely. Patients were triaged by trained triage nurses. If they were fit to sit to wait for treatment, they were observed by the nurse at reception when they were on duty.

Leaders and staff could articulate what risk assessments they used to keep patients safe. Staff in the department consistently assess patients using standardised risk assessment tools. For example, they consistently assessed the risk of venous thromboembolism (VTE), falls, skin integrity, or clinical frailty. NHS guidance states the Clinical Frailty Score (CFS) should be completed within 30 minutes for all adults over the age of 65 who present in ED. Whilst this was not always complied with due to the pressure on the department, we found that risks assessments were undertaken and reviewed during a patients stay.

Sepsis risk assessments were undertaken where appropriate. However, staff told us that winter pressures led to patients being moved through the department due to space constraints before sepsis treatment had begun, which increased clinical risk. We did not see any evidence of harm to patients because of this. Patients' observations were recorded and scored as per the National Early Warning Score (NEWS). In children this was scored in line with the Paediatric Early Warning Score (PEWS). This allowed staff to assess any improvement or deterioration in patients and commence treatment at the earliest opportunity.

Security staff were trained in least restrictive restraint. Restrictive restraint was only used as a last resort. We noted one episode where the security team were called. They arrived promptly and awaited further instruction from the care team. They were not required as the care team were able to manage the situation.

Patients told us they felt safe and supported whilst they were in the ED. They could approach staff if they felt their health was deteriorating and they were confident staff would respond to

their concerns.

We saw posters about Martha's rule, a programme which enabled friends, relatives and patients themselves to make a direct referral to the outreach team if they felt the clinical condition of an adult or child patient was actively deteriorating. However, staff felt that this route was rarely used as family and friends would approach staff within the department first. The hospital had been one of the first to introduce Martha's rule in the UK in September 2024.

Staff we spoke with described the processes to assess and identify patients at risk and how they assessed and documented mental capacity. Staff had a person-centred approach and involved patients, where possible when completing risk assessments.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

The service mostly detected and controlled potential risks in the care environment. They made sure equipment and technology supported the delivery of safe care.

The equipment and facilities, in the main, supported the delivery of safe care. Although patients experienced long waits, waiting rooms and designated areas, such as cubicles built originally for I patient, were often used to admit 2 people, patients told us they were well looked after by staff. There was a separate area for children and their families which was easily accessed from the main waiting room and rest of the department. However, this area was not secure as per Facing the Future Standards for children and young people in emergency care guidance, October 2025. This guidance recommends that "Paediatric areas in the ED should be zoned off, with secure access points to control entry and exit". However, doors at either end of the department were not secured, and patients, visitors and staff could walk through the department unimpeded. Patients were seen quickly and checked on regularly.

Staff, mostly, had access to all the equipment they needed and guidance or instructions for using it. We were told that when the department was busy, staff did run short of thermometers

and cardiac monitors. Maintenance staff undertook planned preventive maintenance and completed electrical appliance tests were completed. All electrical equipment we checked had undergone electrical safety checks within the last 12 months. The department's fire safety equipment and emergency systems such as call bells, were tested and maintained appropriately. Fire exits were not blocked; evacuation routes were signposted.

The department was split into defined areas to treat different types of patients. These included streaming, minors, majors, resus, fit to sit and paediatrics. Ambulance arrivals had four bays where streaming took place for patients arriving by ambulance. Minors was an area where patients with minor injuries were treated. Majors were where those patients with illnesses or chest pain were treated. Resus was an area where the most seriously ill patients were treated. Those patients who did not need urgent treatment were asked to wait in the fit to sit area.

The department had a resuscitation area which had capacity for 15 patients, including an area to treat children. At times of peak demand, the area flexed to 2 trolleys in it to allow for an extended number of patients in the resuscitation area. Whilst the original bay was large enough to easily allow for a multi-professional team to care for and treat the patient this was restricted when 2 patients used the same bay. Screens were used to separate patients and to maintain a sense of privacy and dignity. In the event of an emergency in one half of the cubicle the other patient was moved to ensure staff had space to deal with the emergency.

In the major's area there was an open area which had 8 designated bays. However, at peak activity these bays designed for 1 patient would also be used to admit 2 patients. The central area was also used at times to have patients on trolleys. This made the area very difficult to navigate and to easily observe patients, especially when patients were accompanied. This area was designed for 8 patients but could be used for up 24. Whilst there had been no safety events reported due this this congestion there could be a risk in identifying and treating an emergency within the area. This process was described in their escalation policy for when the department was busy.

Equipment, facilities, and technology supported the delivery of safe care. Each treatment area had a standardised equipment. Standardisation of equipment aims to reduce the risk of harm to patients because staff who work between these areas will have greater familiarity with a smaller number of devices, thereby reducing the risk of error.

The department regularly used a room for supporting people with mental health needs. This

room was at the end of a corridor and in a quieter area of the major's department. The room had minimal furniture in it and did not contain any obvious ligature anchor points. This room was bare apart from 3 heavy chairs. We saw a patient using 2 chairs together to form a bed on which to rest. This room did not conform to the Psychiatric Liaison Accreditation Network January 2026 guidance on caring for patients with mental health needs. The previous guidance was to have 1 door which opened both ways and the new guidance states the room should have 2 doors to improve safety. The trust has a redevelopment plan which is currently in the planning phase. This will include dual entry rooms for high-risk mental health patients. At present the trust utilise a dual entry cubicle in the major's area for this purpose. Patients are risk assessed throughout their stay and placed in the appropriate location to meet their needs.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

The service had enough nursing staff to keep patients safe, and the nursing staff matched the planned numbers on the day. Skill mix was reviewed regularly and adjusted throughout the day. The department had 27 whole time equivalent emergency consultants, who were supported by doctors at different levels of their training. There was consultant cover in the department from 7am to 2am seven days per week. The children's department was staffed with doctors and nurses with the appropriate paediatric competencies. There were 2 consultants with Paediatric Emergency Medicine certification. However, the department was covered by all consultants in the emergency department. The paediatric emergency department had recently opened 24 hours a day, November 2025. However, at the time of the inspection, medical staffing was allocated 10am to 2am as this was seen to be the busiest times for the department. Very sick children were transferred to a nearby unit once stabilised.

Staffing was flexed to meet the needs of the patients attending the different areas of the department. Huddles occurred regularly throughout the 24-hour period to review the needs of patients in the department. Staff were reallocated if necessary.

There were safe recruitment practices to make sure that all staff, including agency staff and

volunteers, were suitably experienced, competent, and able to carry out their role. All new starters received a comprehensive induction. Nurses who had newly qualified followed a standard preceptorship programme. This was extended if required. The department had a cohort of Advanced Clinical Practitioners in training as well as others who already worked in the department. These staff had received additional training to undertake some procedures which would have been undertaken by doctors. Staff told us that the trust were supportive of their personal needs in respect of training.

Leaders told us that there was good team culture within the department, that across the professions there were good training opportunities and multiprofessional relationships. We were told there was a culture of supporting staff to develop and progress. The department had a vacancy rate of 7.8% for nursing staff and 10.4% for medical staff. This is within the expected vacancy rate. Staff undertook additional shifts or an agency was use to cover when necessary. The vacancy rate for medics reflected a gap in registrar staff. The turnover rate for nursing staff over the 12-month period was 3.64% and 7.23% for medical staff. Turnover rates were below the national average. Whilst overall sickness rates were 6.5% the majority of this fell in the non-clinical staffing band. This meant that staff were picking up additional duties below their skill set, which may impact on the care given.

During the inspection, the department was busy with more patients being cared for than the department was built for. The service had seen a rise of 36% in attenders since pre-covid levels. They were now seeing between 450 and 500 patients a day. This put pressure on staff. However, staff said they felt able to respond to increasing demand as staff supported one another well. We observed staff who were busy but remained positive. They could highlight the issues they faced but were resilient to these because of the support they received from leaders and other staff. Nursing staff spoke about doubling the number of patients on their workload as the day became busier. Staffing was assessed at the huddles to ensure that available staff were being utilised appropriately and to maintain the safety of patients. There was a good degree of support and mutual respect among staff working in the department. We observed effective and cohesive teamwork. There was a culture of just “one team” and shared responsibility.

Staff received mandatory training appropriate and relevant to their role. Overall compliance for all staff was 90.15%, which was above the trusts target for compliance at 90%. Where training compliance was lower than the trust target, managers had actions in place to address this. Leaders monitored training and provided extended training as required to staff.

The service had a process for carrying out appraisals, 92% of nursing staff had received an appraisal and 91% of medical staff had received an appraisal. Both were better than the trust target of 90%.

Medical staff were supported by named supervisors. Resident doctors had protected time for teaching. Feedback from resident doctors was positive, they felt supported and invested in to develop and gain new skills.

Staff told us specialised mental health training was available. Staff had access to a mental health resource file within the department. This file contained information on services and how to access them as well as other useful information. It was maintained by the nurse who linked with the mental health team. This was kept up to date by the mental health link nurse. Whilst mandatory training for staff in issues relating to mental health training ranged between 82% and 92%. ED members of staff could attend day training course on mental health. This training included sessions on mental health awareness, the mental health liaison team, conflict resolution, management of agitated patient, substance misuse and the application of the Mental Health Act in ED.

Infection prevention and control

Score

3. Evidence shows a good standard of care

The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

The service had an infection and prevention of infection policy, which staff were aware of, and which set out key information for staff to support maintaining infection, prevention and control standards. 92.3% of staff were up to date with their 3 yearly training and 88% of staff were up to date with their annual training in infection prevention and control. However, mandatory training was paused due to winter pressures. This meant that most training was planned over a 9-month period. Staff had access to essential training if required during this pause.

Hand hygiene, local cleaning and infection prevention and control audits were undertaken by the service. The hand hygiene audit across the last 6 months (September 2025 – February 2026) demonstrated that compliance was consistently rated above 95%. The environmental audit across the last 6 months demonstrated that compliance was consistently rated above 90%.

During the assessment we observed staff comply with the 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance. Personal protective equipment (PPE) and handwashing facilities were readily available. We observed staff washing their hands between patients and good use of PPE when required.

Cleaning staff were visible within the department. We observed both clinical staff and the cleaning staff cleaning equipment and the environment. We saw 'I am clean' stickers placed on surfaces that had been cleaned. The floors were visibly clean despite heavy foot traffic and the constant movement of people and equipment. The cleaning schedule set out by the service was followed. Staff labelled disposable curtains with the date they were last changed. Cleaning records we saw were up to date and demonstrated all areas and equipment were cleaned regularly. Clinical waste was disposed of safely.

Clinical areas we saw were clean and had suitable furnishings which were clean and well-maintained. Toys in the paediatric department were cleaned regularly and checked for their integrity.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that medicines and treatments were safe and met people's needs, capacities and preferences. They did not always involve people in planning.

Staff did not always follow the trust's policy regarding initial assessments including medicine information. For example, staff did not ask patients or paramedics during handover whether they were taking any critical medicines, despite this being a requirement of the trust's protocol

for initial assessment.

The ED did not have pharmacy support in line with national guidance produced by the Royal College of Emergency Medicines (RCEM).

Not all staff recorded medicine information accurately or administered medicines in line with best practice. Medicine reconciliation (the process of identifying an accurate list of a patient's current medicines) was undertaken by pharmacy staff in the major's area in the ED. We reviewed 5 medicines charts and found that allergies were recorded. We followed the care of one patient who was prescribed insulin and found concerns relating to the safe management of their diabetes on arrival at ED. The records were not clear on whether the patient had arrived with their own insulin. The patient presented with a high blood glucose reading, yet insulin was administered 1 hour and 39 minutes later, indicating a delay in treatment. In addition, the patient was given a different brand of fast-acting insulin from the one they normally used, despite the electronic record clearly documenting the correct brand from a recent admission. Different brands can act at different speeds in the body, which can affect blood sugar control and increase the risk of low or high blood sugar if switched. Therefore, posing a potential risk to the patient.

Staff did not always record when liquid medicines were opened, which meant they could not be assured the medicine was within date and safe to give. For example, in the paediatric clinic room, opened liquid medicines were not labelled with the date of opening or an amended expiry date, as required for safe medicines management. We observed a medicine being administered with a 28 day in use expiry, but staff were unable to confirm when it had been opened, indicating a risk that time-expired medicine may be used. Following the inspection, this has been raised as an incident, and learning has been shared within the department. The hospital was able to confirm that the medication was in date as it had recently been dispensed from the pharmacy to the paediatric ED.

Staff raised concerns about the overprescribing of lorazepam for people living with dementia and those receiving mental health care. However, we found that the trust was already aware of this risk and had taken steps to stop inappropriate prescribing. The pharmacy team had recently introduced updates to the electronic prescribing system, designed to give clearer prompts and improve clinical decision-making when prescribing. On the day of the inspection, we observed that the trust continued to review this issue in a patient safety committee meeting

led by a specialist nurse, who discussed the use of lorazepam in patients with dementia.

Staff did not always store patients' own medicines safely or manage general medicine stock well. For example, staff stored patients' own insulin inside the resuscitation medicine fridge, a practice inconsistent with national medicines management guidance. NHS guidance states that once insulin pens or cartridges are opened and in active use, they can be stored at room temperature for up to 28 days without refrigeration. When the resus fridge was checked, it was found to have no lock and to be disorganised with its own stock and patients' stock. We noted that room temperatures were not being monitored in the clinic room. Most medications are required to be stored below a certain temperature. Using medication which has not been stored correctly could negate the effect of the medication.

In the ED, medicines were stored in automated cabinets that supported secure access and effective stock control; however, due to winter pressures, an additional trolley was brought into the clinic room. It was thought that this would make dispensing medications quicker for nursing staff. This medicine trolley was observed to contain loose strips and loose tablets, indicating poor medicines-handling practice. Staff were using this trolley instead of accessing the automated cabinets, which compromised the intended safeguards and did not meet expected standards for the safe storage of medicines.

Medical gases were not managed safely. We saw oxygen cylinders not stored safely. A sign stated that the oxygen rack must be used and cylinders should not be on the floor. However, staff were storing used cylinders on the floor of the area. This was reported on inspection to the senior team and we saw that these had been moved when we returned to the department.

Controlled drugs (CDs) were stored securely. Nursing and pharmacy staff undertook checks to ensure that drugs were reconciled and boxes contained the correct amount of medication. However, we observed a box of controlled medicine from a patient who had left the department 2 months ago for a patient. This could pose a safety issue. A patient's own medicine was observed in a bag in the clinic room and had not been destroyed in a timely manner

There was a policy for the management of prescription (FP10) pads. These were stored securely and access was limited to senior staff. However, on the day of inspection, pad logs were observed to be untidy and lacked clear oversight in ED. This was not in line with the FP10 usage policy.

Effective

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good.

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

Staff had access to a comprehensive range of up-to-date policies and standard operating procedures which reflected current practice. Staff had access to guidance around collaboration with multi-agency teams and for delegation of clinical tasks to ensure the right people delivered evidence-based care and treatment. There were numerous clinical pathways which were well known to staff.

Systems were in place to ensure staff were up to date with evidence-based guidance and legislation. Clinical records we saw demonstrated care was provided in line with current guidance. For example, we reviewed the records of a patient who attended with a head injury. We saw care and treatment provided was in line with NICE guideline: Head injury: assessment and early management May 2023. Triage questions were appropriate for the patient and their needs for example, people presenting with emotional needs were properly and sensitively

assessed and specialist help sought early.

Staff told us treatment plans were evidence based and monitored for outcomes. Patients care was reviewed and updated, and appropriate referral pathways were in place to make sure that needs are addressed. Staff were able to tell us about when treatment had led to learning following debriefs and mortality and morbidity meetings. This included a trauma checklist designed by a member of staff and a generic trauma booklet both of which improved care for trauma patients following an incident that had occurred.

Patients said they had been offered something to eat and drink. We observed staff offering patients refreshments. Patients were offered a range of food which met their dietary requirements. However, hot food was not generally made available to patients. Senior leaders spoke of how they had sought to get hot food for patients who had been in over 24 hours. We were told that the restriction on hot food availability was in response to an incident that had occurred in the past. No one we spoke with was entirely sure what this had been.

The service worked with others to direct patients to other departments and organisations for patients who did not require emergency care. Within the emergency department there was access to and use of treatment units, frailty services and same day medical and surgical units.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

Staff had access to the information they needed to appropriately assess, plan, and deliver care, treatment and support in line with people's individual needs. However, this was often split across paper and electronic records. This meant staff had to review two documents to appraise themselves of the patients' journey and changes in condition or observations. The service was

moving to a new electronic patient record management system, and staff were keen for this to occur. This would enable teams and services to share information more readily.

The service worked well across teams and services to support patients. Leaders told us staff were responsive across the organisation when requested to support the ED. There were specialist teams, such as the psychiatric liaison support team and the substance misuse team who in reached into the department to provide advice and support to the staff working in the ED. The psychiatric team sent staff to undertake initial assessments within 4 hours when called by staff in ED. The internal specialist teams provided support to staff within the emergency department. Staff reported good working relationships with teams who supported the different strands of urgent care such as the Same Day Emergency Care unit and the frailty wards.

Care was coordinated, and everyone involved in their care worked well with together. We observed good quality, kind and compassionate interactions between staff and patients. Information was displayed on notice boards relating to care, advocacy access, information for carers, charities, mental health and feedback on care.

Staff worked well with external partners involved with patients. External partners, such as GPs, community nurses and social workers were involved to enable continuity of care and support for discharge. The ambulance service recognised that the emergency department was slower to implement the sit rep process. This led to slower updates during the day as more patients arrived in the department. However, they described working relationships as strong positive and collaborative. Staff reported good engagement with safeguarding partners.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

Many patients told us that they were not kept up to date with how long they may wait. We noted that there was no signage in the wating room as to how long patients may need to wait to be seen. This was corroborated in the Urgent Emergency Care Survey 2024 results in response to were you kept updated on how long your wait would be rated 2 out of 10. The next survey is currently having data submitted to it.

The trust submitted data to the Royal College of Emergency Medicine (RCEM) three Quality Improvement Programmes (QIPs) in 2025/26. These included self-harm in patients with a mental health issue, care of the older person and time critical medicines. The data submission date had passed a few weeks before our inspection and the department was awaiting the results of their submission. The trust audited practice against evidence-based research. We noted from governance meetings that sepsis was a standing agenda item. We requested the audits presented at the January 2026 meeting however, these were not sent.

There was a joint site assurance meeting(called flow meetings) 5 times a day. We observed a meeting chaired by the Deputy Chief Operations Officer. The focus of the call was to increase capacity and flow in the hospitals, to improve ED capacity and focus on facilitating safe transfers or discharges for patients. The call provided updates from both hospital sites across directorates on staffing, bed capacity and site team updates around discharges and the use of escalation beds. There were updates from estates, infection prevention and control, pharmacy, pathology, psychiatric liaison and community services.

Patients were assessed and triaged in a timely way and escalated as appropriate to their clinical needs. Patients having an initial assessment within 15 minutes of arrival, as per the national standard, was occurring for around a third of patients. Between October 2025 and February 2026, the average time was around 30 minutes. However, this was an improving picture as in November and December 2025 waits were 35 minutes by February 2026 it was reduced to 25 minutes.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Patients understood their rights around consent to the care and treatment they were offered. Patients received information about care and treatment in a way they understood and had the appropriate support and time to make decisions. Staff had access to the trust consent policy and understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (1983), Mental Capacity Act (2005) (MCA), Deprivation of Liberty Safeguards, and the Children Acts (1989 and 2004). Staff knew who to contact for advice.

Staff had access to the mental health team to support them and patients. We were told the team were responsive and supportive. There were no mental health staff employed within the department. Staff said that the mental health team tried to see patients within an hour but this did not always occur if they were busy. However, staff within the department knew how to gain consent for treatment and work with patients who were detained under a section 2 or 3 of the Mental Health Act.

We observed staff gain consent from patients for their care and treatment in line with legislation and best practice guidance. Staff received training on the application of the Mental Capacity Act for staff who would need to assess patients to give consent. Staff received training on the Mental Capacity Act and understood how to apply this. Training compliance for level 1 training was 92% and level 3 training at 86%. Patients were assessed by doctors or senior leaders. Mental health partners assisted staff with compliance with the respective acts to protect patients such as the deprivation of liberty safeguards. We did not see any patients with a mental health issue in the department.

When patients did not have capacity to consent, staff made decisions in their best interests and documented them. Staff had access to translation services should they require these to ensure they gained a valid consent.

Caring

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as

partners in their care.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service always treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

Staff treated people with kindness and compassion. Patients told us they felt reassured by the staff and were confident in their care. Friends and family survey results from December 2025 to February 2026 indicated 82% of patients were satisfied with their care and treatment. The survey had had 4568 responses during these 3 months. The most frequently used words to describe care were kind, caring, reassuring and understanding.

Staff at all levels sought to accommodate patients' needs and demonstrated a caring attitude to people with mental health needs. The electronic and paper patient records system allowed for transparency in patient needs and cultural preferences. There were facilities and support available for patients with dementia, complex needs and those who were neurodiverse.

Staff were able to access appropriate interpretation services to communicate with patients. However, staff told us that due to the diversity of the team, the staff adjusted the allocations so that a staff member who spoke the patient's language could treat the patient. There were two private family rooms where staff could take families and carers, when delivering bad news.

Staff worked to protect patient's dignity. We observed staff escorting patients to the toilet. Where two patients were sharing a bay originally designed for one the service used curtains or screens to screen patients and protect their dignity. Whilst this helped it did not prevent sounds and conversations being heard by the next patient.

There was a culture of collaboration and respect between internal and external colleagues. We observed staff interacting positively with ambulance staff during a handover, handling an

urgent transition with patience. This positive culture allowed staff to provide compassionate care for patients.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or distress.

The department had processes and tools for assessing patients when they first presented to the department. Staff used a national triage tool to triage patients. Most patients were streamed (assessed) by the nurse at reception or in triage and sent to the appropriate services including Urgent Care Centre (UCC), Clinical Decisions Unit (CDU), and Same Day Emergency Care (SDEC). Patients who required the services of the emergency department were triaged and possibly treated by the triage team. The triage team further assessed the patients' needs and ordered tests to assist the clinical staff to treat the patient.

The service had a clear system to identify people with mental health needs and align them to the appropriate pathway. During triage, nurses completed the mental health risk assessment and informed the mental health team on site. Psychiatric liaison members of staff then completed assessments. Mental health passports were in use in the department for patients who were known to services. This passport detailed medication, triggers and care plans. This ensured that all clinical staff were able to continue care of existing patients. Passports were also utilised for patients with autism or learning disabilities. Staff used the experience of carers and relatives to inform care plans to ensure that the distress to patients was minimal.

The children's ED had access to the Children's Adolescence Mental Health service team (CAMHs) for an assessment and treatment of children and young people. The children's ED had a room in which children and young people could stay whilst they awaited further treatment or discharge.

There were mechanisms to address patient's comfort needs. A member of staff or a volunteer conducted comfort rounding to ensure that every patient was offered food and drink throughout their stay which met their needs. Staff told us nutritional needs including cultural and religious needs were identified during the comfort rounding. Staff told us patients were offered sandwiches throughout the day. This nurse also undertook observations of patients for staff.

Staff responded to patient's needs in the moment and acted to minimise any discomfort, concern or distress. We observed a nurse re-assess a patient's pain after discussing the care plan and provided pain relief in line with the patient's pain score. The Urgent and Emergency Care Survey 2024 reflected our observations as it stated that patients rated this issue as 6.3 out of 10. The response to 'Do you think the hospital staff helped you to control your pain?' was about the same as the national average. The service sent us audits which demonstrated that pain relief was generally given in a timely manner.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

There was an inclusive organisational culture which enabled staff to have a sense of belonging. Leaders told us staff wellbeing was important to them. They recognised that staff were often under pressure within a very busy department. Leaders encouraged staff to reflect on their working life but also supported staff to have a good work life balance. Several staff members told us they had worked at the hospital for several years due to the work culture. Several staff members referred to the staff as "one team."' Staff said irrespective of grade staff supported one another when the department was very busy.

There were mechanisms to collect staff feedback and reflect on staff concerns to deliver high quality person-centred care. Staff told us they felt listened to by leaders and were able to

escalate concerns directly to them. The leadership team encourage the staff to become involved in initiatives and offer the team a safe space to fail without fear of blame.

The service supported staff onboarding and continued professional development. Several staff told us about how they had had issues in their personal life which had impacted on their working life. The senior leaders had supported them to adapt and change during this time. One member of staff had moved from a clinical role to a non-clinical role, another had delayed their training for a defined amount of time. Newly qualified nurses received around 18 months of preceptorship and were offered the option to extend this period until they felt comfortable in their role. Training days were organised multiple times a year and focused relevant areas. For example, all staff are invited to governance meetings to discuss where things had not gone well and to learn from this. These were well attended by all grades of staff. Staff told us they were provided cover to attend training. A mentorship programme was in place for staff to continuously identify and develop skills.

Leaders had taken steps to recognise and meet the wellbeing needs of staff, which included the necessary resources and facilities for safe working, such as regular breaks and rest areas. There was adequate staffing coverage during shifts to allow breaks. Staff told us the nurse in charge arranged or provided cover if needed so that nursing staff could take their breaks.

The service valued the wellbeing of staff. The trust had a large wellbeing offering encompassing a variety of groups that staff could obtain support from. Senior leaders in the ED made it a priority to regularly visit each area of the department to ensure that staff felt supported and were able to raise any issues in a timely manner.

Leaders supported staff wellbeing through recognition of cultural diversity. A team building and awareness session had been held which encouraged staff to consider different perspectives and included activities such as receiving Henna tattoos, sampling world foods and listening to the experiences of nursing staff from abroad and how their training varied from British nursing models. Staff told us they were valued by leaders. There were support mechanisms in place to support staff in the event of catastrophic events including a “hot” debrief in the immediate aftermath. Staff told us violence and aggression incidents were increasing. Training supported them to manage these situations.

The trust had a staff excellence awards which were presented to those nominated by their colleagues in the department. The consultants and doctors of the ED won the doctors and

consultant award, and the ED won the award for exceptional contributions to sustainability. Alongside this there was an employee of the month award, as well as Daisy and Tulip awards for clinical and non-clinical staff. These were all nominated by team members. Staff felt that these initiatives demonstrated that their work was valued.

Responsive

Rating Good

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we rated this key question good. At this assessment the rating has remained good. This means we looked for evidence that the service met people's needs.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

Most patients we spoke with told us that they felt they were at the centre of their care and treatment. Patients felt involved in planning and making shared decisions about their care and treatment. In the UEC Survey 2024, in relation to the question, 'were you involved as much as you wanted to be in the decisions about your care and treatment', the hospital scored about the same as the national average.

Patients and their relatives told us staff could not do enough for them. Even when they were

visibly busy, people told us staff took time to talk to people and understand what patients needed.

Staff told us they took in to account patient's individual needs and preferences. They told us they undertook risk assessments to identify specific needs such as nutrition, hydration, mobility, falls risk and frailty score. Staff made reasonable adjustments to help patients access services. The department had access to interpretation services including British Sign Language to support patients, loved ones and carers with face-to-face interpreting and translation needs. There was a multi-faith room on-site for staff and patients with a chaplain team available to visit bedside upon request.

Staff were sensitive to the dietary needs of patients. Staff requested food preferences from patients, Halal options were available. The emergency department (ED) was only able to supply cold food unless a senior member of staff requested a hot meal for patients who had been in the department for some time.

We saw positive interactions between staff and patients. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The trust used registered mental health nurses to add to its staffing to ensure that patients requiring this support had access to person centred care. A senior nurse took the lead on the quality improvement programme for patients with a mental health need. A checklist and observation tool had been designed to ensure that only those patients who required one to one care for safety reasons received it. This protected the privacy and dignity of patients.

The environment of the Children's ED was child-friendly including colourful walls and curtains. There was a sensory play area for younger children. A variety of toys were around to enable children to be kept occupied whilst waiting. Staff could request support from play specialists from the Children's ward if required. Staff used distraction techniques to minimise stress and anxiety in children which included the use of electronic devices, audiobooks, playing with a toy and blowing bubbles.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always supply appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

The service did not provide real time waiting information for patients arriving in the ED. There was no electronic board to tell patients how long it would be before they saw a doctor. Despite this, patients were triaged in a timely manner and clinical staff informed them of what would happen next. The UEC survey in 2024 showed that patients did not always feel that they were kept informed of waiting times at 2 patients out of 10 which was somewhat worse than other trusts. We spoke to patients and those that cared for them and they told us that they were not always sure about what was happening next.

Patients could access information and advice that was accurate, up-to-date and provided in a way that they could understand, and which met their communication needs. The service made reasonable adjustments and supported patients with accessible information. For example, staff told us they were able to provide information in multiple languages for adult patients.

Patients could use the hospitals website to gain information on many conditions. The website had an accessibility bar which allowed patients to make the font size larger and a button to change the contrast to make font appear sharper against the background in accordance with the Accessible Information Standard. However, there were no translation facilities on the website and information leaflets, although plentiful were only in English.

Computers were widely available throughout the department which meant that staff did not have to wait to access them. However, we observed several unlocked and unattended computers displaying confidential patient information on the inspection. White boards displayed where patients were within the department and had some information about the patients. These were for staff and displayed in staff only areas within staff only areas such as the major's area. Staff received General Data Protection Regulation training (GDPR). Compliance with this training was 86% as of March 2026. Some patient records were held on a

secure electronic patient record system which was accessed by individual staff log in. However, paper records were also used and were stored in majors in an area by the central clinical station. Patients could not generally access this area.

Staff we spoke to explained they asked patients if they had any information or communication needs, this would be highlighted on paper and electronic record systems to alert staff. Staff told us they shared information about patient's information and communication needs with other providers of NHS and adult social care, when patients had given consent or permission for them to do so. Several system partners such as 111 service used the same electronic patient record system so information could be shared easily.

Staff told us learning disabilities and autism passports were not frequently seen, however they were a helpful method of communication. The passport was often provided by the family of the patient. Information was copied and used to provide care. If staff required support, advice was always available from the Learning Disabilities Team.

Listening to and involving people

Score

3. Evidence shows a good standard of care

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. They involved people in decisions about their care and told them what had changed as a result.

There was clear signage in the waiting room for patients to raise a complaint. Staff were aware of the complaints process and provided examples of learning from patient complaints. For instance, there was patient feedback regarding the care of trauma patients and what to expect. A generic leaflet that gave patients and loved one's information to help them when someone was brought in urgently suffering with a traumatic injury' was available

The service sought feedback on the care and treatment of patients through the patient experience team. This team received compliments and complaints from patients and those

that cared for them and shared them with the emergency team through an IT system. This then fed into the department's dashboard. Complaints were sent to the divisional triumvirate (three managers of the wider division) for investigation. The senior leadership team led on investigating the complaint and compiling a response. Where there was a cross-service complaint the patient experience team coordinated the responses from the individual services. There were weekly meetings about the complaints and where in the timeline the responses were at. Action plans are developed and monitored by the senior leadership team.

Patient stories are shared with the staff of the ED to highlight learning from them. The patient engagement team facilitated a patient engagement committee which meets quarterly. Investigations are undertaken and action plans drawn up which are shared at these meetings. Every department is represented and shared information on the patient experience to help learning. A biannual report is produced. In the report for April to September 2025 the ED received the highest number of complaints across the trust (25). The ED has a newsletter sent to all staff which highlights themes, trends and actions to be taken in respect of action plans devised.

There were 9 complaints about the care in ED in January 2026. Only 40% of complaints were responded to in the given timeframe. The department had 77% of actions outstanding in the February report from the patient experience team. Themes of complaints centred around delays in treatment and care, communications and staff attitudes. This information has been reviewed alongside other factors which could contribute to a rise in complaints. The national friends and family test results for January were 92% positive. This was driven from a response by 8000 patients. There were service improvement meetings in place to ensure that staff and leaders were aware of the issues.

Patients we spoke to felt confident to raise a complaint should they need to. Most patients were complimentary for the care and attention that they had been provided with. Patients accepted that services were under strain and that waiting was inevitable. Patients and those close to them felt involved in the decisions made whilst in the ED.

Equity in access

Score

3. Evidence shows a good standard of care

The service made sure that people could access the care, support and treatment they needed when they needed it.

Staff worked hard to provide equity in access to care and treatment. This included making reasonable adjustments for people with disabilities, those with communication difficulties or cognitive impairment. Patients were listened to when they wanted to share their experience. For example, one patient told us that staff in the ED were the first people to listen to them and arranged appropriate follow up with a specialist team.

The department was open 24 hours a day all year round. Adults and children were cared for including those seeking treatment for mental ill health. The service worked with other healthcare professionals to provide a timely service for different healthcare needs and serious conditions needing specialist input. The service had policies and procedures for escalation and care of patients in non-designated areas (temporary escalation areas), to reduce the main risks from crowding. One of these areas was the main major's area which had standard bays around 3 edges of a square. The escalation was to place 2 patients in a bay and the to put patients into the centre of the square. This made the area very congested and reduced patients' privacy. The hospital had processes to monitor performance and quality against national targets and standards.

People had timely access to test results and diagnosis. We saw that electrocardiography's (ECGs) were performed by triage staff and reviewed in a timely way by doctors where an issue was highlighted. ECGs are a test to record the electrical signals in the heart.

There were monthly emergency medicine clinical governance meetings. These meetings enabled service leaders and other key personnel to understand, monitor and assess the quality and performance. This meant appropriate action could be taken when performance against set targets deteriorated.

Urgent and emergency services

In February 2026 62% of type 1 patients waited four hours or less to be seen treated in the ED. Type 1 patients are those who are most seriously ill. The numbers of patients waiting less than four hours was 72% this was slightly below the England average of 74%. However, very few patients waited longer than 12 hours in the department (365) in February 2026.

Patient surveys indicated patients would like to see improvement to how quickly they could access the ED. In the 2024 National Urgent & Emergency Care survey the trust ranked about the same as other trusts overall. The patient experience was best for questions around the information given by the clinical staff, their overall experience and feeling safe within the department. Areas which required some further work included information on further health or social care support at home and waiting times.

The most recent data provided by the trust showed in February 2026, 100% of patients with urgent mental health needs were seen in parallel by an appropriate mental health clinician and ED clinician. However, the average time to see a doctor for these patients was 122 minutes. There were action plans in place to reduce this waiting time.

The hospital had processes to monitor inter-specialty reviews and referrals to identify delays in patients being reviewed following referral to specialisms such as medicine and surgery. Staff reported good working arrangements between specialities.

There was signage at the ED front door that stated patients would be treated according to the severity of their condition. The triage team numbers could be increased in line with activity throughout the day. This meant that patients awaiting further assessment or testing were seen as soon as possible.

Well-led

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good. This means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Shared direction and culture

Score

3. Evidence shows a good standard of care

The service had a shared vision and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

There was a good safety culture where managers investigated incidents and learning was embedded to promote good practice. Staff said raising concerns was encouraged and valued. Staff felt listened to. Staff told us that sharing the learning occurred in many ways including emails, at safety huddles or handovers and via a secure messaging app. We saw examples of learning being shared through most of these channels.

Staff and leaders demonstrated a positive and compassionate culture with a focus on learning and improvement. The trust values were named CARE. This included **C** - Communicating and Working together, **A** - Aspiring and Improving, **R** - Respectful, Inclusive and Caring **E** - Efficient and Safe. These were displayed around the trust and department. We saw staff in ED lived these values. We heard staff describe the culture as “all one team” and “all are our patients”. We saw numerous examples of this whilst on site.

Leaders had a shared purpose and strived to deliver and motivated staff to succeed. There were high levels of satisfaction across all staff, despite the challenges they faced. Staff told us that they would bring a family member to be treated in the department.

Staff were helpful, welcoming and professional in their communication with each other, patients and their relatives. Leaders described a positive and compassionate culture. Staff and leaders embodied a positive, compassionate, listening culture. We saw that this culture promoted trust and understanding between staff, leaders and people using the service.

The leadership were focused on resolving the issues with an overcrowded ED and had had several organisations review the practices within the department to assist them to learn and improve. The team had yet to develop their vision and strategy for the department in a formal

sense. The senior team had aligned work programmes to develop a strategic approach. These fell into performance improvement, staff wellbeing, supervision and development, and implementing a quality improvement programme. The senior team and the wider ED staff understood the challenges of their population and were fully aligned, working with partners in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. For example, working with system partners on alternative pathways to avoid ED attendances.

The trust had access to community hospitals which allowed them to increase the flow through the hospital. Services in the community had been developed to support people in their own homes including working with care homes and the ambulance services.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.

The service had inclusive leaders at all levels who understood the context in which they delivered care. Leaders were aware of the issues that the department faced and used national programmes to assist them to resolve or manage these issues. We found that staff and leaders were aligned on the issues that the department faced.

There were processes to support staff and promote their positive wellbeing. Staff we spoke to felt proud to work in the service. Multiple staff told us they felt well supported by their line managers. Line managers made a point of speaking to each area of ED at least 2 or 3 times per shift and to check in on staff wellbeing. Data provided by the trust showed that the staff turnover rate was below 10% for the previous rolling 12 months. Medical staff turnover was just over 7% and nursing turnover was 3.6%. This was a positive indicator of staff satisfaction.

Urgent and emergency services

Following the staff survey in 2024 leaders commissioned a “you said we listened” to provide feedback to staff. This highlighted the areas for focus for the coming year. These included recognition of staff, opportunities for flexible working, relief from burnout and stress, and having resources to undertake their roles. As highlighted above the service nominated several individuals and groups for the staff awarded and the urgent and emergency care department won 4 awards.

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure that the leadership represented the diversity of the workforce. This was across the whole workforce. Staff spoke about being confident to approach any member of the ED team to obtain both professional and wellbeing support.

There were clear reporting structures and key roles were supported by deputies or associate roles to support succession planning. Staff understood their immediate reporting structures and leaders understood their key roles and responsibilities. Staff told us the departmental leads and senior managers were approachable, visible and provided them with good support.

Leaders demonstrated how they worked as part of a multidisciplinary team within the service and how they worked with external stakeholders, such as the local and regional commissioners, integrated care boards and local NHS ambulance and mental health trusts. They said they worked well together and there was regular engagement to review performance and identify improvements to services.

All staff had opportunities to develop including for future leadership roles. There was inclusive recruitment and succession planning for the future. The trust had effective recruitment processes and ongoing checks to ensure all staff met the legal requirements to work in the trust.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The service fostered a positive culture where people felt they could speak up and their voice would be heard.

Staff and leaders actively promoted staff empowerment to drive improvement. The culture supported staff to speak up without fear of detriment. Leaders encouraged staff to raise concerns and promoted the value of doing so. Staff told us that they felt comfortable to raise any concerns and were confident that their voices would be heard and demonstrable action taken.

The service had established Freedom to Speak up arrangements. Information about the guardian and how to contact them was available the intranet. Whilst not all staff knew the name of the trust's Freedom to Speak Up Guardian, they knew how to raise a concern. However, they didn't feel that they would use this route as internally within the department they felt that they could raise anything with leaders. Staff could give examples of issues raised and action taken.

When something went wrong, patients received a sincere and timely apology and were told about any actions being taken to prevent the same happening again. Staff were aware of their responsibilities under the duty of candour regulations.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

The service had clear responsibilities, roles, systems of accountability and good governance. They used these to manage and deliver good quality, sustainable care, treatment and support.

They act on the best information about risk, performance and outcomes, and share this securely with others when appropriate.

Governance arrangements were reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes. Governance was used to learn, improve and innovate.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities. Audits were undertaken and action plans devised to drive improvement and compliance with national guidance. The service complied with the 3 audits commissioned each year by the Royal College of Emergency Medicine, which included the administration of time-critical medicines.

The service had policies and procedures for escalation and care of patients to mitigate the main risks from crowding. The hospital had processes to monitor performance and quality against national targets and standards.

Data systems enabled a good oversight of performance as evident in meeting minutes and in our discussions with staff. The service had developed a 'Non-Elective Self-Service' Dashboard, which not only looked at performance but at the qualitive factors such as patient feedback. This was helpful in identifying themes and trends to drive improvement. Leaders tracked the risks in the ED effectively using the risk register and had oversight of the risks and their mitigations through governance meetings.

Managers attended monthly emergency medicine clinical governance meetings. These discussed and addressed key areas of performance, risk, audit, culture and workforce. Minutes showed areas of concern were identified and actions were taken to learn and improve. Changes had been made when needed to improve the service. This included the extended opening of the paediatric department in December 2025. Good practice was recognised and celebrated.

Information held about patients was held in paper and electronic copy. We saw that staff did not always remove their access cards and anyone could use the computer to access patient records. Staff were reminded when we raised this in the department. Paper records were stored in slots, alphabetically, behind the nurse or doctor station. Staff were aware of the issue of leaving ID cards in computer terminals and removed them promptly when they returned to the

terminal. Staff were part of the emergency preparedness network, and they had the strategies and guidance to respond to major incidents.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. They share information and learning with partners and collaborate for improvement.

Staff told us they felt listened to and heard by the relevant stakeholders and external partners. They were supported by clinical partners. For example, there was a partnership with the local NHS mental health trust providing support to patients with mental ill health in the ED. ED staff said they were responsive and supportive.

The trust worked in partnership with the local system. This included the local community trust, the local ambulance trust, GP's and the Integrated Care Board (ICB). They met to discuss system initiatives to ensure processes and schemes were joined up as well as to discuss responses to issues raised. There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the people. The ambulance service corroborated this when we spoke with them about the relationship and effective working with the emergency department. Staff reported positive relationships with the local police force, mental health providers and the ambulance service.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement across the organisation and local system. Managers encouraged creative ways of delivering equality of experience, outcome and quality of life for people. However, response to patient complaints was slow.

There was a systematic approach to improvement, which made consistent use of a recognised quality improvement (QI) methodology. The trust used a quality improvement methodology. All leaders were involved in improvement projects, and some had been celebrated at national conferences.

Leaders encouraged staff to speak up with ideas for improvement and innovation and actively invested time to listen and engage. Staff were supported to prioritise time to develop their skills around improvement and innovation. Staff told us they were able to influence change and contribute to decision-making in the department. Leaders empowered frontline staff to drive initiatives to improve quality and safety. For instance, in response to an increase in patients with a type 2 respiratory disease, band 6 nursing staff had received training to take arterial blood gas samples to ensure timely assessment and treatment. Similarly, nursing staff had designed the mental health observation and screening tool because of noticing the increasing use of 121 nursing care. This checklist assisted staff to assess patients and had reduced the number of patients requiring 121 care.

Another leader was implementing nursing staff obtaining arterial blood samples in patients within the resuscitation area. All improvement projects followed a Plan, Do Study and Act (PDSA) cycle. Using PDSA cycles enables organisations to test out changes on a small scale, building on the learning from these test cycles in a structured way before implementation.

Medical staff had undertaken improvement projects with their junior staff encouraging the frailty lead to provide a learning workshop for staff. They had also undertaken workshops on point of care delivery of ultrasound for patients to ensure timely diagnosis. Work with the ambulance trust on conveyancing had resulted in 70% of calls to the service not requiring conveyancing.

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 2026	**Date:**	6 August 2026
Prepared By:	Domain leads and Mark Bolton, Associate Director of Operational Performance		
Approved By:	Domains approved by lead Executive		
Presented By:	Domains to be presented by lead Executive		

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

Recommendation

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Domain reports have been considered by the appropriate Trust Board sub-committee.
The full report was approved by Trust Management Team on 29 July 2026.

Acronyms

All acronyms are defined within the paper.

Executive Summary

The Integrated Performance Report (IPR) provides the Board with assurance regarding the performance of the Trust under the following domains: Quality of Care, People and Culture, Timely Care and Best Value Care. Key activity metrics are provided as context to support all domains. The metrics and scorecard have been refreshed following the outputs of the IPR annual review which was approved at the last Board of Director's meeting in public.

This report covers performance to Jun-26. The integrated scorecard presents the last two months data for each metric (where available) together with making data count icons that provide summary messages from the statistical process control charts. The blue and amber icons draw attention to indicators where the performance data is showing areas that are statistically relevant. The integrated scorecard is included at the start of the report and in appendix A. Appendix A also includes graphs for each indicator that identify trends over a multi-year period and the plan or standard for the rest of 2026/27. Appendix B contains relevant benchmarking data to show our performance relative to other Trusts in England.

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

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

The challenges faced post-deployment of our new patient administration system in our Emergency Department (ED) in mid-Apr-26 (Nervecentre) have adversely impacted several headline metrics. The impact was far greater and more prolonged than we anticipated. Alongside a period of adjustment to the new system, we have observed demand and capacity pressures with the average daily ED attends to our King's Mill Hospital type one service and our Newark Urgent Treatment Centre being at an all-time high in Jun-26.

Briefly considering each performance domain over the past two months:

- **Quality of Care** saw four off-track metrics in May-26 and Jun-26, including elevated number of gram-negative bloodstream infections May-26, a Hospital-Acquired Pressure Ulcer (cat3/4) and upgradable pressure ulcers with lapse in care in May-26, increasing number of complaints per 1,000 occupied beds days in Jun-26, and higher still birth per 1,000 live birth than standard in Jun-26. Positive outcomes included zero MRSA bacteraemia, reduced rate of c-difficile and zero never events.
- **People and Culture** had a mixture of on and off-track metrics in the latest period. Strong performance verses our plan was seen in our time to hire, turnover, mandatory and statutory training, and medical job plan compliance metrics. Challenging performance areas in this domain include vacancy rate, appraisals, sickness absence and bank and agency use.
- Within the **Timely Care** domain, May-26 and Jun-26 were challenging for our Urgent and Emergency Care (UEC) pathway following a strong end to 2025/26. This is reflected in the fact that all our IPR-reported UEC performance metrics were averse to plan. From a planned care perspective, areas of strength include 18-week, cancer 28-day and cancer 31-day metrics. Challenged areas with recovery actions in place include 52-week waits, diagnostic DM01 and cancer 62-day performance. We have remedial action plans in place which have been shared with NHS England and our Integrated Care Board across 4-hour, 12-hour, DM01 and cancer 62-day performance metrics.
- Financially, from a **Best Value Care** perspective, the Trust has reported an in-month deficit of £4.3m in Jun-26 with a year-to-date deficit of £8m; this is £4.3m adverse to plan. The year-to-date position is driven by several factors including Industrial Action in Apr-26, under-delivery of our Financial Improvement Programme and bank and agency expenditure being higher than our plan. We are forecasting a breakeven year-end position in line with our plan.

There were eight metrics triggering special cause variation in the last two months of reporting. There were five metrics triggering due to challenges/deteriorations and three because of improvements:

- The number of **gram-negative bloodstream infections** reported in May-26 was at the highest level in recent years at 10 and above the upper control limit.
- **Complaints** per 1,000 occupied bed days increased to 2.2 in Jun-26, the highest level in recent years and above the upper control limit.
- **Vacancy rate** has triggered a step change (increase) in the control limits due to deterioration in recent months with the last seven months data being above the previous mean. The latest reported position is 9.4% which remains higher than our 9% standard.
- **Mandatory and Statutory training** continued to trend below the lower control limit in May-26 and Jun-26. This metric has triggered as special cause variation due to low performance four times in 2026 to date. However, performance remains favourable to the standard of 90% at 92.5% in Jun-26
- **52-week wait** performance triggered as special cause variation in Jun-26. Performance deteriorated to sit above the upper control limit and has not achieved plan (as a percentage of our waiting list) for the last two reported months.

- The number of **inpatients medically safe for transfer** for greater than 24 hours reduced below the lower control limit in May-26 to trigger as special cause variation at an average of 57 patients. However, in Jun-26 the number of delayed discharges increased to return within control limits and at the highest level since Jan-26 at 82 patients on average (an increase equivalent to an inpatient ward).
- **18-week RTT** performance triggered as special cause variation due to continued strong performance in May-26 and Jun-26. Performance has been above the upper control limit for the last four months and has been better than our plan.
- **Day case activity levels** triggered as special cause variation in Jun-26 due to levels being higher than the upper control limit. Day case activity levels have also consistently been above plan.

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

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

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Integrated Performance Report

Reporting Period: To June 2026

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Integrated Scorecard (1/2)

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

The scorecard presents the last two months data for each metric (where available) together with making data count icons that provide summary messages from the statistical process control charts. The blue and amber icons draw attention to indicators where the performance data is showing areas that are statistically relevant. Where the metric is being assessed against plan; details of the plan for the forthcoming year are included in the graphs in the appendix. The graphs present monthly data typically from Apr-22. Where appropriate, the graphs are Statistical Process Control (SPC) charts.

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

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

Domain	At a Glance	Indicator	May-26	Jun-26	Standard (June 26)	Benchmark	STAR Data Quality
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	2.5	2.4	No standard		
		Never events reported in month	0	0	0		
		Hospital-onset MRSA reported in month	0	0	0		
		Rate of c-difficile	0.1	0.2	≤0.3		
		Rate of e-coli	0.3	0.1	≤0.3		
		Number of gram-negative bloodstream infections reported in month	10	7	≤8		
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0.3	0.1	No standard		
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	1	0	0		
		New category 3 or 4 pressure ulcers per 1000 occupied bed days	0.0%	0.0%	0		
		Patient Safety Incident Investigations (PSII) and Duty of Candour	11	4	No standard		
		Percentage of inpatient Service Users undergoing risk assessment for VTE	TBC	TBC	≥95%		
		Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)	38	54	TBC		
	Caring	Complaints per 1000 occupied bed days	1.7	2.2	≤1.9		
		Compliments received in month	109	134	No standard		
	Effective	SHMI	104	107	As expected		
		Still births per 1000 live births	3.3	6.7	≤4.4		
		Early neonatal deaths per 1000 live births	0.0	0.0	≤1		
		30 day readmission rate band	TBC	TBC	TBC		
		14 day readmission rate	9.30%	9.40%	TBC		
People and Culture	Belonging in the NHS	NHS staff survey engagement theme score	-	-	≥6.74	66 / 121	
		National Education and Training Survey satisfaction rate	TBC	TBC	TBC		
		NHS staff standards score	TBC	TBC	TBC		
	Growing the Future	Vacancy rate	10.4%	9.4%	≤9.0%		
		Time to hire	31	33	≤40		
		Turnover in month	0.4%	0.4%	≤0.9%	55 / 118	
		Appraisals	87.3%	87.3%	≥90%		
		Mandatory & statutory training	92.4%	92.3%	≥90%		
		Medical job plan compliance (Consultants)	98.9%	99.6%	≥95%		
		Medical job plan compliance (SAS Doctors)	99.2%	99.2%	≥95%		
	Looking after our People	Sickness absence	4.5%	5.0%	≤4.2%	52 / 118	
		Flu vaccinations uptake (front line staff)	-	-	≥56.9%		
		Employee relations management	21	22	<24		
	New Ways of Working	Bank usage	5.9%	6.0%	≤5.3%	119 / 195	
		Agency usage	2.5%	2.6%	<1.5%	158 / 193	
		Agency (off framework)	0.0%	0.0%	0%		
		Agency (over price cap)	34.3%	38.1%	≤40.0%		

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Summary Icon Key

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

Benchmark Key

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

STAR Data Quality Key

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

- Substantial assurance
- Limited assurance
- No assurance

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Integrated Scorecard (2/2)

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

Domain	At a Glance	Indicator	May-26	Jun-26	Standard (June 26)	Benchmark	STAR Data Quality
Timely Care	Urgent Care	Average ambulance handover time (mins)	26	27	≤20	4 / 15	
		Percentage of ambulance handovers within 15 minutes	23.8%	22.0%	≥66.0%	125 / 174	
		Percentage of ambulance handovers within 45 minutes	86.6%	85.9%	100%	5 / 15	
		ED 4-hour performance	64.1%	63.5%	≥79.0%	124 / 140	
		ED 12-hour length of stay performance	7.0%	8.1%	≤2.1%	83 / 177	
		ED 24-hour length of stay performance	0.5%	0.7%	0%		
		Number of ED patients cared for in corridors for over 45 minutes	TBC	TBC	0%		
		Adult G&A bed occupancy	95.9%	97.0%	≤96.2%	80 /177	
		Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base	57	82	≤40		
		Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base	1757	2454	≤1200		
	Electives	Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment	64.7%	64.8%	≥64.7%	88 / 148	
		Percentage of RTT waits over 52 weeks for incomplete pathways	1.1%	1.2%	≤1.0%	77 / 148	
	Diagnostics	Diagnostic DM01 performance under 6-weeks	87.5%	88.8%	≥91.6%	45 / 135	
	Cancer	Cancer 28-day faster diagnosis standard	81.6%	-	≥80.4%	49 / 127	
		Cancer 31-day treatment performance	99.2%	-	≥90.8%	26 / 134	
		Cancer 62-day treatment performance	61.1%	-	≥74.4%	112 / 130	
Best Value Care	Financial Performance	Financial surplus / deficit	-£1.68	-£4.29	≥-0.49		
		Variance YTD to financial plan	£0.08	-£3.80	≥£0.00m		
	Efficiency	Financial efficiency variance YTD to plan	-£0.79	-£0.39	≥£0.00m		
		Risk adjusted efficiency forecast to plan (%)	53.0%	56.0%	100%		
		Relative cost difference (National Cost Collection Index)	103	103	TBC		
		Implied productivity growth (YTD compared to last year)	-	-	TBC		
	Variable Pay	Reported agency expenditure	£0.78	£0.82	≤£0.46		
		Reported bank expenditure	£1.84	£1.91	≤£1.66		
		Temporary staffing cost relative band	TBC	TBC	≤7.0%		
	Cash & Liquidity	BPPC - Number of bills paid within target (%)	25.0%	11.8%	≥95%		
		BPPC - Value of bills paid within target (%)	79.6%	78.1%	≥95%		
		Operating expenditure days	1	1	≥5		
	Capital	Capital expenditure against plan	£0.86	£0.32	≤1.53		
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	561	589	≤588		
		Non-elective admissions	137	153	≤152		
	Electives	Average daily elective referrals	302	360	No plan		
		Outpatients - first appointment	309	357	≥364		
		Outpatients - follow up	716	853	≤878		
		Outpatients - procedures	256	308	≥316		
		Day case	130	144	≥132		
		Elective inpatient	11	13	≥15		
	Diagnostics	Diagnostics	490	516	≥481		

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Summary Icon Key

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Quality of Care

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Scorecard: Quality of Care

Quality of Care

At a Glance	Indicator	May-26	Jun-26	Standard (June 26)	STAR Data Quality
Safe	Rate of inpatients to suffer a new hip fracture	2.5	2.4	No standard	STAR
	Never events reported in month	0	0	0	STAR
	Hospital-onset MRSA reported in month	0	0	0	STAR
	Rate of c-difficile	0.1	0.2	≤0.3	
	Rate of e-coli	0.3	0.1	≤0.3	
	Number of gram-negative bloodstream infections reported in month	10	7	≤8	STAR
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0.3	0.1	No standard	STAR
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	1	0	0	STAR
	New category 3 or 4 pressure ulcers per 1000 occupied bed days	0.0	0.0	0	
	Patient Safety Incident Investigations (PSII) and Duty of Candour	11	4	No standard	STAR
	Percentage of inpatient Service Users undergoing risk assessment for VTE	TBC	TBC	≥95%	
	Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)	38	54	TBC	
Caring	Complaints per 1000 occupied bed days	1.7	2.2	≤1.9	STAR
	Compliments received in month	109	134	No standard	STAR
Effective	SHMI	104	107	As expected	
	Still births per 1000 live births	3.3	6.7	≤4.4	STAR
	Early neonatal deaths per 1000 live births	0.0	0.0	≤1	STAR
	30 day readmission rate band	TBC	TBC	TBC	
	14 day readmission rate	9.3%	9.4%	TBC	

Summary Icon Key

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Domain Summary: Quality of Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Overview

Lead: Executive Chief Nurse and Chief Medical Officer

During the latest reported period of May-26 and Jun-26, the Trust continued to face challenges across the Urgent and Emergency Care (UEC) pathway. We maintained patient services and safety during days of high emergency attendances that created operational pressure and strained our ability to deliver timely and safe care. Persistent delays for admission beds and overcrowding in the Emergency Department (ED) affected patients, carers and staff. Despite these challenges, our teams performed exceptionally, enabling us to continue providing safe, high-quality care.

Within the Quality of Care domain, there were four off-track metrics during May-26 and Jun-26:

- **Number of Gram-negative bloodstream infections reported in month -** there has been an increase in the number of cases identified compared to the same period last year. The source of over 50% of cases is urinary tract infection. Benchmarking shows we are the worst performing for Pseudomonas and fourth worst performing for Klebsiella among peer acute trusts. Actions are detailed on slide 6.
- **Hospital-acquired category 3 / 4 (ungradable) pressure ulcers with lapse in care** – we reported one hospital-acquired category 3 pressure ulcer in May-26, which occurred in the ED and was investigated in early Jun-26.
- **Complaints per 1000 bed days -** The Patient Experience Team saw a continued rise in complaints in 2026/27 quarter one, alongside an increase in AI-generated contacts, which is making early informal resolution more challenging.
- **Still birth rate and early neonatal deaths per 1000 live births:** In May-26 and Jun-26, we reported seven cases through the NHS Perinatal Mortality Review Tool (PMRT): two antenatal stillbirths both pre-term and no neonatal deaths.

The Infection Prevention Control (IPC) national trajectories were released on 20 Jun-26 and will be used to calculate the standard moving forward: C. diff remains at 65; Klebsiella remains at 15; Pseudomonas remains at 9; E. coli has been reduced to 72.

Three Patient Safety Incident Investigations (PSIIs) were commissioned during May-26 and Jun-26. There were no incidents that met the threshold for reporting to Maternity and Newborn Safety Investigations (MNSI) and no Never Events.

Summary Hospital-level Mortality Indicator (SHMI) remains as expected and continues to be monitored monthly using the value as reported by NHS Digital (national database) alongside the Trust benchmarking tool; HED (Healthcare Evaluation Data).

The Trust Insights Team support wider and more granular understanding, with triangulation and further analysis of changes and trends, including outlier areas, methodology triggers and or any highlighted diagnoses with deteriorating changes. These are discussed within the Learning from Deaths group where next steps, including targeted review or other escalations, are established.

Performance relating to the percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE) has been temporarily removed from reporting whilst a validated and accurate position is established in alignment with the new national definition.

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

Indicator in Focus: Infection Prevention and Control

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

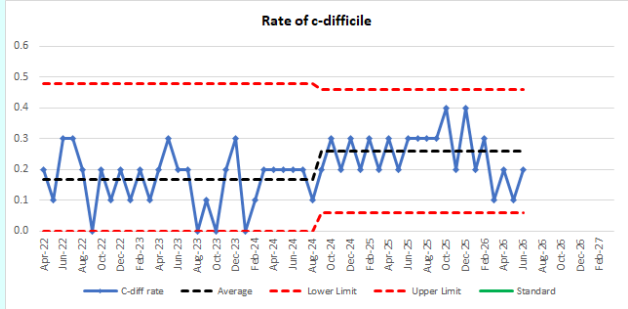
Clostridioides difficile (C. diff)
Our 2026/27 target for hospital-onset (HOHA) and community-onset hospital-associated (COHA) C. difficile is 65 cases. We ended 2026/27 quarter one on 18 cases, which is four below the position from last year. Benchmarking shows that we sit mid-group among our peer trusts. In the last three months, we recorded 12 hospital-onset (HOHA) and six community-onset (COHA) infections. Overall, we are seeing lower numbers than the same period last year.

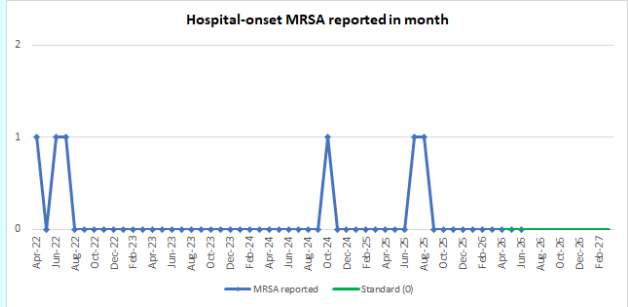
MRSA
We have not met our zero-tolerance threshold for MRSA in 2026/27. Although we recorded no hospital-onset (HOHA) MRSA cases during 2026/27 quarter one; we identified one COHA. Benchmarking shows a continued regional and national rise in MRSA, with seven peer organisations exceeding their thresholds to date.

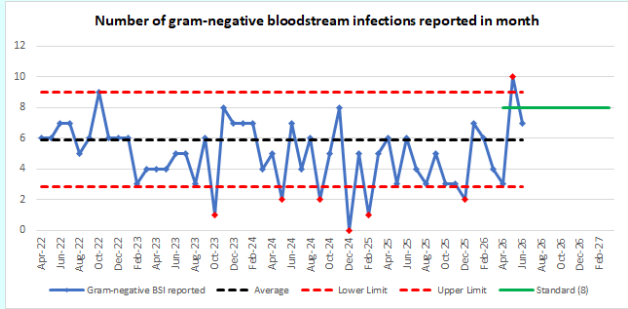
Gram-negative bacteraemia
Our thresholds for 2026/27 have been set: E. coli is 75, a reduction of 5 from last year's trajectory. Klebsiella and Pseudomonas trajectories have stayed the same at 15 and 9, respectively.
For 2026/27 quarter one, there has been an increase in the number of cases identified compared to the same period last year. The source of over 50% of cases is urinary tract infection. Benchmarking shows we are the worst performing for Pseudomonas and fourth worst performing for E. coli and Klebsiella among peer acute trusts.

Root causes	Actions and timescale	Impact
Increase in our Gram-negative infections	Raise awareness of hydration and cleansing needs for patients to reduce UTI's. Creating a UTI prevention campaign and training packages.	Improve the patient journey and reduce number of UTI blood stream infections identified.
Increase in our Gram-negative infections	Deep dive into patients with urinary tract infection to monitor correct treatment.	Improve the patient journey and reduce number of UTI blood stream infections identified.

Data







Indicator in Focus: Hospital-acquired category 3 / 4 (ungradable) pressure ulcers with lapse in care

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

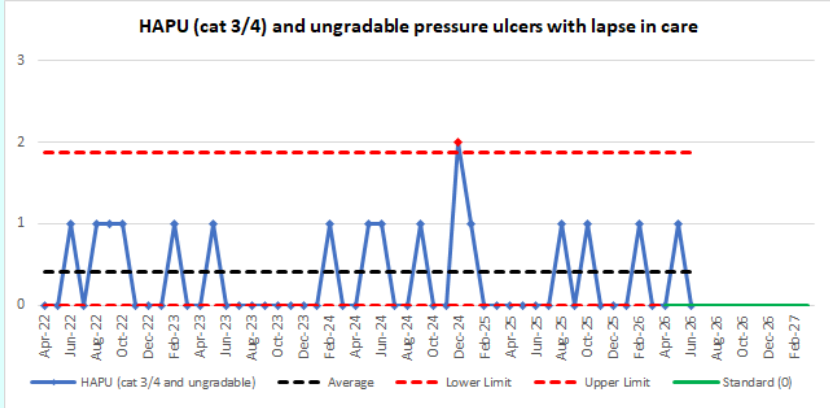
For the reported period of May-26 and Jun-26, SFH reported one hospital acquired category 3 pressure ulcer, which occurred in the ED and was investigated in early Jun-26. This incident involved a 34-year-old lady who was admitted with a five-day history of reduced sensory function to her lower limbs due to a spinal abscess. Investigations found a delay of 15 hours for a visual skin assessment from admission to the department and lack of appropriate pressure-relieving equipment given the risk of pressure ulcer development for this individual. It was also evident that the digital ED Pressure Ulcer Prevention (PUP) chart had not been completed during the period that this lady was in the department. This incident has been presented at divisional scoping and is awaiting further discussion at the panel meeting on 23 Jul-26. Although lapses in care are evident within ED, the presentation of this damage suggested that it likely began prior to arrival in ED.

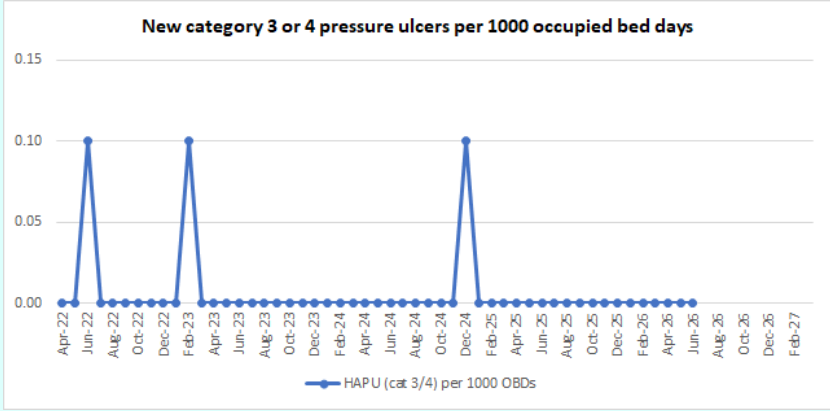
Actions from the investigation are detailed below:

Actions and timescale

- The incident was shared on the daily brief within ED dept by the ED lead nurses (completed 5 Jun-26).
- Lead nurses have reviewed the practice of all registered nurses (RNs) involved, including agency staff, and immediate actions have been taken to strengthen consistency and confidence.
- The ED induction for agency nurses is being updated to ensure Nervecentre PUP requirements are fully covered. Staff involved have completed Pressure Ulcer (PU) training with the Tissue Viability team, ensuring the required standards are now embedded.
- Approx 67 ED RNs and Healthcare Assistants (HCAs) have been booked onto planned Pressure Ulcer Prevention training sessions.
- ED Tissue Viability (TV) link nurses have undertaken local training of staff
- The Lead Tissue Viability Nurse (TVN) is working with the digital team to merge the ED Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE T) and ED PUP to improve compliance in the department. Further training will be implemented once this new tool is finalised.
- Ongoing monthly audit by ED and quarterly audit by TV to monitor compliance of digital PUP
- Decision made to avoid consecutive handovers between agency staff within ED
- ED has purchased ten dynamic trolley mattresses (Mercury Advance) which are currently awaiting MEND testing before roll out.

Data





Indicator in Focus: Patient Safety Incident Investigations (PSII)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

In line with SFH's Patient Safety Incident Response Plan, three PSII's were commissioned during May-26 and Jun-26.

- No incidents met the threshold for reporting to Maternity and Newborn Safety Investigations (MNSI) and zero Never Events were reported.
- There is one PSII with potential coronial interest. This is currently RAG rated as red and is at the Coroner's Investigation stage – a formal inquest has not yet been initiated.

PSII with potential coronial interest	MSNI investigation	Never Events
1	0	0

During May – Jun 26, there were zero PSII's signed off at Patient Safety Incident Response Group (PSIRG). As outlined above, there were three PSII's commissioned within the PSIRG meetings;

PSII 1: Aspiration pneumonia following aspiration on induction for anaesthesia:

- Aspiration of gastric content on induction – subsequently developed pneumonia.
- Deviation of the anaesthetic induction process noted.
- Communication failure.

PSII 2: Delayed escalation of deterioration:

- Patient presented to the Emergency Department following a fall, sustaining fractures.
- There were delays in the clinical review of the patient.
- There was a lack of timely escalation in response to deterioration.

PSII 3: Delayed escalation of deterioration:

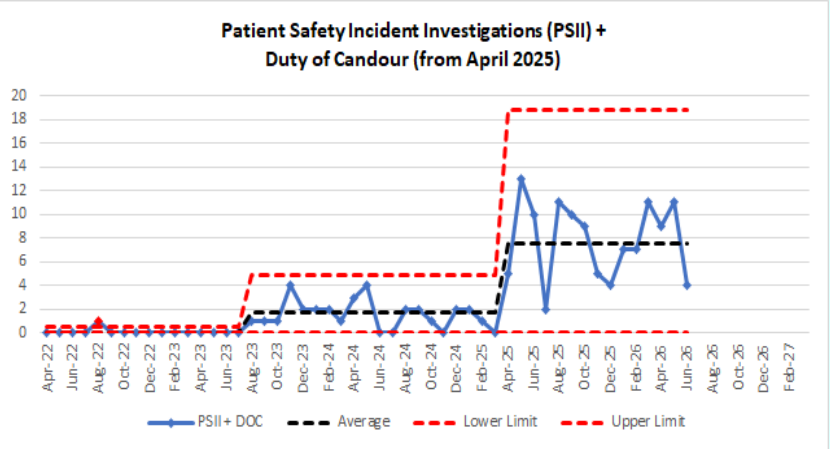
- Patient presented to the Emergency Department following a fall. Initial assessment and investigations were appropriate.
- Subsequent deterioration was not escalated, and blood tests were not acted upon.
- Overcrowding and workload were also noted as contributing factors within this incident.

An After-Action Review (AAR) was commissioned following a paediatric death, with specific consideration of overcrowding and skill mix. Although a PSII was not initiated / required for this case, the learning identified through the AAR will be shared with the author of PSII 3 to ensure alignment of themes and to strengthen organisational learning.

Addendums:

- Two addendums to MNSI investigation reports were signed off. It was confirmed that all recommendations from the MNSI review had been addressed.
- Regulation 28 actions were also agreed regarding Fitness to Drive actions.

Data



Indicator in Focus: Still Birth Rate

Sherwood Forest Hospitals NHS Foundation Trust

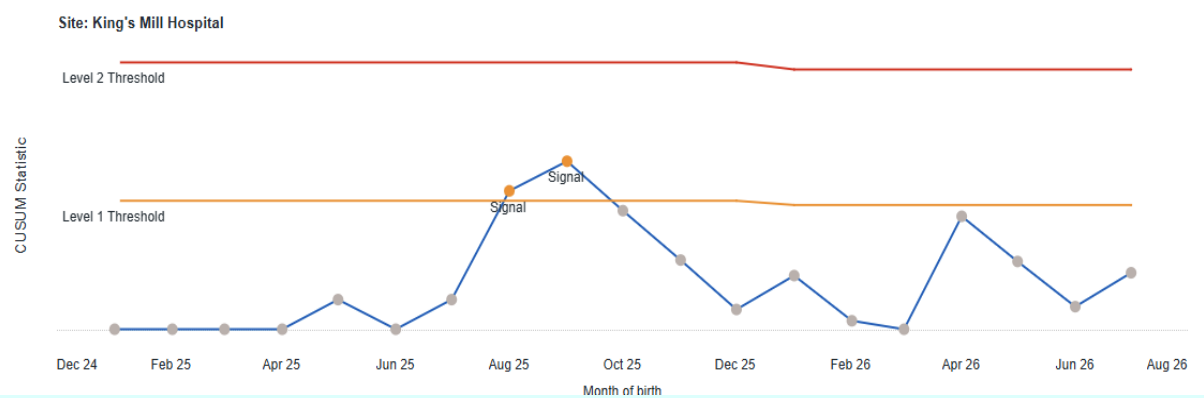
Overview and national position

In May and Jun-26, we reported seven cases through the NHS Perinatal Mortality Review Tool (PMRT): two antenatal still births that were both pre-term, and no neonatal deaths.

As part of the Maternity Outcome Signal System (MOSS), a trust-level safety signal system is now in operation. This provides a near real-time safety signal to support early detection and rapid response to potential safety issues in intrapartum care delivery.

All term stillbirth data are now reported via the Submit a Perinatal Event Notification (SPEN) portal, a centralised web-based reporting system developed by NHS England and introduced in late 2025. The extract below shows whether reporting triggers a safety concern and is supported by a comprehensive Standard Operating Procedure (SOP) to enable reporting to Trust Board.

Based on the data, the cases in both May-26 and Jun-26 did not generate a safety signal but will be reviewed through local governance processes, supported by the national tools.



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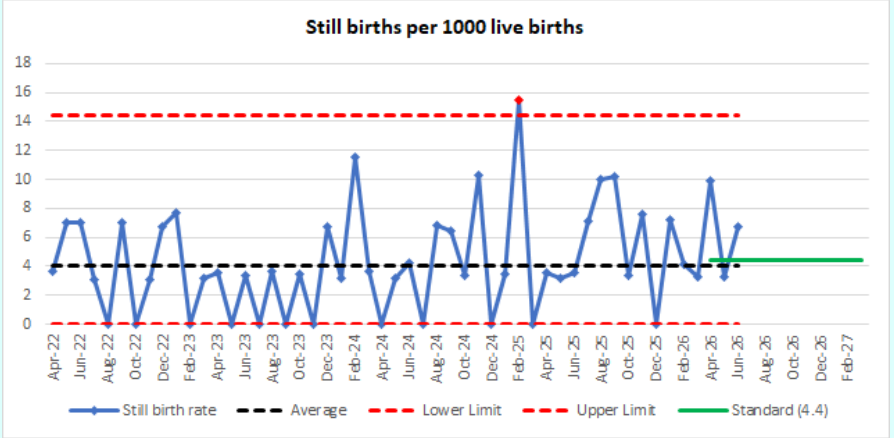
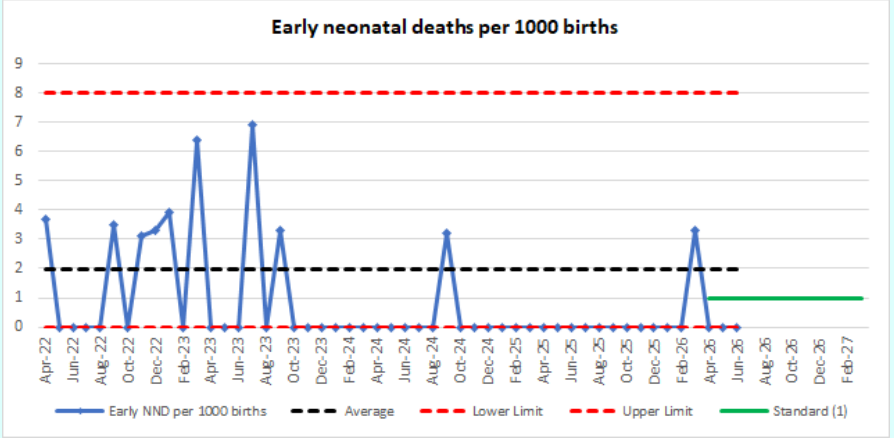




Indicator in Focus: Complaints per 1000 bed days

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Throughout 2025/26, the Trust saw a 39% increase in the number of formal complaints received compared with the previous financial year. This reflects both local pressures and a wider national trend across health services.

The Patient Experience Team continues to receive an increasing number of complaints, which are reflected in the 2026/27 quarter one figures. There has also been a noted rise in the number of contacts using AI, which can make it increasingly challenging to resolve concerns informally at an early stage.

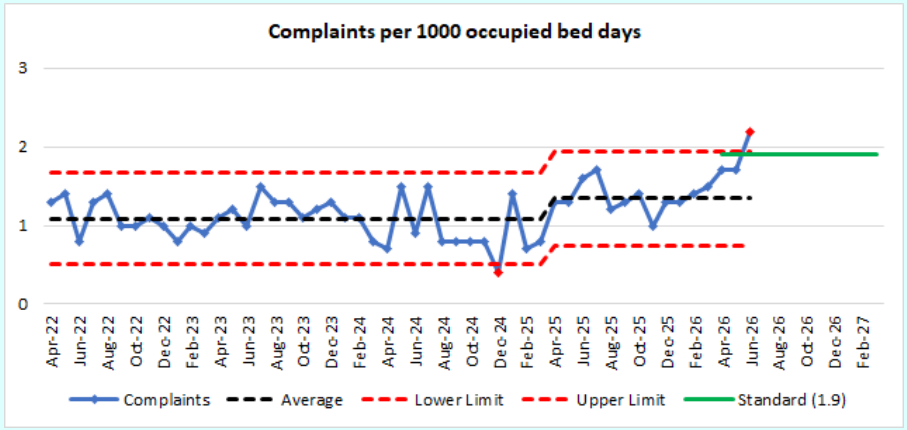
The team continues to monitor feedback trends closely, working with divisions to ensure that complaints and concerns are responded to in a timely, proportionate and person-centred way while also identifying opportunities for learning and service improvement.

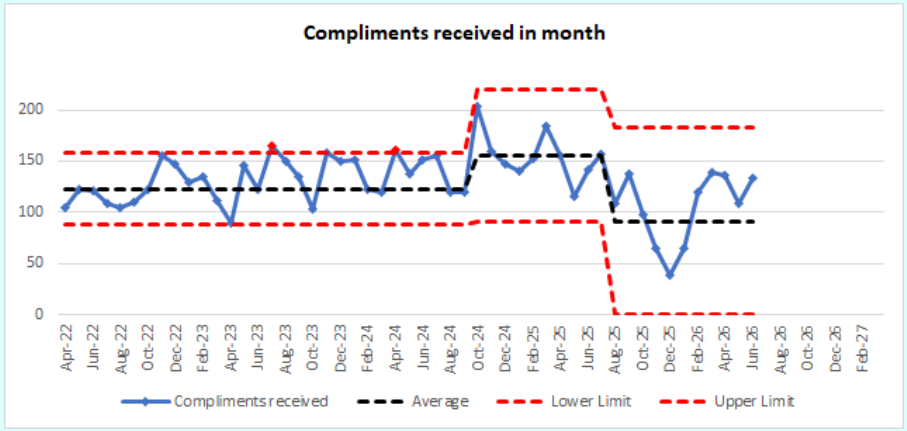
It is important to note that the Trust continues to receive low numbers of complaints referred to the Parliamentary Health Service Ombudsman (PHSO). In 2025/26, the PHSO initiated six new complaint reviews; however, it closed four without further investigation.

There was a 21% reduction in compliments recorded compared with the previous financial year. Divisions continue to be encouraged to record compliments locally, and positive feedback continues to be shared with teams to recognise good practice and support staff morale.

Feedback received through Healthwatch, Care Opinion and social media continues to highlight examples of compassionate and responsive care across services, while also identifying areas for further improvement, including appointment cancellations and discharge communication.

Data





Outstanding Care,
Compassionate People,
Healthier Communities

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People and Culture

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Scorecard: People and Culture

People and Culture

At a Glance	Indicator	May-26	Jun-26		Standard (June 26)	Benchmark (Mar-26)	STAR Data Quality
Belonging in the NHS	NHS staff survey engagement theme score	-	-		≥6.74	66 / 121	
	National Education and Training Survey satisfaction rate	TBC	TBC		TBC		
	NHS staff standards score	TBC	TBC		TBC		
Growing the Future	Vacancy rate	10.4%	9.4%		≤9.0%		
	Time to hire	31	33		≤40		
	Turnover in month	0.4%	0.4%		≤0.9%	55 / 118	
	Appraisals	87.3%	87.3%		≥90%		
	Mandatory & statutory training	92.4%	92.3%		≥90%		
	Medical job plan compliance (Consultants)	98.9%	99.6%		≥95%		
	Medical job plan compliance (SAS Doctors)	99.2%	99.2%		≥95%		
Looking after our People	Sickness absence	4.5%	5.0%		≤4.2%	52 / 118	
	Flu vaccinations uptake (front line staff)	-	-		≥56.9%		
	Employee relations management	21	22		<24		
New Ways of Working	Bank usage	5.9%	6.0%		≤5.3%	119 / 195	
	Agency usage	2.5%	2.6%		<1.5%	158 / 193	
	Agency (off framework)	0.0%	0.0%		0%		
	Agency (over price cap)	34.3%	38.1%		≤40.0%		

Summary Icon Key

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

Benchmark Key

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

STAR Data Quality Key

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

- Substantial assurance
- Limited assurance
- No assurance

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Domain Summary: People and Culture

Overview

Lead: Chief People Officer

In Jun-26, eight of thirteen People and Culture indicators were meeting or exceeding standards, reflecting our continued commitment to supporting and investing in our people. Areas of strong compliance against our targets include staff turnover, recruitment timelines, medical job plan compliance, off-framework agency levels and Mandatory and Statutory Training (MaST), although Mandatory and Statutory Training is flagging special cause variation for deteriorated performance. This performance demonstrates sustained operational grip and effective workforce management. Benchmarking comparators are once again included, providing greater insight into the Trust's performance against other organisations nationally and further strengthens our assurance and improvement focus.

Within the People and Culture domain, the off-track metrics during May and Jun-26 include:

- **Vacancy rate** remains outside the 9% standard for 2026/27, with a decreasing position driven by the re-coding of disestablished posts within the ledger, that were present in Apr-26 and May-26. This represents a more accurate vacancy position. To support a sustainable reduction, we have strengthened our vacancy control processes and have communicated revised expectations and key changes to Vacancy Control Panel (VCP) principles and controls to our divisions.

- **Appraisal** compliance is slightly below the 90% Trust target, with performance overall at 87.3% in 2025/26 fluctuating within normal variation month-to-month. This reflects the continued pressures across services, including high patient demand, annual leave, and staff absence, which have impacted the capacity to release time for appraisals. Focus is on the areas of non-compliance, with a view to understand these drivers, including individuals who are on the top of the banding and near retirement. Focused support will continue to reinforce the importance and benefits of appraisal conversations in supporting our people and organisational performance.

- **Sickness absence** remains above the 4.2% standard, with a Jun-26 position of 5.0%. While outside of target, this position has worsened since May-26. The Jun-26 position does follow a seasonal pattern and is under the Jun-25 level (5.1%). Stress and anxiety remain the leading causes of absence, reflecting the sustained operational pressures experienced across the Trust. Most areas have seen an increase in both long-term and short-term absences. In response, we have introduced a refreshed Managing Attendance at Work policy, embedded absence management within leadership fundamentals training, and are delivering targeted preventative programmes focused on musculoskeletal (MSK) and stress-related absence hotspots. Through this, combined focus on proactive prevention and strengthened management of absence, the Trust is well positioned to deliver on the planned absence levels (4.2%) and achieve more sustainable improvements in staff wellbeing and attendance.

- **Bank usage** is currently outside standard at 6.0% (against a 5.3% target), and agency usage is 2.6%, also outside the standard. Plans for 2026/27 set out a clear trajectory towards achieving the planned position over the course of the year and will be closely monitored. Positively, there has been zero use of off-framework agency, with over price-cap agency below standard.

The following pages provide more detailed performance insights across five identified areas of exception within the People and Culture domain. These areas were explored in depth at the Trust People Committee, supported by comprehensive analysis.

Indicator in Focus: Vacancy Rate

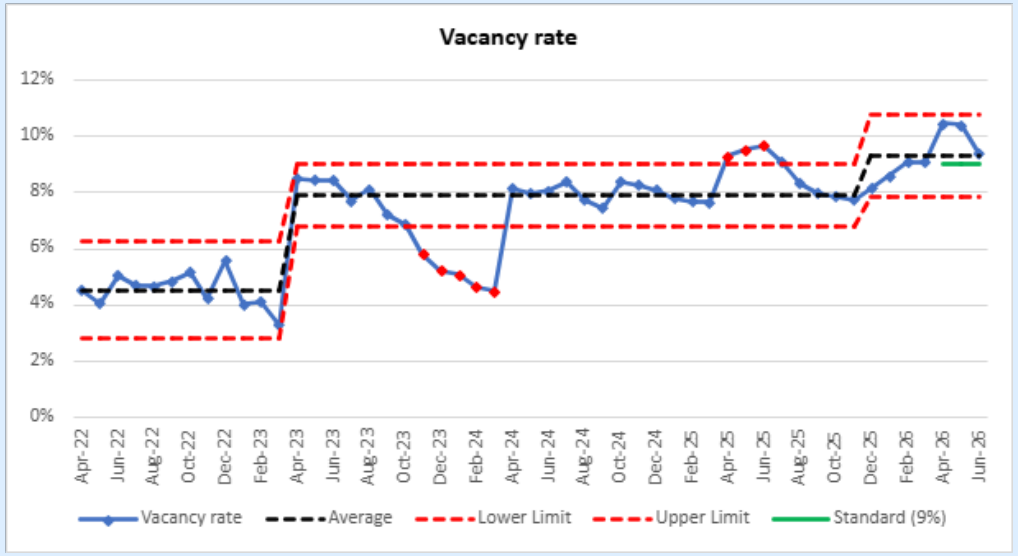
Sherwood Forest Hospitals NHS Foundation Trust

Observations

The vacancy rate position for Jun-26 sits outside the standard and recent performance has triggered a deteriorating step-change in the control limits. However, the position has seen an improvement over the last month. This is due to the exclusion of disestablished posts within the ledger that reduces this to a more accurate vacancy level.

A seasonal increase across the first quarter is typically expected and is largely down to the balance between revised budgets, workforce growth and recruitment lag times. A reduction over the rest of the year is expected.

Local Data (to Jun-26)



Root Causes	Actions and Timescale	Impact
Balance between the budget setting process and recruitment and growth.	Over 2026/27, we will be measuring our actual Whole Time Equivalents (WTEs) vs plan to a divisional level. Where we see variations, we will report to the relevant committees.	Although elevated levels were recorded during Apr-26 and May-26, adjustments have been made to support the accurate recording of vacancies against the ledger.
Strengthened Vacancy Control Panel (VCP) processes.	Aligned to financial control, we monitor vacancies via our VCP. We have re-assigned role categories where all roles are scrutinised prior to being advertised.	

Indicator in Focus: Appraisals

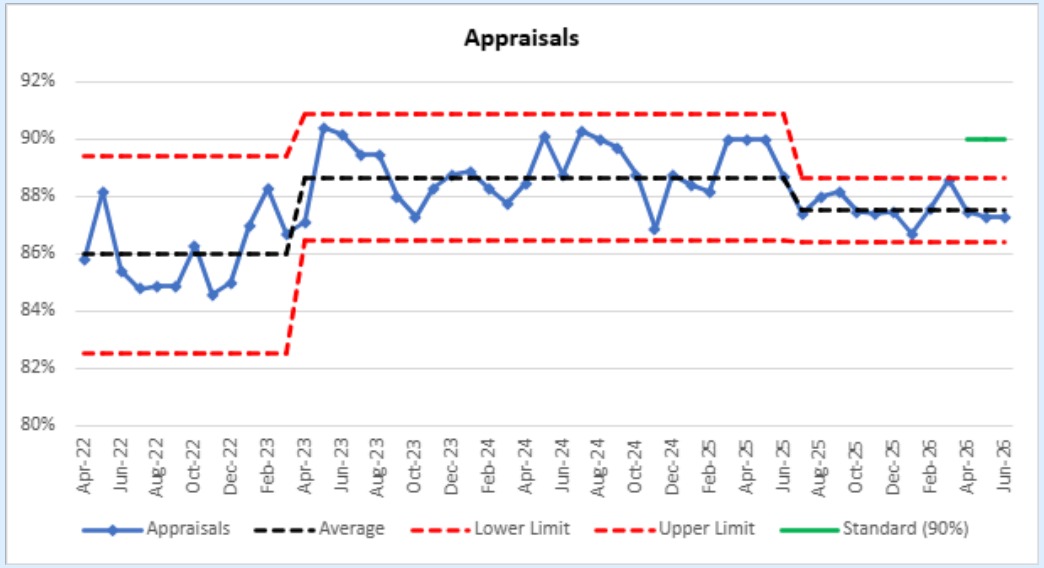
Sherwood Forest Hospitals NHS Foundation Trust

Observations

Our appraisal level sits at 87.3% in Jun-26, below the Trust target (90%). Performance plateaued across 2025/26, remaining at a level that is lower than the standard and at the lower levels observed since the step-change in control limits observed from Jun-25.

Although the position is below standard, this is a strong level compared to the wider Integrated Care Board (ICB) performance (81.2% in Mar-26).

Local Data (to Jun 26)



Root Causes	Actions and Timescale	Impact
Patient demand and hospital acuity has impacted on compliance. Annual leave and absence levels.	To support with meeting compliance level, additional actions have been implemented. These actions, which are aligned to the staff survey, include: • Communication around promoting the importance and benefits of appraisals • For a short period, enhanced reporting to managers to support achievement of the standard • Proposing showing a monthly and rolling average appraisal position. We will be revisiting options to support and increase our compliance levels.	Appraisal compliance levels to gradually increase, with an ambition to see levels of 90% and above.

Indicator in Focus: Sickness Absence

Sherwood Forest Hospitals NHS Foundation Trust

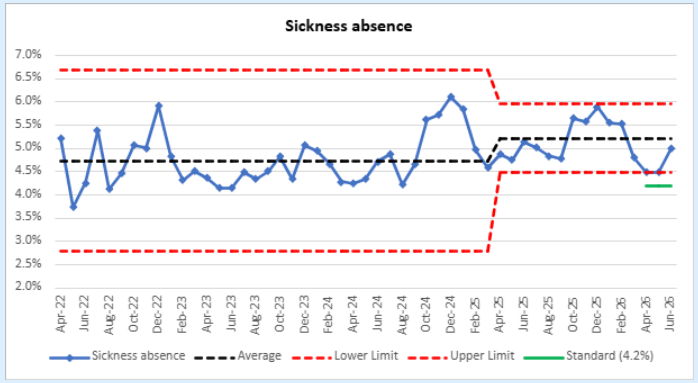
Observations

The monthly sickness position for Jun-26 is reported at 5.0%, sitting outside our standard (4.2%) and above the lower statistical process control limit (4.5%). There has been a decrease in both short and long-term sickness. Stress and anxiety remain the leading causes of absence.

The Mar-26 benchmarking shows the Trust ranking within the sixth decile; our overall position rank as 52 out of 118 trusts. We are showing an improving position relative to other Trusts nationally and across the Integrated Care System (ICS).

The increase in sickness absence directly relates to the workload and stresses of the hospital. However, the current position sits below the previous Jun-25 period (5.1%).

Local Data (to Jun-26)



Root Causes

Our sickness level is reflective of the acuity of the hospital, including being on a high level of escalation (OPEL 4), Business Continuity Incidents (BCI) and at times implementing our Full Capacity Protocol (FCP).

Higher levels are attributed to higher physical and emotional demands on frontline staff, greater exposure to infectious diseases and increased stress and burnout, especially in emergency and inpatient services.

Actions and timescale

We are focusing on the management of sickness absences and re-enforcing the basics to managers. We have reviewed the Sickness Absence Policy, renaming this to 'Managing Attendance at Work', re-defined the discretion element and set managers expectations. We will bring absence management into the leadership fundamentals training and focus on absence prevention in-line with the NHS sickness absence toolkit.

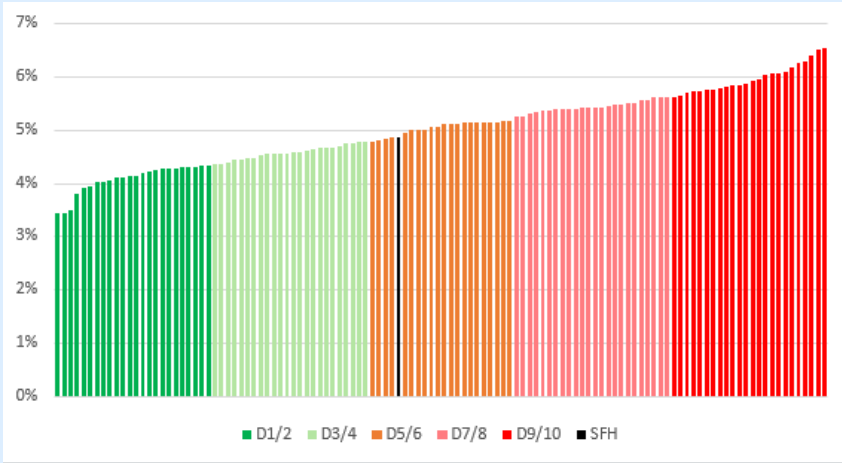
As well as the management of absences, we are looking at root causes. We are seeing absence hotspots, primarily across our healthcare assistant workforce, and have identified service line and ward areas. Aligned to these areas, we are validating our assumptions and plan to bring in preventative programmes to support a sustained reduction to absence. This is primarily focused across musculoskeletal (MSK) and stress and anxiety reasons.

Impact

Reduce levels of sickness.

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

Benchmark Position (Mar-26)



Indicator in Focus: Bank Usage

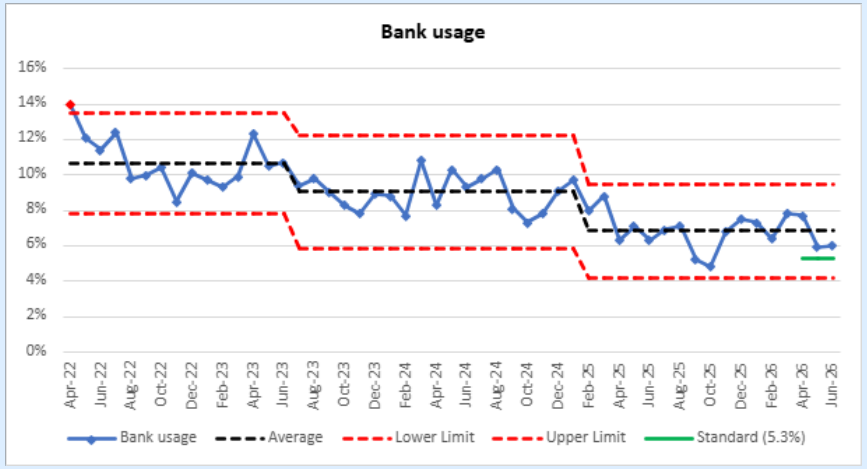
Sherwood Forest Hospitals NHS Foundation Trust

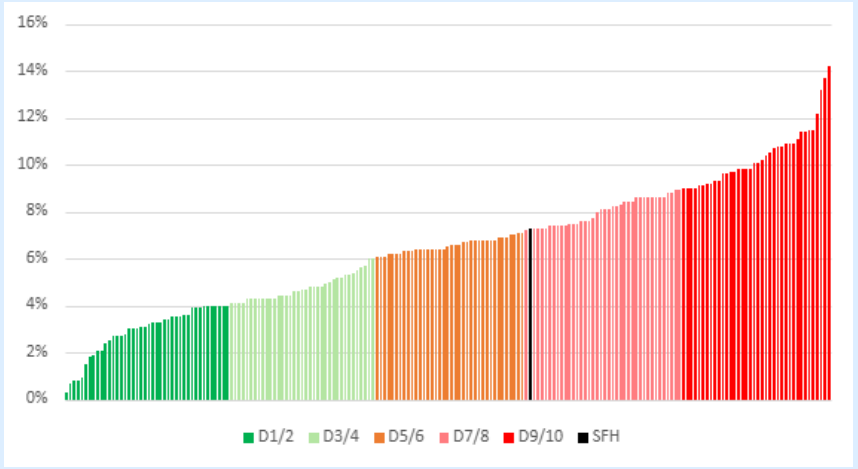
Observations

The Jun-26 bank usage position is reported at 6.0% and sits outside the new standard (5.3%). This shows a marginally improved position from Apr-26, where a level of 7.7% was reported. The current position sits below the previous Jun-25 period (6.3%).

The latest benchmarked position shows that the Trust sits within the seventh decile nationally. It is noted that this is Feb-26 position, when the Trust bank usage level was at 6.4% and was adversely impacted by winter pressures and sustained OPEL pressures.

Local Data (to Jun-26)



Root Causes	Actions and Timescale	Impact	Benchmark Position (Feb-26)
Reliance on bank to fill rota gaps and escalated rates where substantive recruitment has lagged or where services are under-established.	Deliver exemplar rostering and improve e-rostering utilisation.	Target to reduce the bank level to 5.3%.	
	Increase job plan compliance (targeting near-full compliance).		
Increased activity levels and service models (e.g. 7-day services, clinic changes) driving short-term workforce requirements.	Strengthen approval processes for bank usage (daily / weekly review).		

Indicator in Focus: Agency Usage

Sherwood Forest Hospitals NHS Foundation Trust

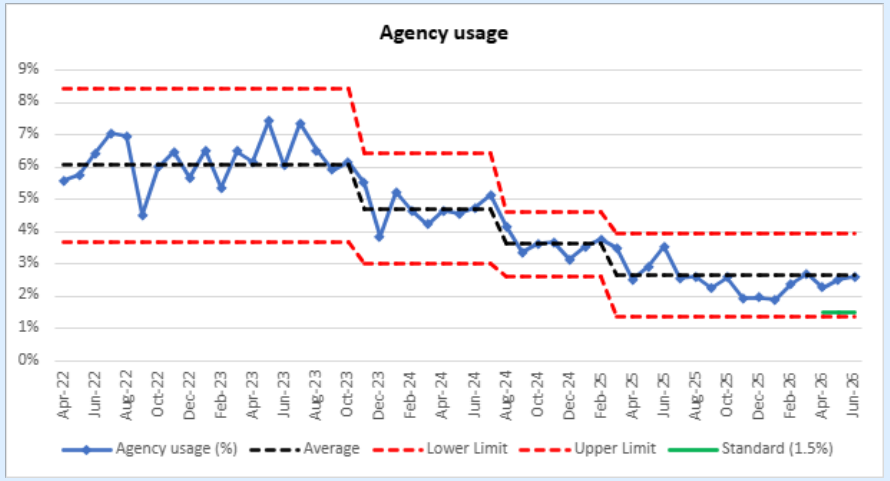
Observations

The Jun-26 agency position is reported at 2.6% and sits outside the standard (1.5%). The position shows a worsening position over the quarter and is moving within the statistical process control limits. The current position sits below the previous Jun-25 period (3.5%).

There has been zero use of 'off framework' agency and over-price cap agency is below the the standard.

The latest benchmarked position from Feb-26 shows that the Trust sits within the ninth decile nationally.

Local Data (to Jun-26)



Root Causes

Our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services where there are national specialty shortages.

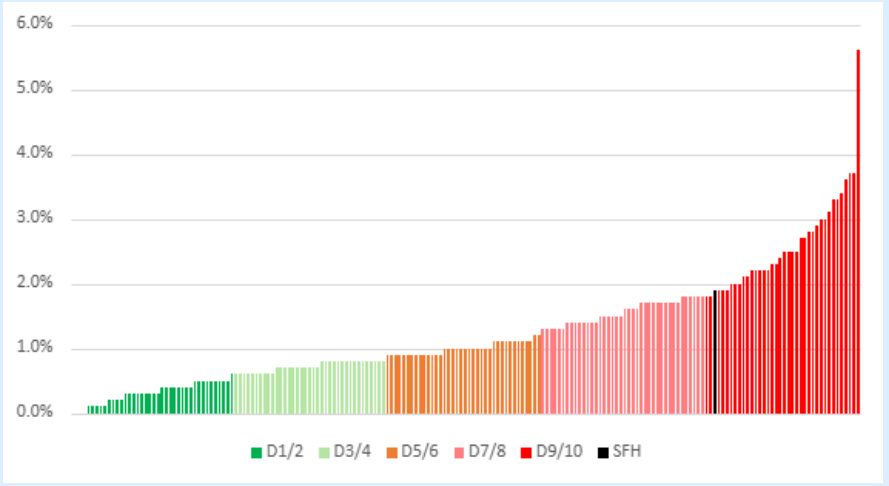
Actions and Timescale

There are ambitious agency reduction plans over 2026/27 aligned to the NHS England target. Our clinical divisions are focusing on the development of plans. We are engaging with Kendall Bluck Consultancy to support our overall reduction.

Impact

Target to reduce the agency level to 1.5%.

Benchmark Position (Feb-26)



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Timely Care

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Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

During the latest reported period of May and Jun-26, we saw continued challenges across our headline Urgent and Emergency Care (UEC) pathway performance metrics. Extensive analysis has shown that the key drivers related to: (1) the impact of Nervecentre electronic patient record system roll out in our Emergency Department mid Apr-26; and (2) demand and capacity pressures which include high average daily non-elective attends. Our King's Mill type one service saw record-breaking daily average attends of 388 in Jun-26 (1.6% more than Jun-25), and Newark also saw record-breaking daily average of 130 attends (8.5% more than Jun-25). These two issues resulted in poor 4-hour, 12-hour and ambulance handover performance with our reported position being worse than our operational plan. The challenges following the Nervecentre deployment were far greater and lasted longer than anticipated and were due to validation, system interfaces and use of the system. We recognise that there is learning from this implementation that we can build into future Electronic Patient Record module deployments.

The deterioration we have seen in our 4 and 12-hour performance metrics and the variance to plan has resulted in us strengthening our recovery plans and agreeing remedial actions with both NHS England and our local Integrated Care Board (ICB). In Jun-26, our 4-hour performance dropped to 63.5% which is our most challenging position since Dec-24. Across all UEC metrics we are seeing material improvement in Jul-26 as our recovery actions are beginning to have impact; this will be reported in our next Integrated Performance Report. There remain challenges in hospital flow with high bed occupancy and a more challenging position with higher numbers of medically safe for transfer patients remaining in our hospitals (delayed discharges) following a lower levels in Feb-26 to May-26. We have an internal discharge improvement programme in place and are working with system partners to resolve capacity issues relating to the availability of packages of care for patients requiring a supported discharge.

In terms of planned care, the headline 18-week Referral to Treatment (RTT) performance continues to improve, achieving 64.8% in Jun-26; this is achieving operational plan and triggered as special cause variation for the fourth consecutive month. However, our 52-week wait backlog has deteriorated to circa 1.2% of the total Patient Tracking List (PTL) in May-26, which is outside of our operational plan and now triggering as special cause variation. We have driven reductions in the overall PTL waiting list size which are now at the lowest level post the Covid-19 pandemic.

Our diagnostic DM01 position has shown recovery over the last two months following a drop in performance in the Spring at variance to our operational plan. This drop in performance was driven primarily by demand for non-obstetric ultrasound where primary care started directing more patients to secondary care and less to community ultrasound services. The referral routes have been reviewed and communications issued to primary care. Some patients have been repatriated back to community services. We continue to increase Community Diagnostic Centre (CDC) activity and progressed in Jun-26 to be above our NHS England agreed activity plan. We are recovering back towards our plan with the variance reducing from 8.9% off plan in Apr-26 to 2.8% in Jun-26. We are working to be back on plan by 2026/27 quarter three. There are some challenges in Endoscopy that we are also working to resolve; again, progress is being made in recovering our performance in this modality.

Cancer 28-day faster diagnosis performance continues to perform strongly and within normal variation. Our cancer performance for the 31-day treatment standard achieved the best level of performance since the pandemic in May-26. However, cancer 62-day performance deteriorated over the last two months and closed below plan at 61.1% in May-26. The positive is that we have seen a reduction in the number of patients on our 62-day backlog (which does result in a deterioration in performance as we treat patients that have breached). Our focus is on sustainably reducing the backlog of patients waiting over 62-day for treatment to enable consistently strong long-term performance. Recovery plans are in place across several tumour sites with further details included in this report.

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

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Scorecard: Timely Care

Timely Care

At a Glance	Indicator	May-26	Jun-26		Standard (June 26)	Benchmark (May 26)	STAR Data Quality
Urgent Care	Average ambulance handover time (mins)	26	27		≤20	▲ 4 / 15	
	Percentage of ambulance handovers within 15 minutes	23.8%	22.0%		≥66.0%	▼ 125 / 174	
	Percentage of ambulance handovers within 45 minutes	86.6%	85.9%		100%	▲ 5 / 15	
	ED 4-hour performance	64.1%	63.5%		≥79.0%	▼ 124 / 140	
	ED 12-hour length of stay performance	7.0%	8.1%		≤2.1%	▬ 83 / 177	
	ED 24-hour length of stay performance	0.5%	0.7%		0%		
	Number of ED patients cared for in corridors for over 45 minutes	TBC	TBC		0		
	Adult G&A bed occupancy	95.9%	97.0%		≤96.2%	▬ 80 /177	
	Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base	57	82		≤40		
	Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base	1,757	2,454		≤1200		
Electives	Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment	64.7%	64.8%		≥64.7%	▬ 88 / 148	
	Percentage of RTT waits over 52 weeks for incomplete pathways	1.1%	1.2%		≤1.0%	▬ 77 / 148	
Diagnostics	Diagnostic DM01 performance under 6-weeks	87.5%	88.8%		≥91.6%	▲ 45 / 135	
Cancer	Cancer 28-day faster diagnosis standard	81.6%	-		≥80.4%	▲ 49 / 127	
	Cancer 31-day treatment performance	99.2%	-		≥90.8%	▲ 26 / 134	
	Cancer 62-day treatment performance	61.1%	-		≥74.4%	▼ 112 / 130	

Summary Icon Key

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

Benchmark Key

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

STAR Data Quality Key

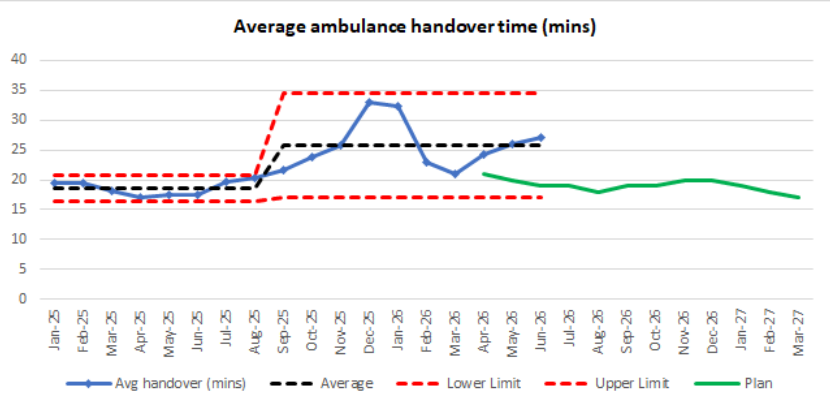
Sign-off and validation
Timely and complete
Audit and accuracy
Robust systems and data capture

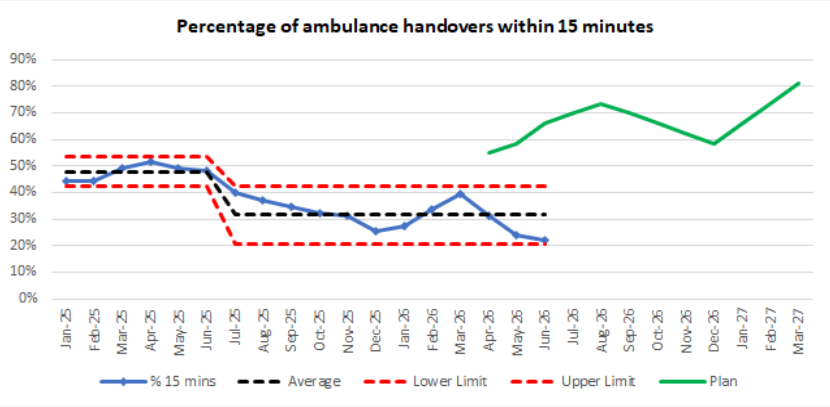
- Substantial assurance
- Limited assurance
- No assurance

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

Sherwood Forest Hospitals NHS Foundation Trust

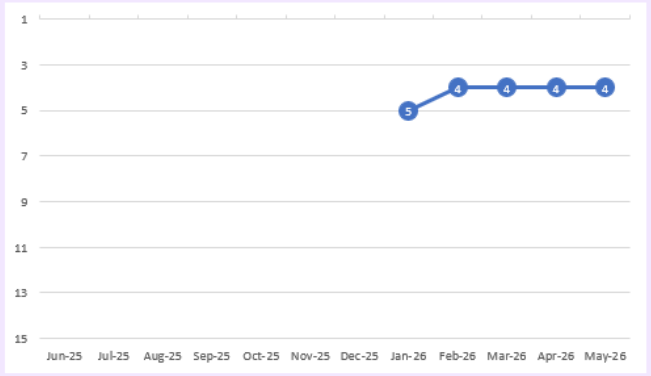
Local data (to Jun-26)



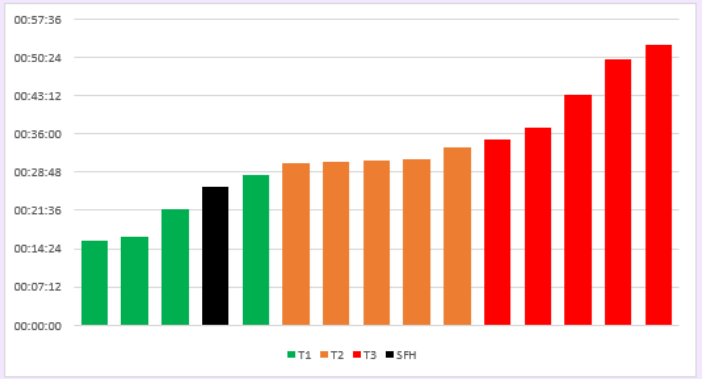


Benchmark position (to May-26)

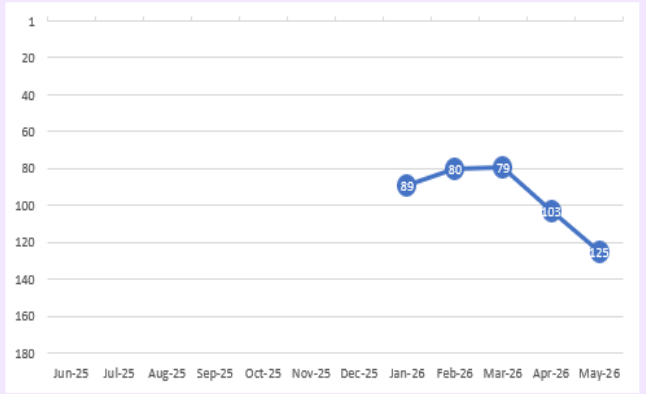
Average ambulance handover time (mins) - Local Benchmarks only, data sourced from EMAS



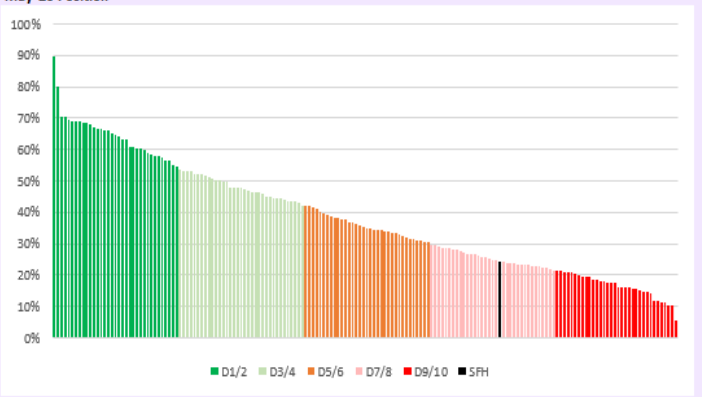
May-26 Position



Ambulance turnaround times <15mins



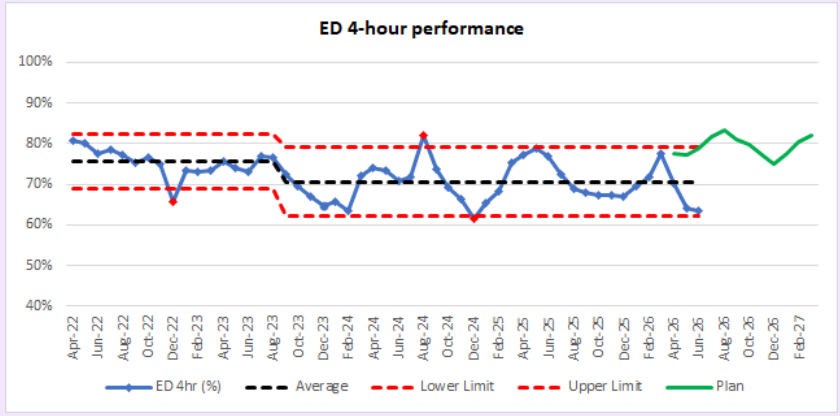
May-26 Position

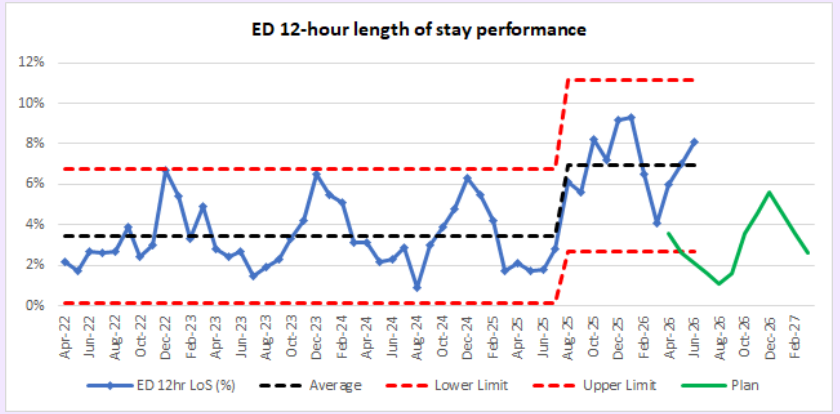


Indicators in Focus: Urgent Care – A&E (2/4)

Sherwood Forest Hospitals NHS Foundation Trust

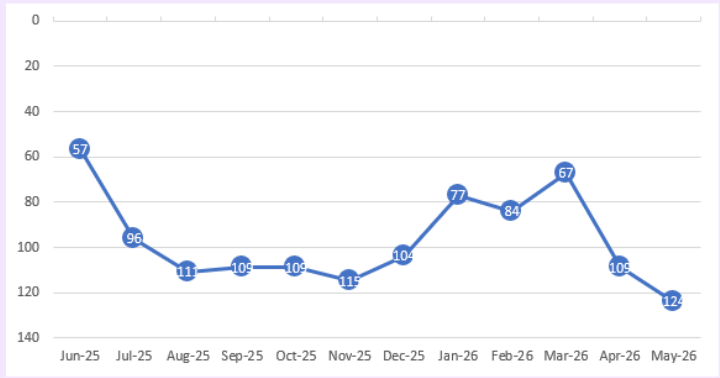
Local data (to Jun-26)



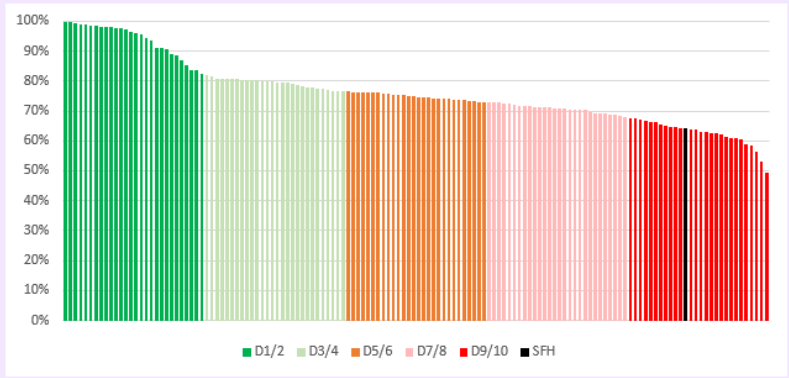


Benchmark position (to May-26)

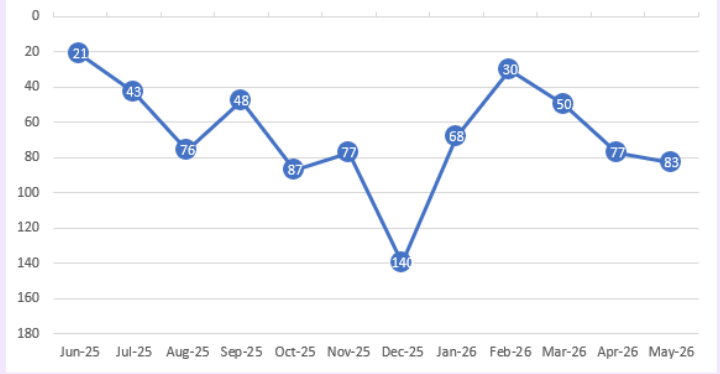
ED 4-hour performance



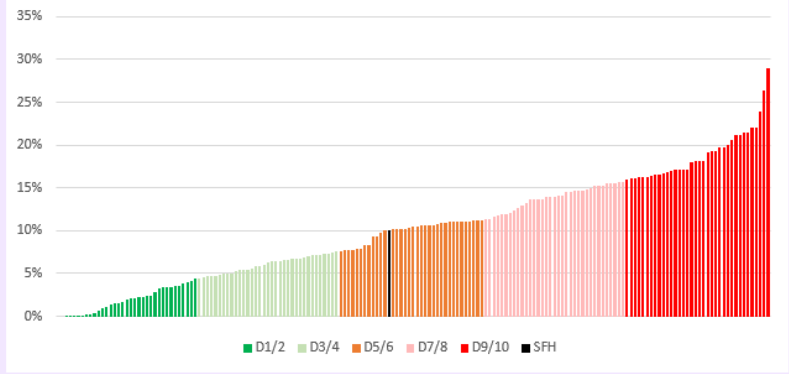
May-26 Position



ED 12-hour length of stay performance



May-26 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

During the latest reported period of May and Jun-26, we saw continued challenges across our headline Urgent and Emergency Care (UEC) pathway performance metrics. Extensive analysis has shown that the key drivers related to:

(1) The impact of Nervecentre electronic patient record system roll out in our Emergency Department in mid Apr-26; and
(2) Demand and capacity pressures which include high average daily non-elective attends.

These two issues resulted in poor 4-hour, 12-hour and ambulance handover performance with our reported position being worse than our operational plan.

The challenges following the Nervecentre deployment were far greater and lasted longer than anticipated and were due to validation, system interfaces and use of the system. We recognise that there is learning from this implementation that we can build into future Electronic Patient Record module deployments.

From a demand perspective, our King's Mill type one service saw record-breaking daily average attends of 388 in Jun-26 (1.6% more than Jun-25), and Newark also saw record-breaking daily average of 130 attends (8.5% more than Jun-25). Despite the demand pressures, performance at Newark Urgent Treatment Centre remains very positive. Conversely, Since Sep-25, the Nottingham Emergency Medical Services (NEMS) primary care 24 service has seen less patients than in the same periods in the last three years.

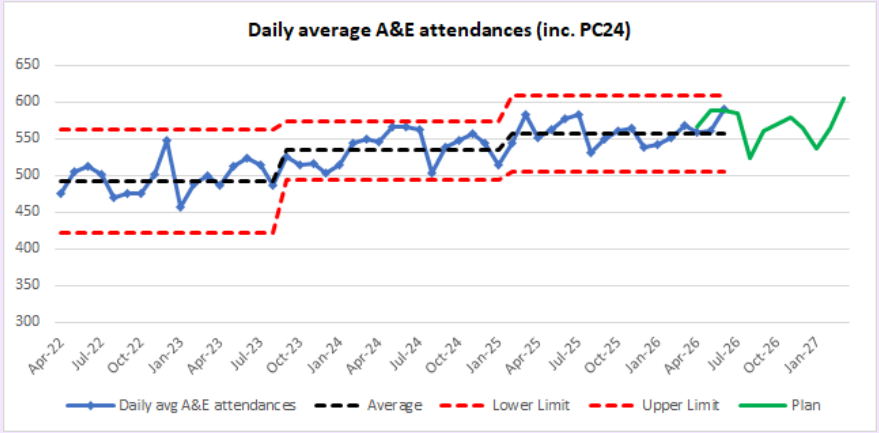
In Jun-26, our 4-hour performance dropped to 63.5% which is our most challenging position since Dec-24. Emergency Department (ED) 12-hour length of stay performance remained challenged and above plan, and ED 24-hour length of stay performance closed at 0.7% against an expectation and plan of zero. Across all UEC metrics we are seeing material improvement in Jul-26 as our recovery actions are beginning to have impact.

From a benchmarking perspective, ED 4-hour and 12-hour performance have been deteriorating, and we sit in the ninth decile based on latest data for 4-hour performance, having been firmly mid-table prior to the Nervecentre roll-out. ED 12-hour length of stay performance shows a more favourable position and sits mid-pack, though we aspire to be much better.

Our ambulance handover performance is deteriorating slowly and remains off plan with an average handover time of 27 minutes. However, we continue to benchmark well regionally for average clinical handover time and the percentage of 45-minute handovers.

We have improvement initiatives in place across our UEC pathways with headline actions described in the subsequent pages.

Additional data (to Jun-26)



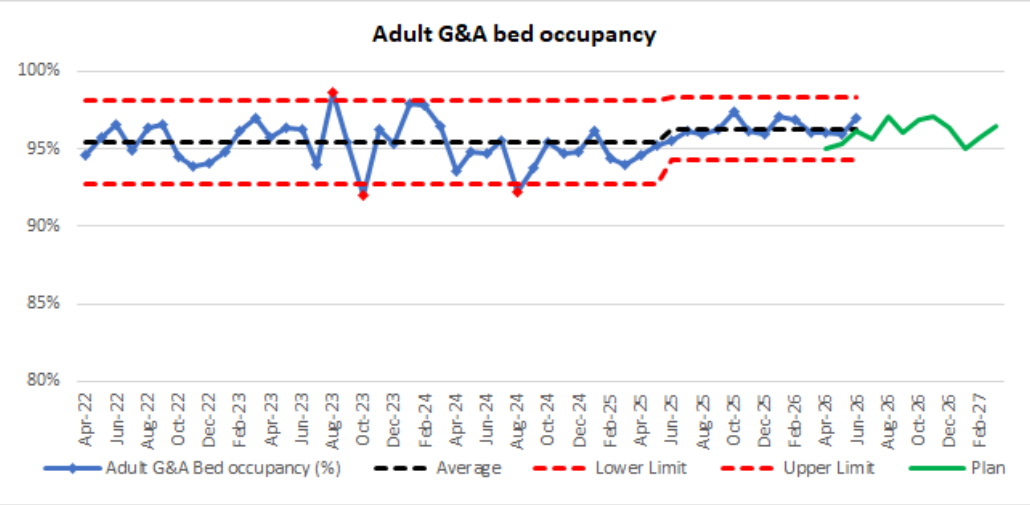
Indicators in Focus: Urgent Care – A&E (4/4)

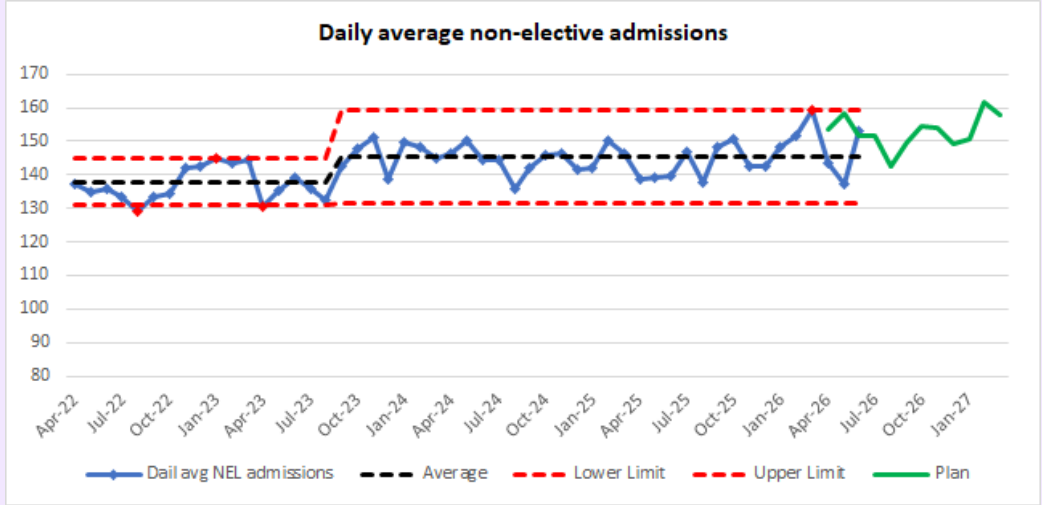
Root causes	Actions and timescale	Impact
High ED attendance demand, acuity and ambulance conveyance, including patients who could be managed through alternatives to ED.	• System demand avoidance: EMAS engagement on out-of-area conveyances; frailty “call before convey”; urgent community response; redirection to Urgent Treatment Centre (UTC) / PC24; NEMS interceptor pilot (complete and awaiting feedback); direct routing to Same Day Emergency Care (SDEC) where clinically appropriate. Actions underway throughout 2026/27 quarter two.	• Fewer avoidable ED attendances and conveyances; more patients treated in type 3 / SDEC pathways; sustained UTC and PC24 performance above 95%.
	• Command, control and escalation workstream (including establishment of smaller working groups across ED ‘time capsule’ elements, and the programme for delivery of the new ED build is being developed through a dedicated working group. Programmes underway.	• Increase the number of patients cared for in ambulatory pathways and via alternatives to ED.
Post-Nervecentre workflow instability, timestamp variation and validation burden affecting operational visibility and confidence in reported 4-hour performance.	• Daily validation of breaches and missing departure / outcome times; timestamp definition review; configuration fixes; ED dashboard redevelopment; staff process guide, focused user support, supplier escalation and peer review. Detailed programme of 25 digital actions in place within our Emergency Care Improvement Plan which are either complete or due to complete by the end of Aug-26.	• Improved data quality and transparent reporting; quicker identification of patients approaching four hours; reduced validation backlog and clearer operational focus.
A&E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Additional bed spaces created across our medical base wards over winter by installing additional curtain rails. These spaces are used during periods of local escalation to allow our wards to accommodate more patients earlier in the day to help improve hospital flow. Ongoing action deployed in line with our Managing Patient Flow Policy.	• Reduced ED crowding and 12-hour length of stay; fewer patients waiting in escalation areas; improved patient safety, experience and progress toward 4-hour recovery.
	• Expand / optimise ambulatory pathways and combine Clinical Decisions Unit (CDU) with medical SDEC; reinforce specialty ownership and urgent review standards; use escalation bed spaces; maintain discharge focus and align admission / discharge demand. Ambulatory work to be completed in line with our Emergency Care Improvement Plan during 2026/27 quarter two.	
Variable front-door grip, streaming and deployment, with delays to plans, disposition and use of ambulatory areas.	• Two-hourly huddles across ED areas; clarified Nurse in Charge / Consultant in Charge roles; DLT walkarounds 08:00–02:00; three to four-hour non-admitted progress chaser; protection of ambulatory staffing. Actions underway in Jul-26 with successful interventions being adopted as business as usual.	• Earlier clinical plans, faster decisions and fewer avoidable non-admitted breaches; improved mean time in department and better use of CDU capacity before four hours.

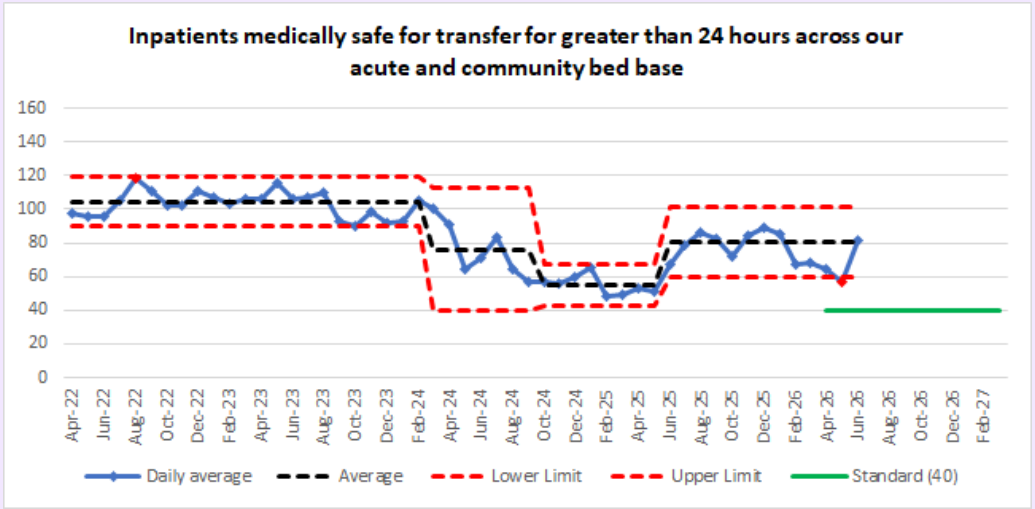
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

Data (to Jun-26)







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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

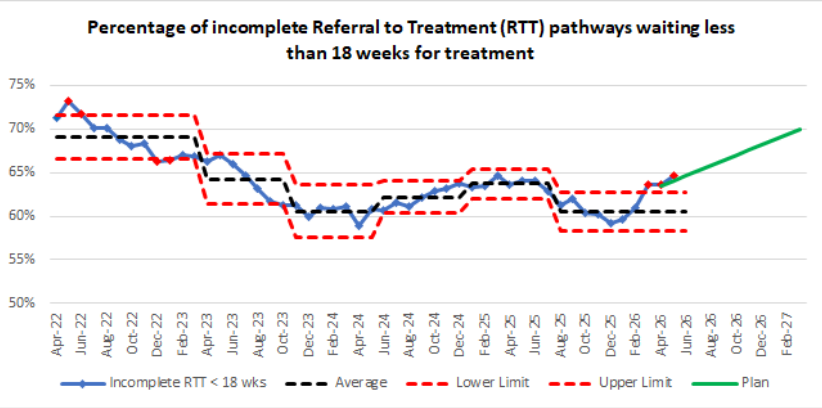
- General and Acute (G&A) bed occupancy remains high at 97%, equivalent to levels seen in Jan-26 and Feb-26.
- Daily average non-elective admissions increased in Jun-26 and exceeded plan for the first time in 2026/27.
- The number of inpatients medically safe for transfer for greater than 24 hours have increased in Jun-26 following lower levels seen between Feb-26 and May-26 (with special-cause variation in May-26 due to low levels). Package of Care availability has been a key constraint in recent weeks.

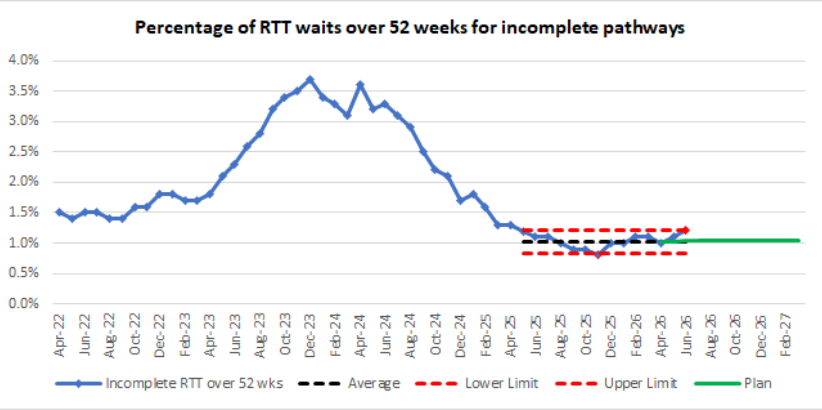
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards (flow through our hospitals).	• The ongoing 'Getting the Basics Right' programme championed by the Chief Operating Officer and Chief Medical Officer. Focus on effective board rounds, ward processes and weekend discharges to reduce delays and improve patient length of stay. Ward 23 Ward Leader presented positive outcomes to Leaders Forum in Jul-26. Focus to date has been on Medicine Division wards. From Aug-26 we will commence work with Surgery Division wards.	• Reduced delays and improved patient length of stay across all discharge pathways.
	• Daily ward-level discharge targets in place since Nov-25 and used daily in Capacity and Flow meetings. From Jul-26 there has been additional focus on delivery of weekend discharge targets.	
	• Continued focus on the importance of keeping our clinical systems up to date with items including the predicted date of becoming medically safe, medically safe status and home today status.	
	• Progressing with the implementation of Optica platform to better manage flow for patients requiring discharge planning. Working toward a launch date in Sep-26.	
Delays to post-medically safe discharge processes (flow out of our hospitals).	• The Discharge Improvement Group, including internal colleagues and system partners, is focussing on all key areas of delayed discharge. At present, focus is on package of care waiters, TTO delays and planning and placements for fast-track patients. This focus is to be sustained over the next 12-months with fortnightly updates provided in our Integrated Remedial Action plan. The programme has completed training on transport booking processes and commenced a 4-week trial for Trusted Assessor (due for review in Aug-26).	• Improve length of stay (LOS) for complex discharges across our hospitals. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges.
	• A cost-neutral new flow and transfer team trial remains underway, operated from the flow room, and is managing bed bookings and the physical movement of patients through and out of the organisation. Initial feedback is positive. Looking for opportunities to expand further in Aug-26.	• Swifter bed bookings and patient movements from EAU to base ward, and base ward to Discharge Lounge.
Insufficient community capacity to meet supported discharge demand.	• Working with health and care partners; Adult Social Care and Notts Healthcare, to resolve issues with delayed allocation (and lack of) Packages of Care (POCs). There are also delays in allocation of social workers to complex cases. This issue has been regularly escalated to system partners throughout Jun and Jul-26.	• Reduce the number of bed days lost due to patients with no criteria to reside.
	• Review of Therapy process during quarters two and three to reduce demand on "double-up" care calls.	

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

Sherwood Forest Hospitals NHS Foundation Trust

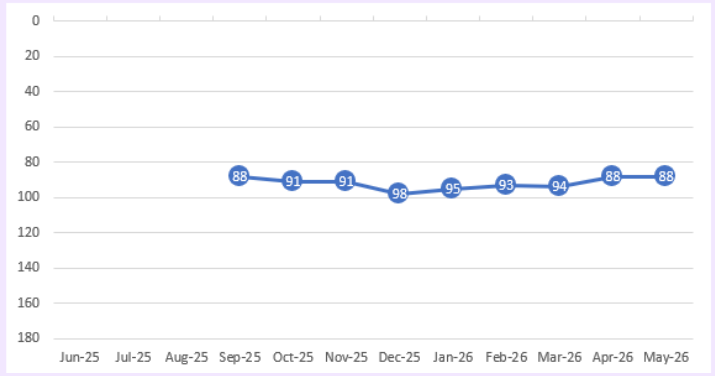
Local data (to May-26)



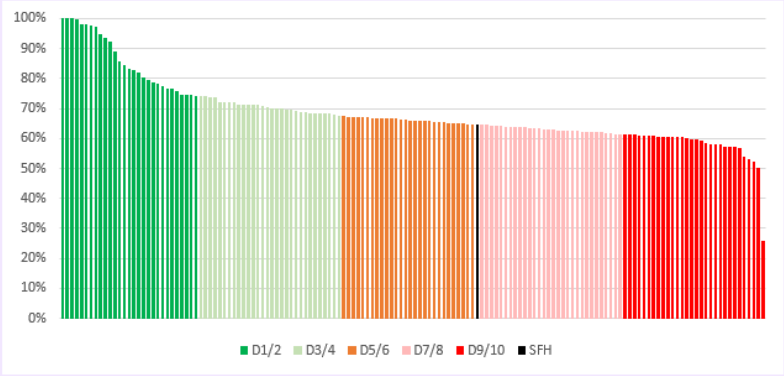


Benchmark position (to May-26)

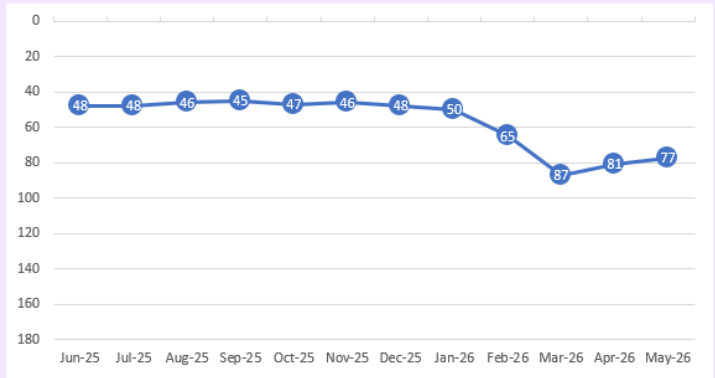
Elective RTT 18-Week Performance



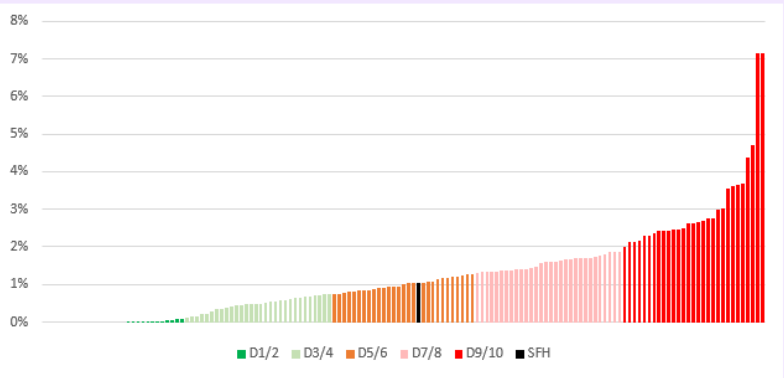
May-26 Position



Incomplete RTT pathways +52 weeks



May-26 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

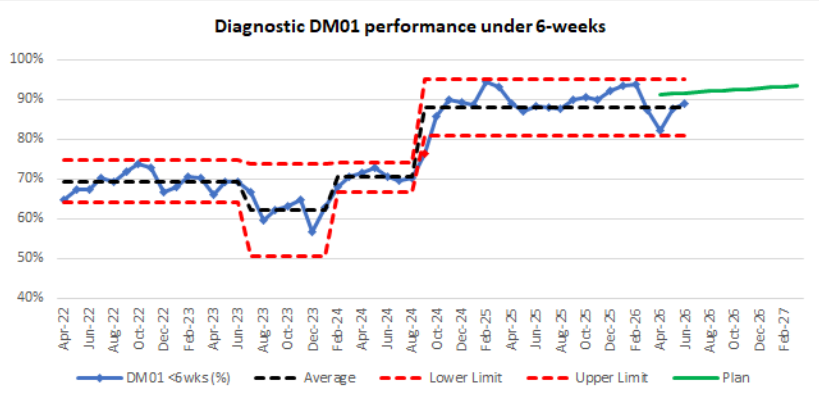
- Referral to Treatment (RTT) 18-week performance improved to 64.8% in Jun-26; triggering as special cause variation for the fourth month in a row. Performance in Jun-26 was 0.1% above our operational plan, which is set to deliver 70% at the end of 2026/27. Latest national benchmarking data places us in the seventh decile as a stable position, which means that the improvements observed in May-26 were reflected across the country.
- 52-week wait pathways deteriorated to circa 1.2% of the total Patient Tracking List (PTL) in Jun-26, triggering as special cause variation. Our PTL size decreased in Jun-26 to the lowest level since the pandemic. Our 52-week wait benchmark for May-26 position put us in the sixth decile nationally.

Root causes	Actions and timescale	Impact
Insufficient anaesthetic capacity (deficit of seven Consultant vacancies) increasing the risk of list cancellation due to insufficient staffing cover.	• Strategy for anaesthetic staffing levels and recruitment plan in place for four Whole Time Equivalent (WTE) Consultant vacancies including: – Two appointments made from Jul-26 interviews (following no appointments in Mar-26). Start dates to be confirmed following ongoing recruitment processes. Further interviews planned in 2026/27 quarter three. – Interim escalated rates in place for Consultants extended to Sep-26. – Senior oversight of clinical anaesthetic rotas in place weekly. – Plan to phase out insourcing from Sep-26.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations. • Sufficient and sustainable workforce.
Insufficient baseline capacity to reduce first appointment backlogs.	• GIRFT Further Faster speciality action plans for phased delivery throughout 2026/27.	• Improve Trust performance against first appointment trajectory. • Impact the Trust long wait position. • Reduce the number of patients waiting >18 weeks for their first appointment.
	• General Surgery clinic template restructure to increase new capacity underway for implementation in 2026/27 quarter two. Consultant commencing Aug-26.	
	• Endocrinology job plan review and identification of additional short-term capacity completed. New outpatient appointment capacity will increase in 2026/27 quarter two over a 30-week period to reduce backlogs.	
Insufficient capacity to reduce 52-week wait backlogs in Maxillofacial and Gynaecology.	• Joint working with NUH to deliver Maxillofacial service level agreement and provision of additional weekly sessions commenced from the end of 2026/27 quarter one. • Gynaecology Consultant appointment, commencing in 2026/27 quarter two pending recruitment processes.	• Reduction in 52-week waits.
Administrative capacity to deliver typing turnaround targets.	• Implementation of Artificial Intelligence (AI) solution for clinical correspondence in 2026/27 quarter three.	• Improve typing turnaround and patient experience.
PTL data quality and ability to sustain a 'clean' PTL and management of all failsafe reports due to insufficient validation resource.	• Federated Data Platform (FDP) to support validation and developments to manage patient pathways fully operational by end of Jun-26 as planned. Review and refinement of system functionality and standard operating procedure through 2026/27 quarter two based on user feedback following go live completion.	• 'Clean' PTL. • Timely management of patient pathways and oversight of actions.
	• Source Clear PTL model to review the total PTL for any quick validation opportunities completed as planned in Jun-26.	• Reduce incomplete PTL size through validation. 55% removal rate.

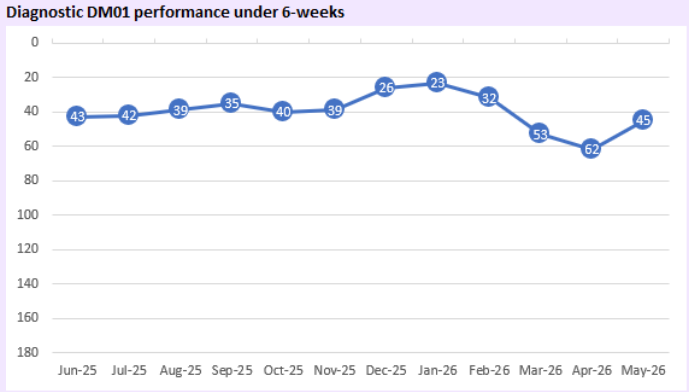
Indicators in Focus: Diagnostics (1/2)

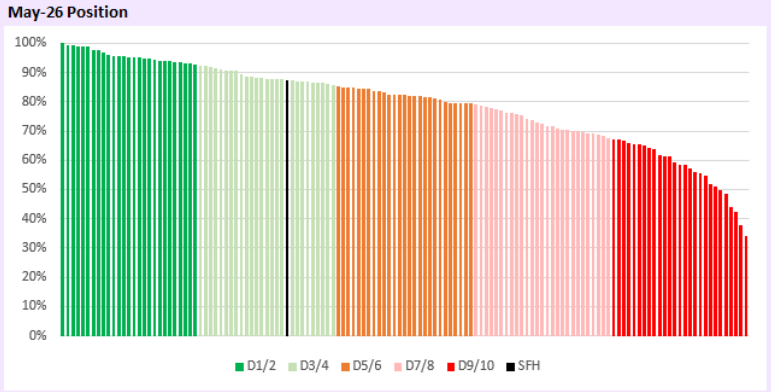
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Jun-26)



Benchmark position (to May-26)





Performance observations

- Our diagnostic DM01 performance improved in Jun-26. We are recovering back towards our plan with the variance reducing from 8.9% off plan in Apr-26 to 2.8% in Jun-26. Performance remains between the control limits of the statistical process chart. This performance improvement is reflected in our benchmarking position, where we have improved and risen into the fourth decile nationally.
- Our improvements in DM01 performance are being largely driven by recovery in our Ultrasound service, which saw a significant increase in referral demand that was identified and corrected as part of joint-working with system partners. We have also seen some challenges, to a lesser extent, in Endoscopy and DEXA.
- Echocardiography remains in a strong position, following the delivery of their recovery plans after their performance challenges in early to mid 2025/26.
- We continue to increase Community Diagnostic Centre (CDC) activity and expect that this will enable us to further drive improvements in DM01 performance and enable better access to care for patients.

Indicators in Focus: Diagnostics (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact
Increase in referrals causing increased waiting list size and insufficient capacity to meet Ultrasound demand.	• Recovery action plan developed with actions to temporarily increase activity signed off in May-26. • Following full commissioner review of activity and referrals to community providers, a recovery plan was agreed. This has led to communication with primary care on referral routes and redirection of referrals to community providers which commenced in 2026/27 quarter one and will continue throughout quarter two.	• Reduce the number of patients waiting less than six weeks for a scan. • Improve DM01 performance. • Circa 1,000 NOUS referrals redirected to community providers to date.
Insufficient baseline capacity to reduce backlogs and achieve DM01 performance for specialist Endoscopy tests.	• Increased Endoscopy capacity for 2026/27 following the opening of the second room at Community Diagnostic Centre (CDC) in Apr-26, delivering above the activity plan. • Dedicated pre-operative assessment capacity for General Anaesthetic (GA) Endoscopy pathways commenced from Apr-26. • Additional bi-weekly GA Endoscopy list commenced from Apr-26. • Increased weekend and bank holiday working to sustain activity levels is ongoing. • Identifying additional in-week capacity where possible and flexing job plans to realise specialist consultant capacity.	
Insufficient baseline capacity to reduce backlogs and achieve DM01 DEXA performance.	• Demand and capacity modelling undertaken to determine the workforce model and job plans to ensure sufficient baseline capacity is underway for completion by the end of Aug-26. • Additional weekend working to reduce backlogs undertaken in Jun-26 and Jul-26. Scoping capacity for additional lists in 2026/27 quarter two. • Expansion of capacity at Newark to commence utilisation of new scanner from 2026/27 quarter three, subject to recruitment and training.	

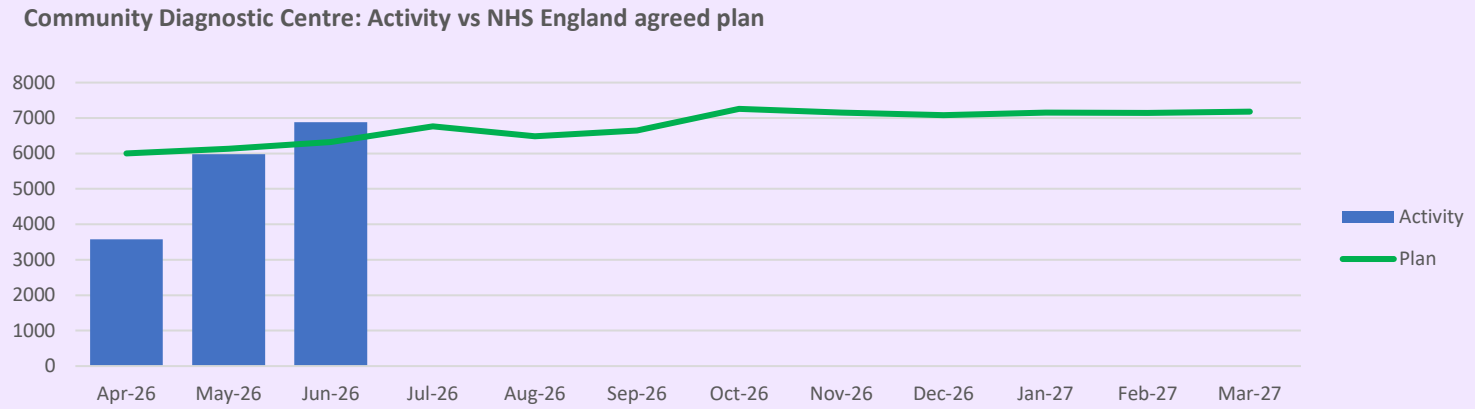
Community Diagnostic Centre (CDC)

Sherwood Forest Hospitals NHS Foundation Trust

Performance Observations

- Following the opening of the CDC in Apr-26, activity has increased monthly and exceeded plan in Jun-26 by 558 tests.
- Endoscopy, Ultrasound, Echocardiography and Respiratory Physiology modalities are fully operational and performing above plan.
- CT and Phlebotomy are performing well and are taking further actions to become fully operational and/or sustain delivery in line with our plan.

Activity vs Plan



Actions and timescale

Fibroscan to go live in 2026/27 quarter three. Delayed due to new equipment compatibility and training.

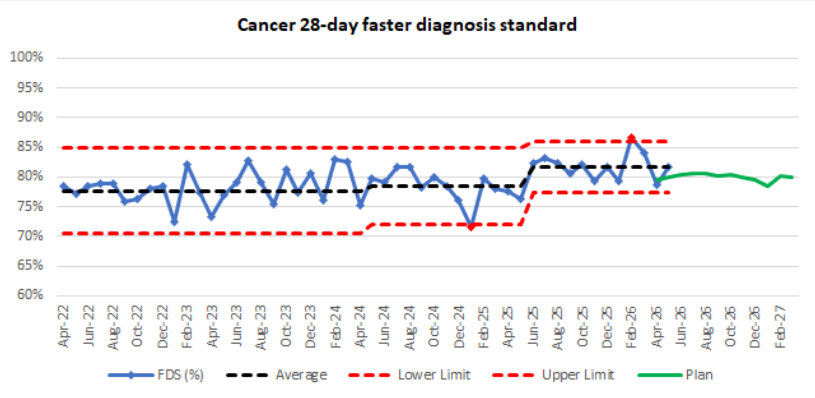
CT are introducing seven day working to become fully operational by end of 2026/27 quarter three, subject to recruitment and training.

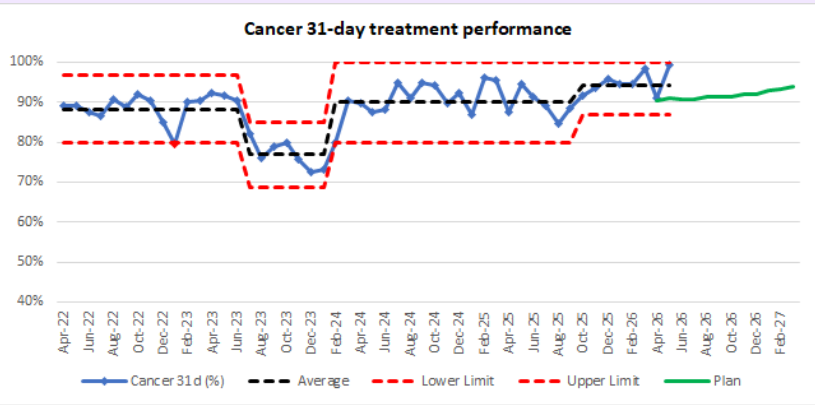
Phlebotomy have agreed with the Integrated Care Board (ICB) to cease King's Mill Hospital walk-in capacity and redirect to the CDC (specialist bloods excluded). This will commence at the end of 2026/27 quarter three. Ongoing review of walk-in and bookable capacity to maximise utilisation.

Indicators in Focus: Cancer (1/3)

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

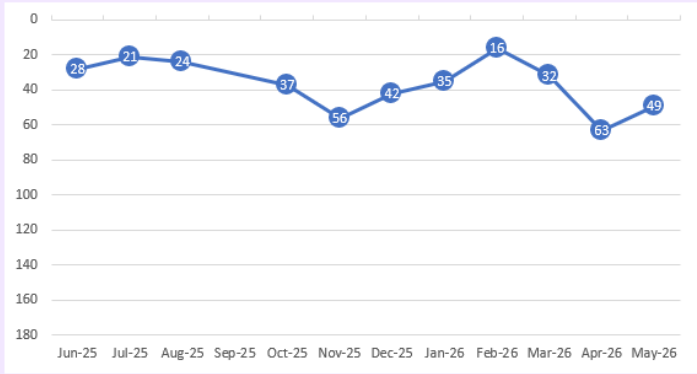
Local data (to May-26)



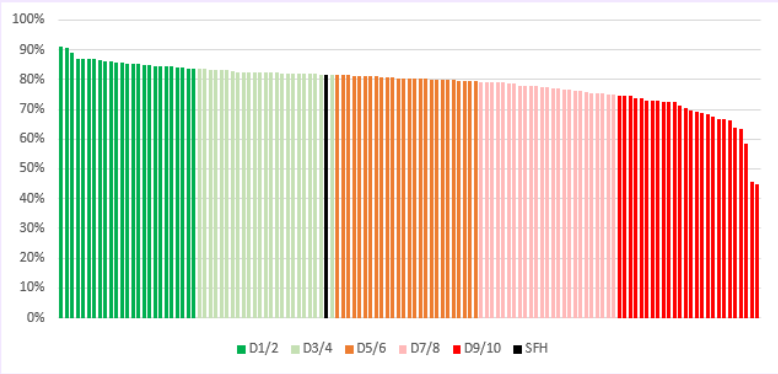


Benchmark position (to May-26)

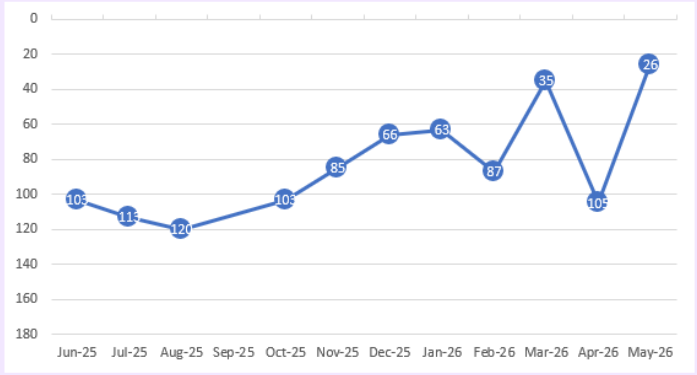
Cancer 28-day faster diagnosis standard



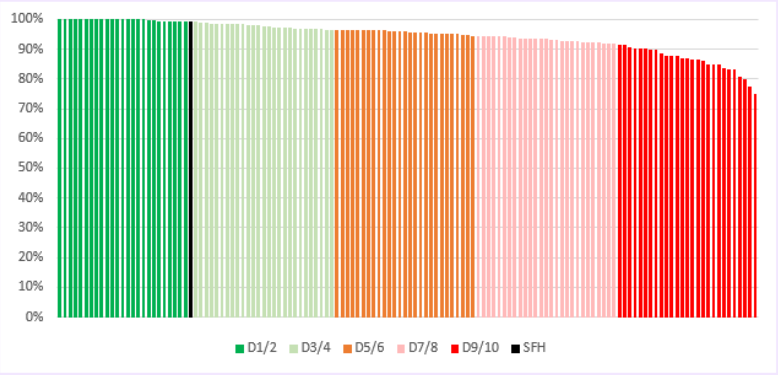
May-26 Position



Cancer 31-day treatment performance



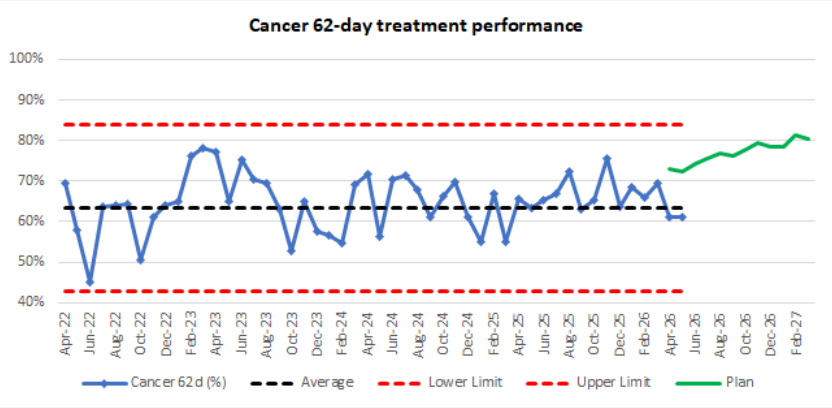
May-26 Position



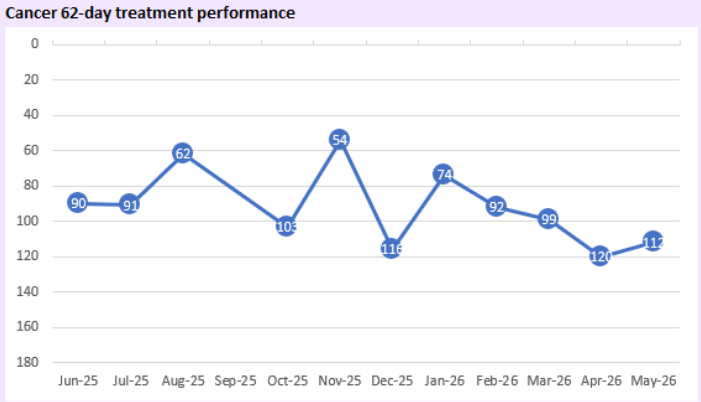
Indicators in Focus: Cancer (2/3)

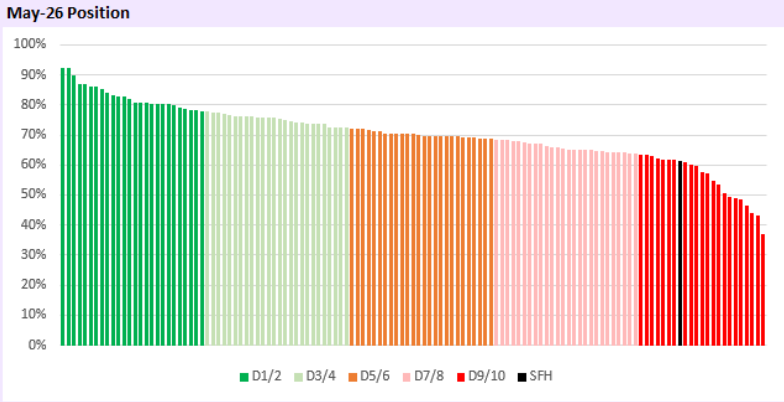
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Jun-26)



Benchmark position (to Mar-26)





Performance observations

- Cancer 28-day Faster Diagnosis Standard (FDS) has improved in May-26 following the seasonally-observed dip in Apr-26, remaining within control limits at 81.6%. Our operational plan is set to deliver 80% on average during 2026/27.
- Cancer 31-day treatment performance (first treatment) closed at 99.2% in May-26; the highest level since the pandemic, and above our operational plan which is set to deliver 94% by the end of 2026/27. Our benchmarking position improved to decile two in May-26 due to our strong performance.
- Cancer 62-day treatment performance was 61.1% in May-26, significantly below our operational plan and our lowest position since Mar-25. The operational plan requires improvement to 80% by the end of 2026/27 as part of the national ambition. Our May-26 performance resulted in our benchmarking position deteriorating into the ninth decile.

Indicators in Focus: Cancer (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact
Insufficient capacity to meet Radiology reporting turnaround targets and specialist capacity.	• Recruitment to four Whole Time Equivalent (WTE) Consultant Radiologists for 2026/27. Recruitment process underway for the remaining three WTE to commence Aug-26. • East Midlands Cancer Alliance (EMCA) funding additional sessions and increased outsourcing for reporting throughout 2026/27.	• Improve Radiology reporting turnaround.
Insufficient Histopathology capacity to deliver the 10-day turnaround standard of 98% across multiple tumour sites.	• Job planning to move from 5-day to 7-day reporting from Jan-27. • Estate work to create extra dissection capacity, timescales are awaiting confirmation from estates. • Commence AI in histopathology processing and analysis from Jul-26. • Use of agency to support specialist microtomy turnaround is ongoing. • Joint working with NUH is underway to ensure Nottingham and Nottinghamshire wide solutions.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
Best Practice Timed Pathway (BPTP) guidance identifying opportunity to reduce pathway delays.	• Undertake a review of all tumour site pathway alignment with Best Practice guidance in 2026/27 quarter two. • Implementation of one-stop models, including the expansion of the Gynaecology see and treat capacity and a Haematuria pathway for Bladder Cancer in 2026/27 quarter three. • Implement a community-based Breast Pain pathway and explore self-referral pathways through NHS 111 in 2026/27 quarter three.	• Improved 28, 31 and 62-day performance. • Increased number of patients first seen within 7 days. • Reduced backlog.
Delays in patient pathways following MDT or delays to MDT due to volumes of patients being discussed.	• Implementation of approved clinical guidelines (Standards of Care) to be reviewed and implemented following East Midlands Cancer Alliance Clinical Expert Advisory Group development in 2026/27 quarter three. • Implementation of a Triage MDT for timely clinical decision making where a full MDT discussion is not required for completion by end of 2026/27 quarter three.	• Increase timeliness of clinical decision making to improve 62-day performance. • Improved patient experience. • Lung triage Multi Disciplinary Team (MDT) live reducing full MDT by circa 5-10 patients per week.
Decision to treat (DTT) is made but patients are not optimised for treatment causing both 31-day and 62-day breaches.	• Undertake an audit and validation of DTT dates to be undertaken in Aug-26 where additional clinical intervention or decision making is required to reduce delays on patient pathways.	• Improved 31-day and 62-day performance.
Manual administrative processes relied upon to ensure patients are upgraded to the cancer pathway following diagnostic test.	• Development of Infoflex, the cancer tracking system, to implement an automatic upgrade of patients to a cancer pathway where a diagnostic test shows suspicion of cancer by Oct-26.	• Release Cancer pathway tracking team capacity to progress patients along cancer pathways, improving 28-day FDS, 31-day and 62-day performance metrics

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Best Value Care

Outstanding Care,
Compassionate People,
Healthier Communities

Domain Summary: Best Value Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead: Chief Financial Officer

The financial plan for 2026/27 is break-even. The Trust has reported an in-month deficit position of £4.3m in Jun-26; this was £3.8m behind the £0.5m deficit plan with the inclusion of the impact of International Financial Reporting Standard 16 (IFRS16) on the Private Financial Initiative (PFI). Year-to-date position is a deficit of £8.0m, which is £4.3m behind the deficit plan of £3.7m. The reason for the year-to-date position being behind plan is due to several factors; these include Industrial Action in Apr-26, shortfalls in the delivery of our Financial Improvement Programme, and bank and agency expenditure being higher than our plan.

We are forecasting a break-even position to NHSE in line with the planning submission for 2026/27.

The annual Financial Improvement Programme (FIP) target is £34.9m in 2026/27. Jun-26 saw an in-month delivery of £2.0m against an in-month plan of £2.4m, giving a shortfall of £0.4m. Year to date delivery is £4.8m against a plan of £7.4m, giving a shortfall of £2.6m.

Capital expenditure in-month was £0.3m against a plan of £1.5m. The variance relates to the rollout of the Electronic Patient Record system (EPR) in our Emergency Department, which has been phased in twelfths across the year. The full-year plan including PFI lifecycle is £21.7m.

Closing cash on 30 Jun-26 was £1.2m; a decrease of £0.3m in-month and £14.9m year-to-date (YTD). The large opening cash balance was due to the receipt of capital funding in 2025/26 quarter four, which has unwound as capital creditors were paid in Apr-26. There remains an underlying pressure on available revenue cash resource due to the requirement to deliver significant efficiency savings, and while this can be partly managed by extending creditors. A working capital borrowing request was submitted in Jun-26, with £4.9m was approved for receipt in Jul-26.

The Trust's agency expenditure in Jun-26 was £0.8m against a plan of £0.5m, which is £0.4m over the limit (75%). This is £0.9m over plan (65%) year-to-date. The largest proportion of our agency spend is on medical pay. Total agency expenditure as a proportion of our total pay spend is 2.5%.

The Trust's bank expenditure in Jun-26 was £1.9m against a plan of £1.7m, which is £0.3m over the limit (15%). This is £1.1m over plan (22%) year-to-date. Total bank expenditure as a proportion of our total pay spend is 6.6%.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Best Value Care

Best Value Care

At a Glance	Indicator	May-26	Jun-26		Standard (June 26)	STAR Data Quality
Financial Performance	Financial surplus / deficit	-£1.68	-£4.29	F	≥-0.49	STAR
	Variance YTD to financial plan	£0.08	-£3.80	F	≥£0.00m	STAR
Efficiency	Financial efficiency variance YTD to plan	-£0.79	-£0.39	F	≥£0.00m	STAR
	Risk adjusted efficiency forecast to plan (%)	53.0%	56.0%	F	100%	STAR
	Relative cost difference (National Cost Collection Index)	103	103		TBC	STAR
	Implied productivity growth (YTD compared to last year)	-	-		TBC	STAR
Variable Pay	Reported agency expenditure	£0.78	£0.82	F	≤£0.46	STAR
	Reported bank expenditure	£1.84	£1.91	F	≤£1.66	STAR
	Temporary staffing cost relative band	TBC	TBC		≤7.0%	
Cash & Liquidity	BPPC - Number of bills paid within target (%)	25.0%	11.8%	F	≥95%	STAR
	BPPC - Value of bills paid within target (%)	79.6%	78.1%	F	≥95%	STAR
	Operating expenditure days	1	1	F	≥5	STAR
Capital	Capital expenditure against plan	£0.86	£0.32	P	≤1.53	STAR

Summary Icon Key

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

Benchmark Key

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

STAR Data Quality Key

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

- Substantial assurance
- Limited assurance
- No assurance

Indicator in Focus: Financial Performance

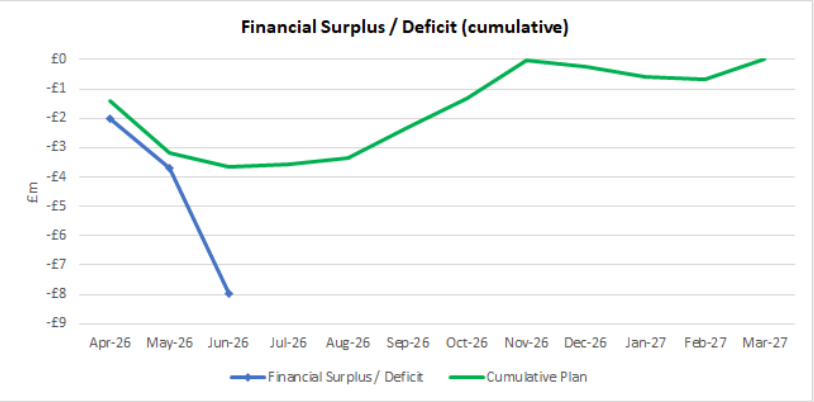
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the Trust financial plan, which is a break-even position for 2026/27.
- The Trust has a £4.3m deficit in Jun-26, which is £3.8m behind the planned deficit of £0.5m. The year-to-date position is a deficit of £8.0m, which is £4.3m behind the deficit plan of £3.7m.
- Forecast is currently break-even in line with plan.

Root Causes	Actions and timescale/areas of risk	Impact
Emergency Department (ED) and Non-Elective (NEL) demand pressures.	• If Urgent and Emergency Care (UEC) pathway (ED and NEL) growth is higher than planned levels, then it presents the opportunity to earn additional income under the blended payment arrangements. However, if activity levels drop below the planned levels, then there is a risk that our income levels will drop under the same blended payment terms agreed as part of the 2026/27 contract with the Integrated Care Board (ICB).	Deliver annual plan.
Non-delivery of the Financial Improvement Programme (FIP).	• At Apr-26, the Trust has delivered £4.8m of efficiency year-to-date, which is £2.6m behind the £7.4m plan. The full-year unweighted forecast of £34.9m is being reported to NHS England, with the weighted target being £19.4m, which is £15.5m behind plan. Divisional and corporate areas are continuously working towards this target and identifying opportunities for 2026/27.	
Variable activity plan.	• We need to ensure as a Trust that we maintain the variable elements of our activity to ensure we maintain the level of income associated with this.	
Industrial Action.	• Apr-26 saw six days of Industrial Action. This had a net impact of £0.6m driven by additional pay costs and lost income. We have not received funding to support this pressure.	

Data



Indicator in Focus: Efficiency

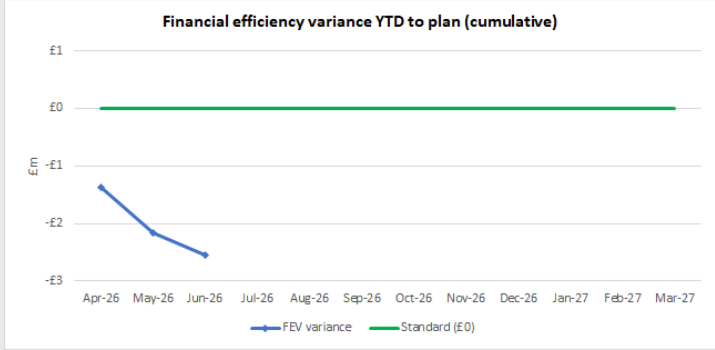
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is delivery of the Trust Financial Improvement Programme (FIP).
- The Trust has a £34.9m efficiency programme for 2026/27, which is currently £2.6m behind plan YTD.
- We are forecasting full delivery of our efficiency programme for 2026/27.

Root causes	Actions and timescale	Impact
Non-delivery of Financial Improvement Programme.	• Monthly Income, Pay and Non-Pay oversight groups have been set up to monitor the delivery of efficiency programmes.	Deliver annual plan.
	• Bi-weekly Divisional Delivery group meetings are in place to focus on progress against divisional FIP targets and focus on key lines of enquiry.	
	• Increased workforce controls that were established in 2025/26 are continuing. This includes Vacancy Control Panel.	
	• Finance Recovery Cabinet (FRC) governance framework in place for 2026/27 with divisions and corporate progressing with efficiency ideas and their development for 2026/27.	
	• Enhanced oversight and grip strengthened further to support delivery within the financial year.	
Risk adjusted forecast.	• Currently, the weighted target at Apr-26 is £19.4m, which is 56% of the target. This value is expected to significantly increase as efficiency schemes progress to being implemented and in delivery.	

Data



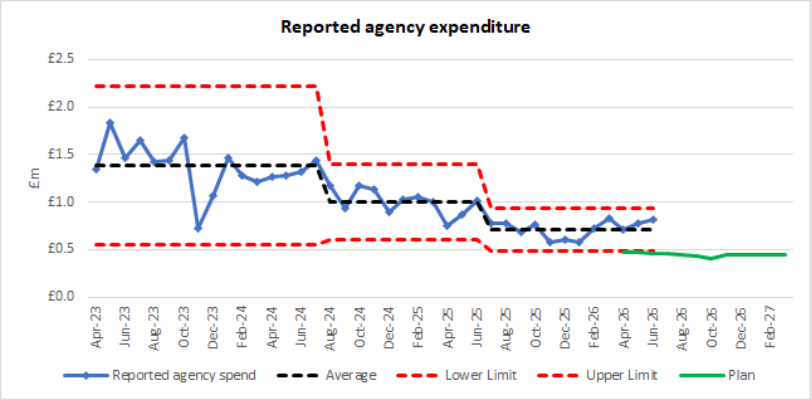
Indicator in Focus: Agency Pay

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the planned agency expenditure for 2026/27.
- The Trust reported agency expenditure of £0.8m in Jun-26 and £2.3m year to date
- Our Jun-26 plan was £0.5m; we were £0.4m (75%) over this plan. We are £0.9m over plan year-to-date.
- Agency expenditure accounted for 2.5% of our total pay bill in 2026/27 quarter one.

Data



Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Our Pay Oversight Group alongside Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required reduction in agency expenditure. • Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews. • Divisional bi-weekly divisional and performance group is in place, which includes focus on bank and agency. • No new agency bookings. Any exceptions to be signed off by the Executive lead. • All medical agency bookings that are above cap are reviewed at bi-weekly Vacancy Control Panels. There are still shifts filled over-cap, but this has begun to reduce. • The use of off-framework agencies is not permitted. Any exceptions are to be approved by the Chief Executive Officer. All internal escalation forms have been updated to reflect this.	Reduced agency run rate to achieve financial plan.

Indicator in Focus: Bank Pay

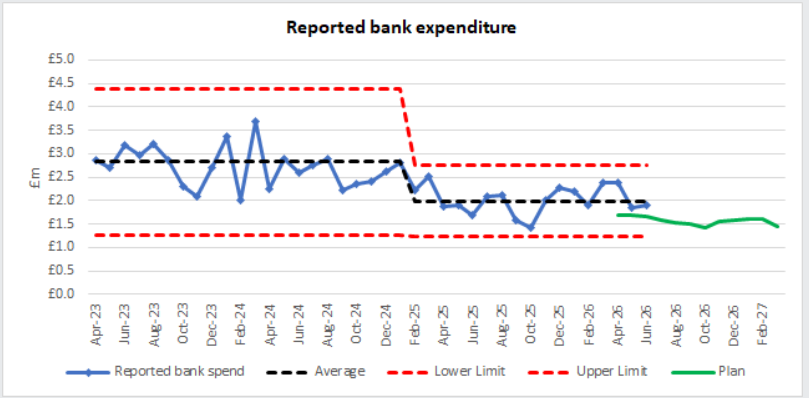
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the planned bank expenditure for 2026/27.
- The Trust reported bank expenditure of £1.9m in Apr-26 and £6.1m year-to-date.
- Our Jun-26 plan was £1.7m; we were £0.3m (15%) over this plan. Year-to-date we are £1.1m over plan (22%)
- Bank expenditure accounted for 6.5% of our total pay bill in 2026/27 quarter one.

Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Our Pay Oversight Group alongside Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required reduction in agency expenditure. • Enhanced financial governance focus on bank spend and compliance at Divisional Performance Reviews. • Divisional bi-weekly divisional and performance group is in place, which includes focus on bank and agency.	Reduced bank run rate to achieve financial plan.

Data



Indicators in Focus: Cash and Liquidity

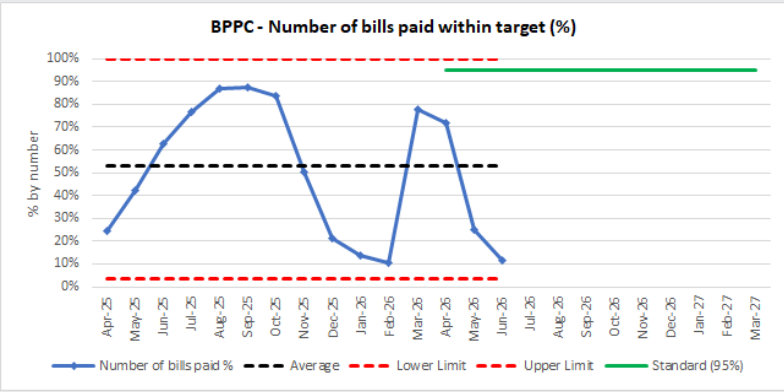
Sherwood Forest Hospitals NHS Foundation Trust

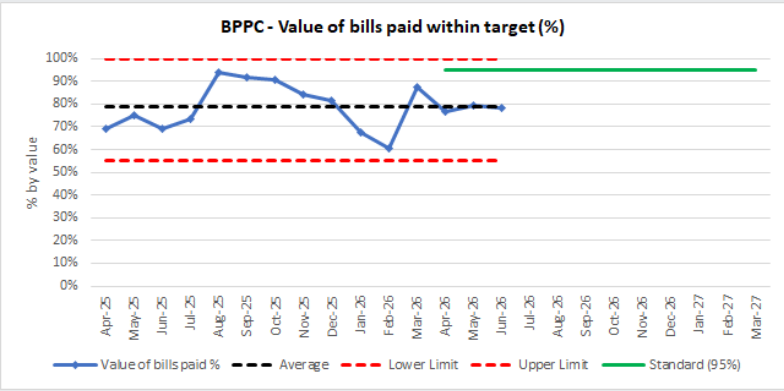
Performance observations

- The standard is the minimum cash balance (£2.8m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of Jun-26, cash in bank was £1.2m, which was below plan and the minimum cash balance.
- The submitted plan for 2026/27 does not require revenue borrowing Public Dividend Capital (PDC). However, the 12-month cash forecast indicates the need for working capital support PDC. In addition, the plan requires £10.4m of capital PDC to support delivery of the capital programme.

Root causes	Actions and timescale	Impact
Standard is the plan and the minimum cash balance required by DHSC of £2.8m as part of our support.	• Management of available cash balances to accounts payable payments due. • Prioritisation matrix of supplier payments agreed at the Trust Management Team. • Submission of working capital PDC application in Jun-26 to support the available cash balance.	• Requirement to ensure minimum balance is met/ maintained. • Risk of disruption to services if suppliers cannot be paid in a timely manner.
Plan requires significant capital PDC in-year of £10.4m to support the 'business as usual' allocation.	• Monthly capital PDC drawdowns to be submitted from Jul-26.	• Extended payment terms to suppliers. • Risk of failure to achieve Better Payment Practice code (BPPC). • Unsupportable capital plan.
Failure to deliver efficiency programme on a cash releasing basis.	• Delivery of efficiency improvement programme, which includes full-year savings in 2026/27 of £34.9m.	• Requirement to submit working capital applications to support payments.

Data





Indicator in Focus: Capital

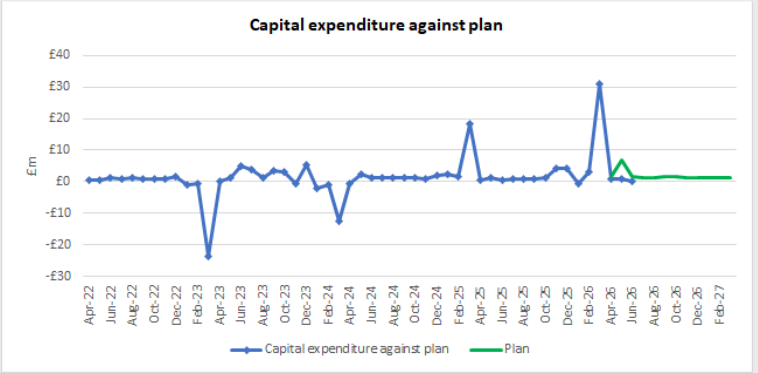
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the 2026/27 Capital Expenditure Plan.
- The plan requires capital borrowing support from the Department of Health and Social Care (DHSC).
- There are known risks due to the value of pre-commitments in the plan.

Root causes	Actions and timescale	Impact
Pre-commitments to Trust priorities limiting business as usual capital.	• Monitoring of spend to ensure pre-commitments deliver within plan.	Delivery of Capital Expenditure Plan.
Requirement for Public Dividend Capital (PDC) to support the plan £10.42m.	• Monthly capital PDC drawdowns to be submitted from July 2026.	Spend impacting available cash to meet revenue payments as drawdown are based on previous month reported spend.
		Overspends impacting other capital delivery requirements.

Data



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Activity Data and Trends (1/2)

Activity (for context)

Based on daily averages

At a Glance	Indicator	May-26	Jun-26		Plan (June 26)
Urgent Care	A&E attendances (inc. PC24)	561	589		≤588
	Non-elective admissions	137	153		≤152
Electives	Average daily elective referrals	302	360		No plan
	Outpatients - first appointment	309	357		≥364
	Outpatients - follow up	716	853		≤878
	Outpatients - procedures	256	308		≥316
	Day case	130	144		≥132
	Elective inpatient	11	13		≥15
Diagnostics	Diagnostics	490	516		≥481

Summary Icon Key

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

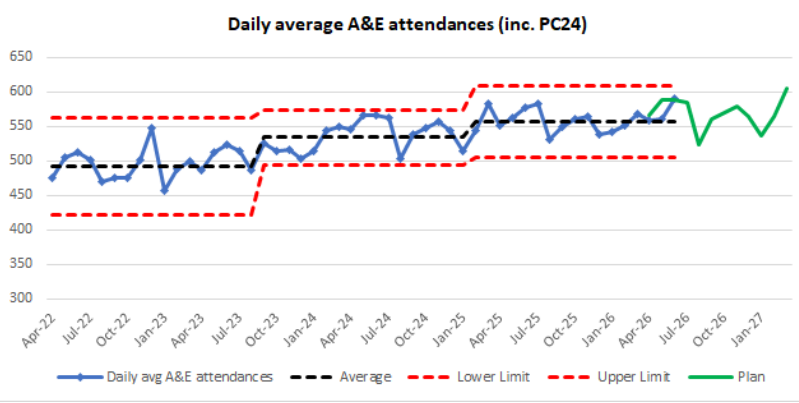
Benchmark Key

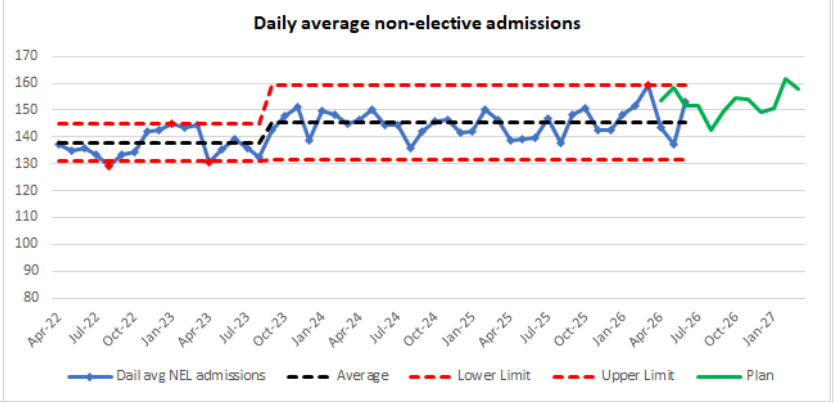
- Best performing 40%
- Middle performing 20%
- Worst performing 40%

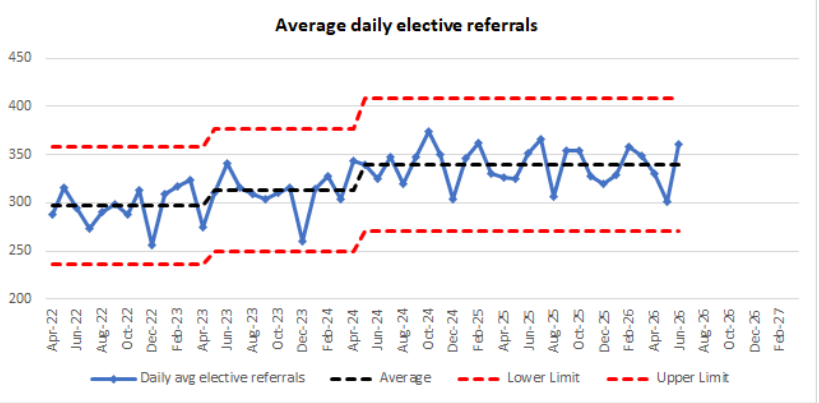
STAR Data Quality Key

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

- Substantial assurance
- Limited assurance







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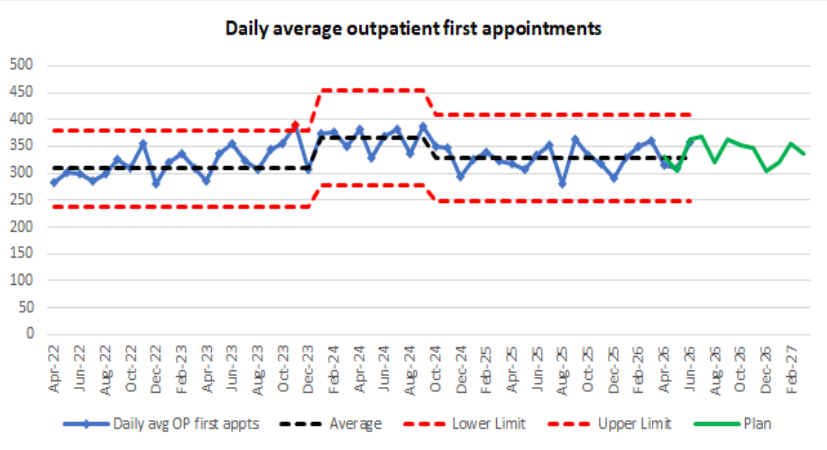
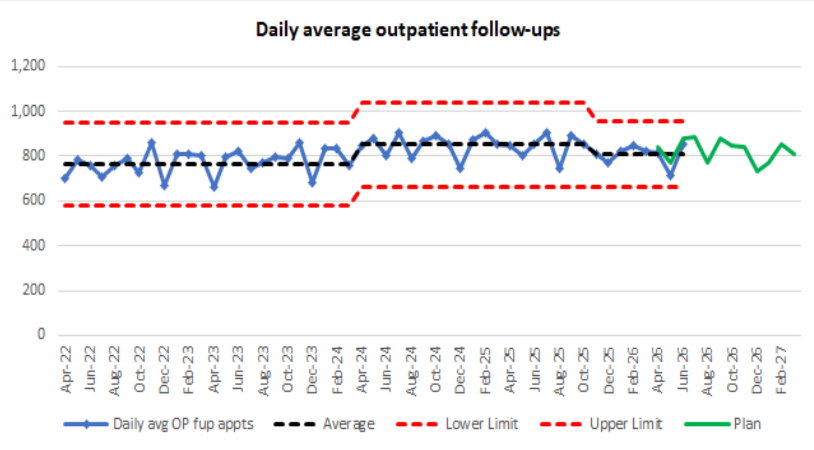
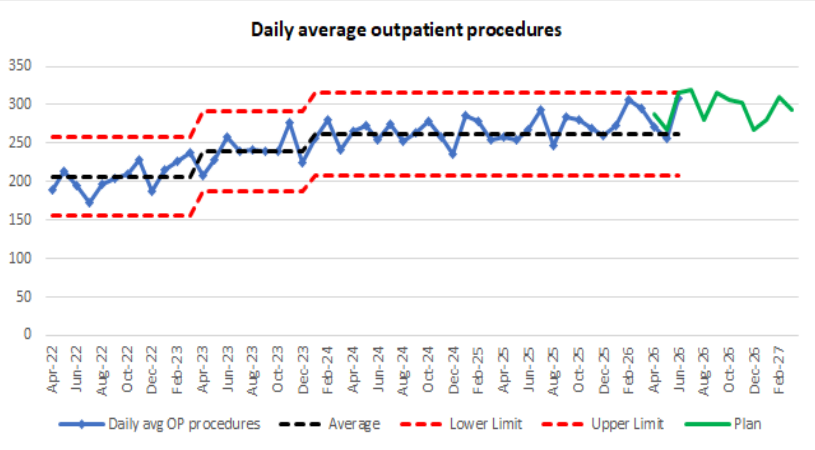
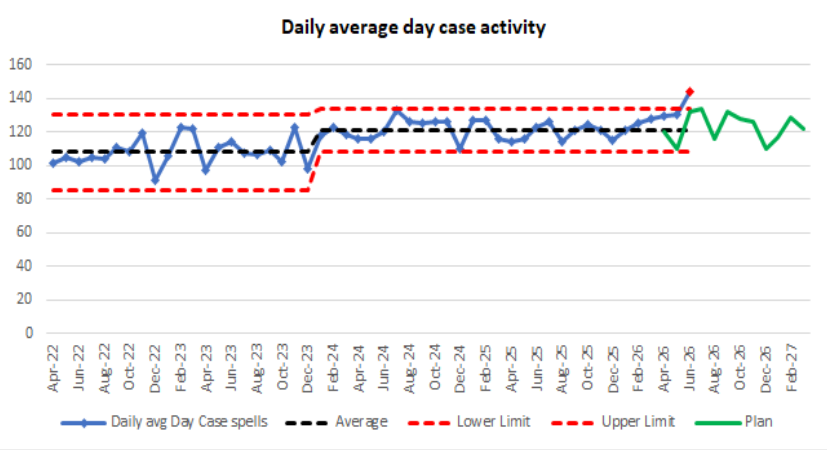
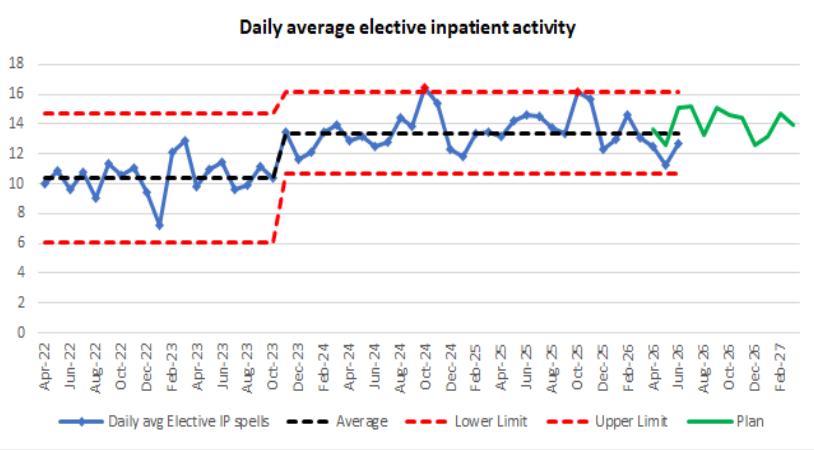
Activity Data and Trends (2/2)

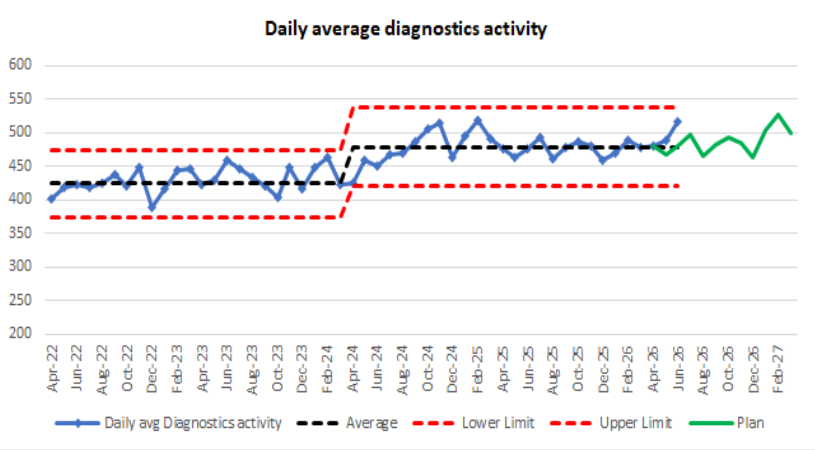












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Appendix A: Integrated Scorecard & Graphs for each indicator

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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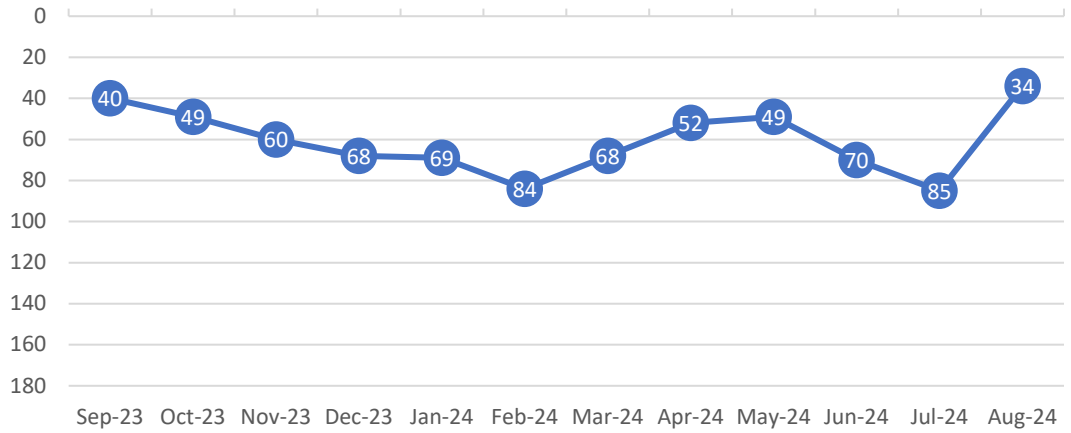
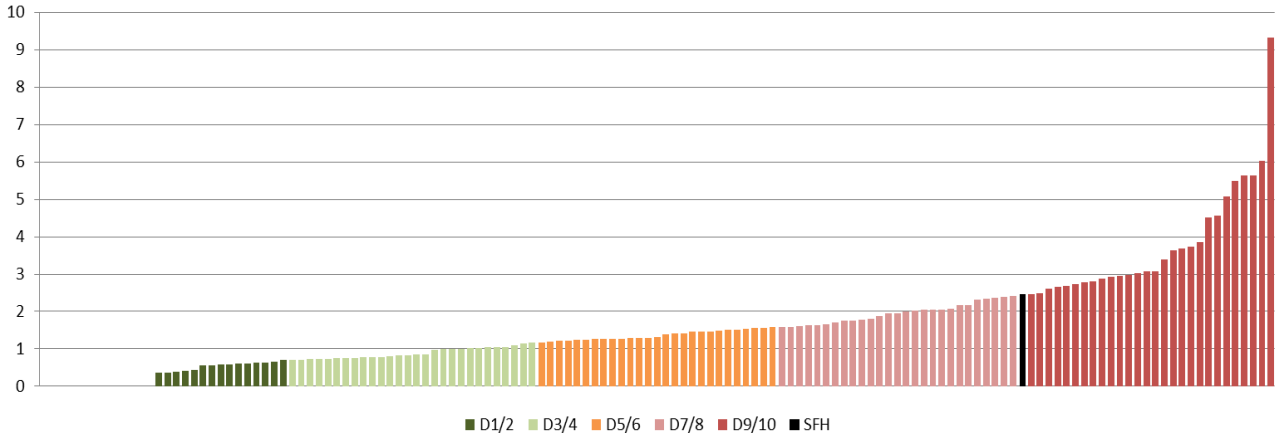
Appendix B: Benchmarking Guidance (2/2)

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

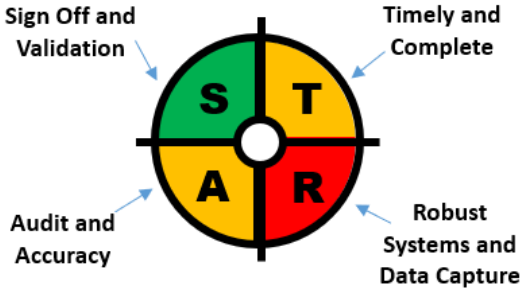
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

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



Integrated Report

Domain	At a Glance	Indicator	May-26	Jun-26	Standard (June 26)	Benchmark	STAR Data Quality
Quality of Care	Safe	Rate of inpatients to suffer a new hip fracture	2.5	2.4	No standard		
		Never events reported in month	0	0	0		
		Hospital-onset MRSA reported in month	0	0	0		
		Rate of c-difficile	0.1	0.2	≤0.3		
		Rate of e-coli	0.3	0.1	≤0.3		
		Number of gram-negative bloodstream infections reported in month	10	7	≤8		
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0.3	0.1	No standard		
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	1	0	0		
		New category 3 or 4 pressure ulcers per 1000 occupied bed days	0.0%	0.0%	0		
		Patient Safety Incident Investigations (PSII) and Duty of Candour	11	4	No standard		
		Percentage of inpatient Service Users undergoing risk assessment for VTE	TBC	TBC	≥95%		
		Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)	38	54	TBC		
	Caring	Complaints per 1000 occupied bed days	1.7	2.2	≤1.9		
		Compliments received in month	109	134	No standard		
	Effective	SHMI	104	107	As expected		
		Still births per 1000 live births	3.3	6.7	≤4.4		
		Early neonatal deaths per 1000 live births	0.0	0.0	≤1		
		30 day readmission rate band	TBC	TBC	TBC		
		14 day readmission rate	9.30%	9.40%	TBC		
People and Culture	Belonging in the NHS	NHS staff survey engagement theme score	-	-	≥6.74	66 / 121	
		National Education and Training Survey satisfaction rate	TBC	TBC	TBC		
		NHS staff standards score	TBC	TBC	TBC		
	Growing the Future	Vacancy rate	10.4%	9.4%	≤9.0%		
		Time to hire	31	33	≤40		
		Turnover in month	0.4%	0.4%	≤0.9%	55 / 118	
		Appraisals	87.3%	87.3%	≥90%		
		Mandatory & statutory training	92.4%	92.3%	≥90%		
		Medical job plan compliance (Consultants)	98.9%	99.6%	≥95%		
		Medical job plan compliance (SAS Doctors)	99.2%	99.2%	≥95%		
	Looking after our People	Sickness absence	4.5%	5.0%	≤4.2%	52 / 118	
		Flu vaccinations uptake (front line staff)	-	-	≥56.9%		
		Employee relations management	21	22	<24		
	New Ways of Working	Bank usage	5.9%	6.0%	≤5.3%	119 / 195	
		Agency usage	2.5%	2.6%	<1.5%	158 / 193	
		Agency (off framework)	0.0%	0.0%	0%		
		Agency (over price cap)	34.3%	38.1%	≤40.0%		

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

June 2026 (Qtr 1)

Integrated Report

Domain	At a Glance	Indicator	May-26	Jun-26	Standard (June 26)	Benchmark	STAR Data Quality
Timely Care	Urgent Care	Average ambulance handover time (mins)	26	27	≤20	▲ 4 / 15	
		Percentage of ambulance handovers within 15 minutes	23.8%	22.0%	≥66.0%	▼ 125 / 174	
		Percentage of ambulance handovers within 45 minutes	86.6%	85.9%	100%	▲ 5 / 15	
		ED 4-hour performance	64.1%	63.5%	≥79.0%	▼ 124 / 140	
		ED 12-hour length of stay performance	7.0%	8.1%	≤2.1%	▬ 83 / 177	
		ED 24-hour length of stay performance	0.5%	0.7%	0%		
		Number of ED patients cared for in corridors for over 45 minutes	TBC	TBC	0%		
		Adult G&A bed occupancy	95.9%	97.0%	≤96.2%	▬ 80 /177	
		Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base	57	82	≤40		
		Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base	1757	2454	≤1200		
	Electives	Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment	64.7%	64.8%	≥64.7%	▬ 88 / 148	
		Percentage of RTT waits over 52 weeks for incomplete pathways	1.1%	1.2%	≤1.0%	▬ 77 / 148	
	Diagnostics	Diagnostic DM01 performance under 6-weeks	87.5%	88.8%	≥91.6%	▲ 45 / 135	
	Cancer	Cancer 28-day faster diagnosis standard	81.6%	-	≥80.4%	▲ 49 / 127	
		Cancer 31-day treatment performance	99.2%	-	≥90.8%	▲ 26 / 134	
		Cancer 62-day treatment performance	61.1%	-	≥74.4%	▼ 112 / 130	
Best Value Care	Financial Performance	Financial surplus / deficit	-£1.68	-£4.29	≥-0.49		
		Variance YTD to financial plan	£0.08	-£3.80	≥£0.00m		
	Efficiency	Financial efficiency variance YTD to plan	-£0.79	-£0.39	≥£0.00m		
		Risk adjusted efficiency forecast to plan (%)	53.0%	56.0%	100%		
		Relative cost difference (National Cost Collection Index)	103	103	TBC		
		Implied productivity growth (YTD compared to last year)	-	-	TBC		
	Variable Pay	Reported agency expenditure	£0.78	£0.82	≤£0.46		
		Reported bank expenditure	£1.84	£1.91	≤£1.66		
		Temporary staffing cost relative band	TBC	TBC	≤7.0%		
	Cash & Liquidity	BPPC - Number of bills paid within target (%)	25.0%	11.8%	≥95%		
		BPPC - Value of bills paid within target (%)	79.6%	78.1%	≥95%		
		Operating expenditure days	1	1	≥5		
	Capital	Capital expenditure against plan	£0.86	£0.32	≤1.53		
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	561	589	≤588		
		Non-elective admissions	137	153	≤152		
	Electives	Average daily elective referrals	302	360	No plan		
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Integrated Performance Report 2026/27

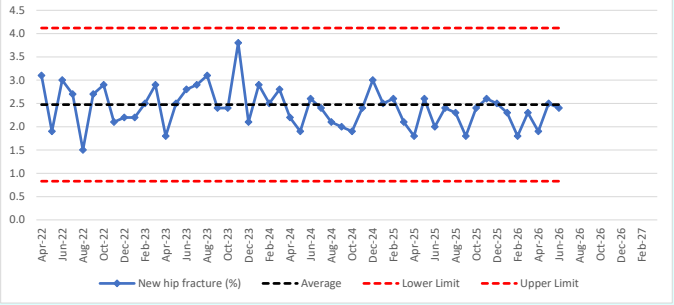
June 2026 (Qtr 1)

Cover Page | Definitions

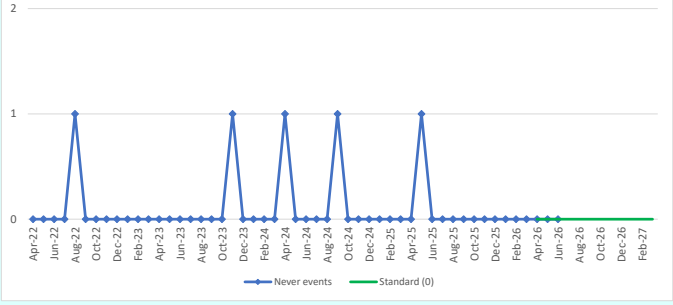
Charts

Quality of Care

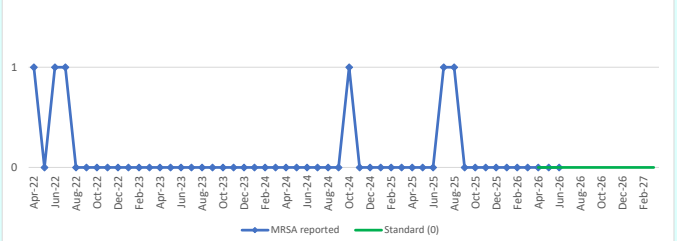
Rate of inpatients to suffer a new hip fracture



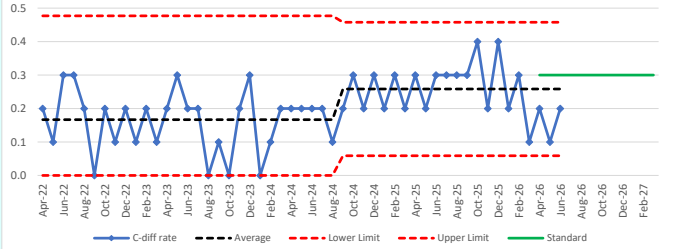
Never events reported in month



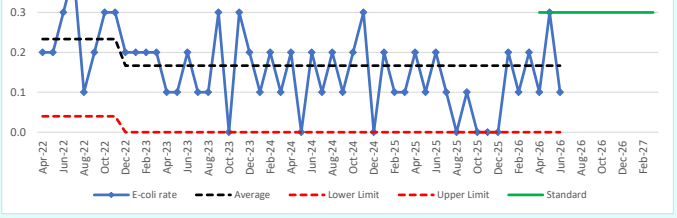
Hospital-onset MRSA reported in month



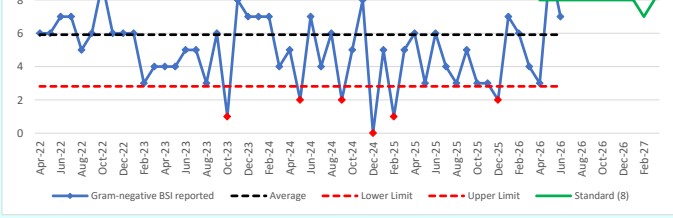
Rate of c-difficile



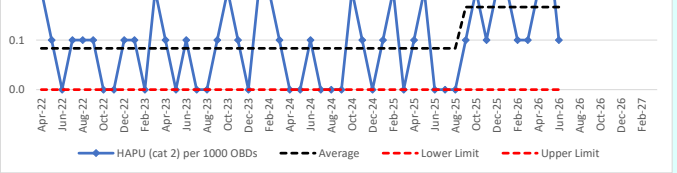
Rate of e-coli



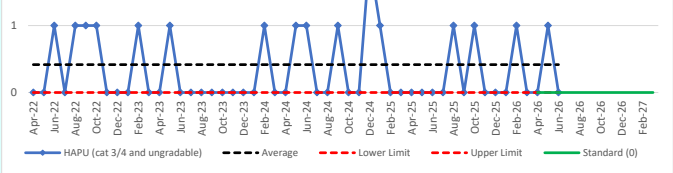
Number of gram-negative bloodstream infections reported in month



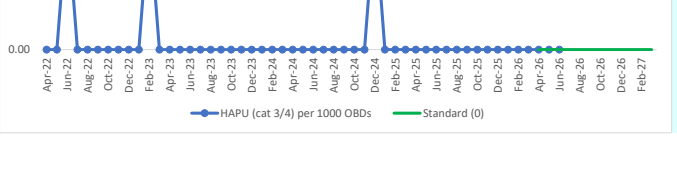
HAPU (cat 2) per 1000 occupied bed days with a lapse in care



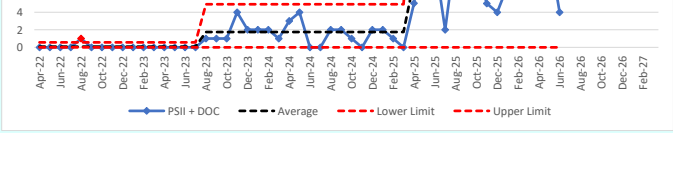
HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care

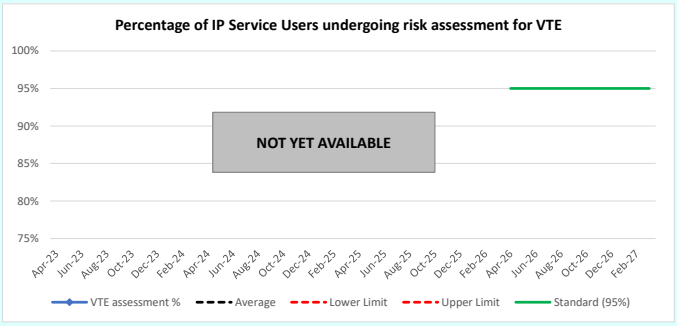


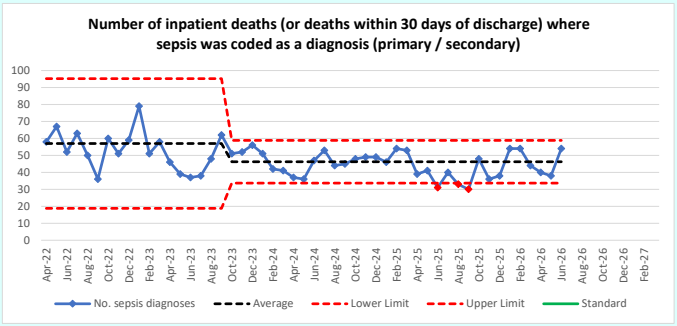
New category 3 or 4 pressure ulcers per 1000 occupied bed days

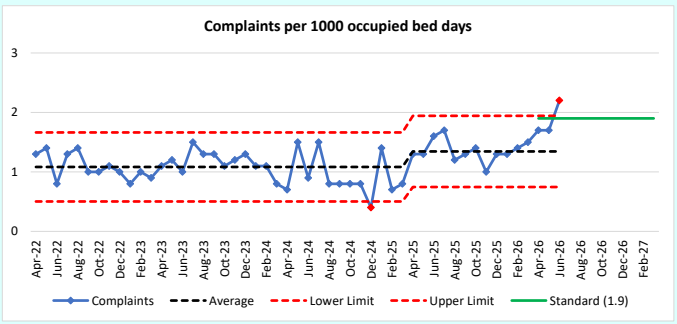


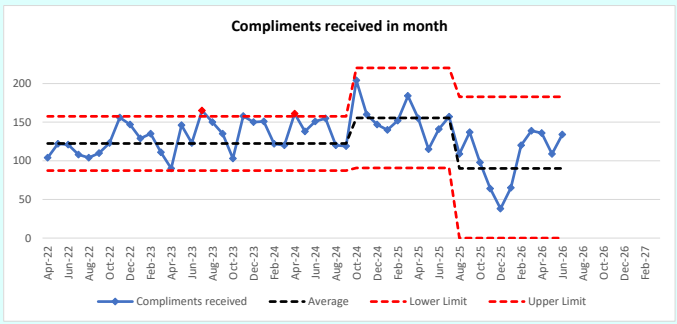
Patient Safety Incident Investigations (PSII) + Duty of Candour (from April 2025)

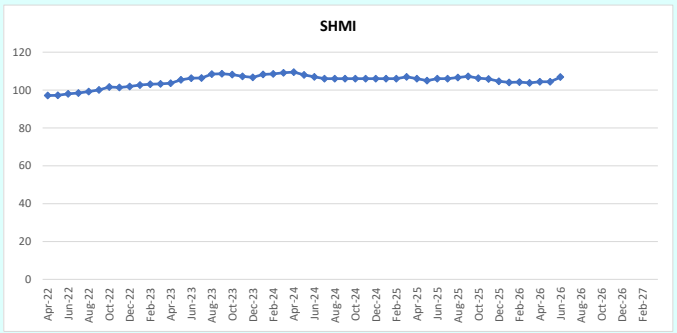


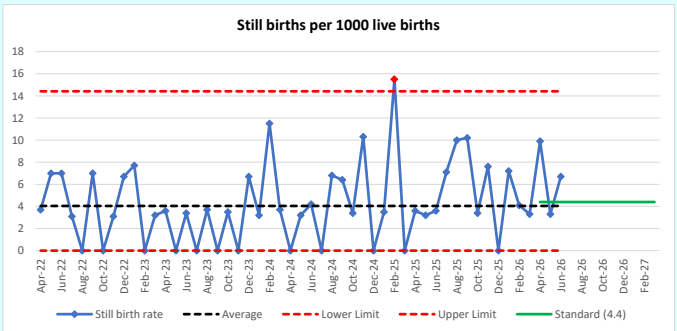

Percentage of IP Service Users undergoing risk assessment for VTE
NOT YET AVAILABLE
VTE assessment %
Average
Lower Limit
Upper Limit
Standard (95%)

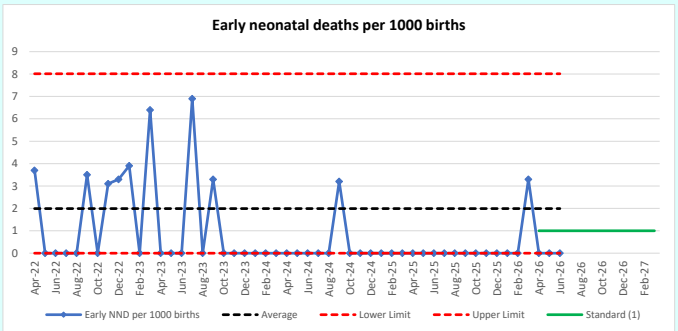

Number of inpatient deaths (or deaths within 30 days of discharge) where sepsis was coded as a diagnosis (primary / secondary)
No. sepsis diagnoses
Average
Lower Limit
Upper Limit
Standard

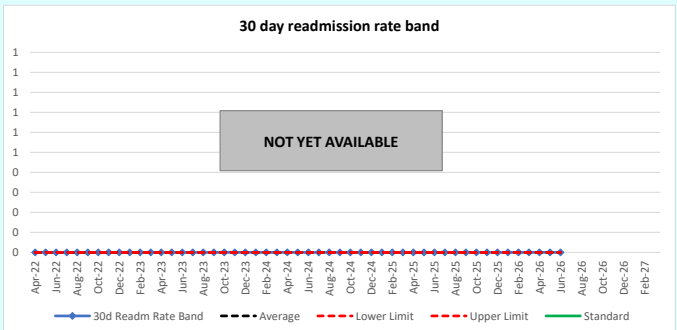

Complaints per 1000 occupied bed days
Complaints
Average
Lower Limit
Upper Limit
Standard (1.9)

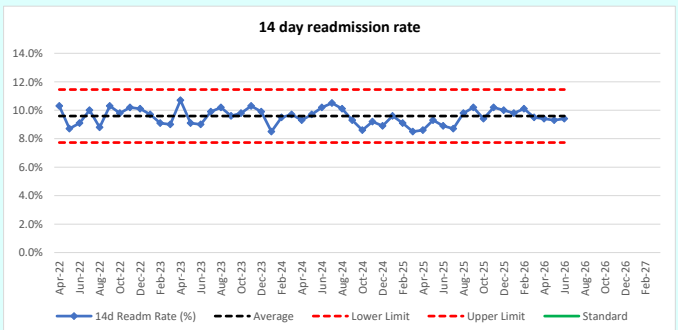

Compliments received in month
Compliments received
Average
Lower Limit
Upper Limit


SHMI


Still births per 1000 live births
Still birth rate
Average
Lower Limit
Upper Limit
Standard (4.4)

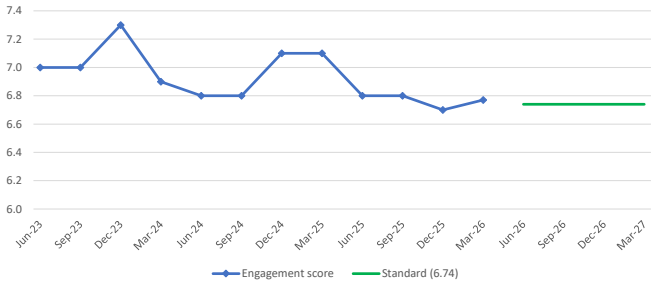

Early neonatal deaths per 1000 births
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard (1)


30 day readmission rate band
NOT YET AVAILABLE
30d Readm Rate Band
Average
Lower Limit
Upper Limit
Standard

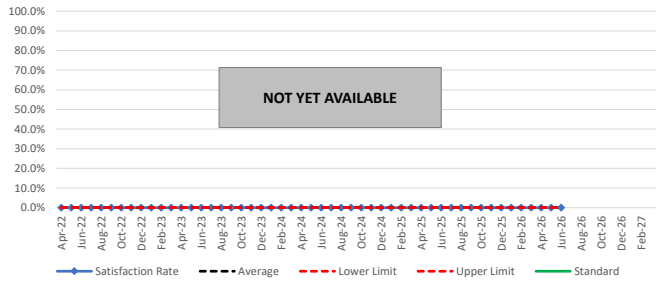

14 day readmission rate
14d Readm Rate (%)
Average
Lower Limit
Upper Limit
Standard

People and Culture

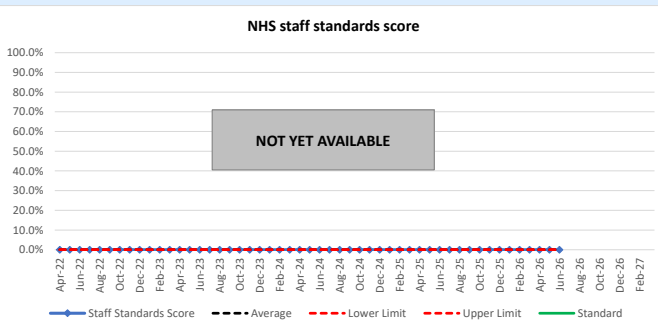
NHS staff survey engagement theme score



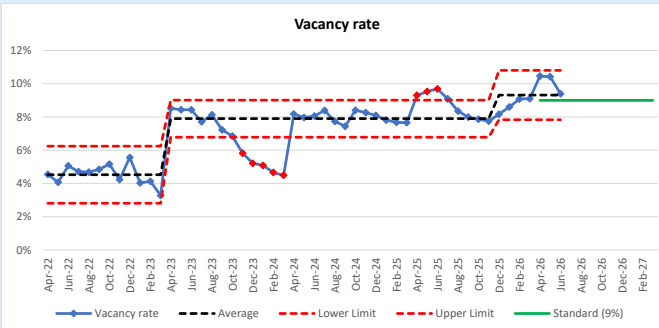
National Education and Training Survey satisfaction rate



NHS staff standards score

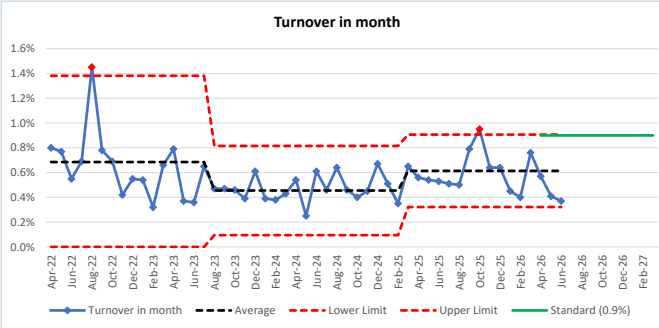


Vacancy rate

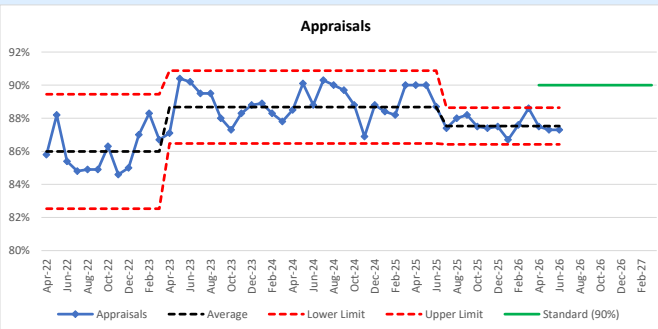


Time to hire

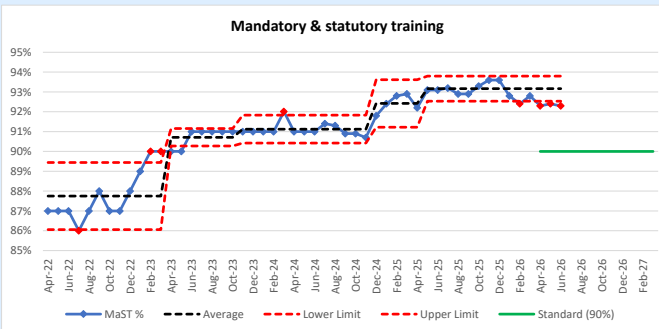
Turnover in month

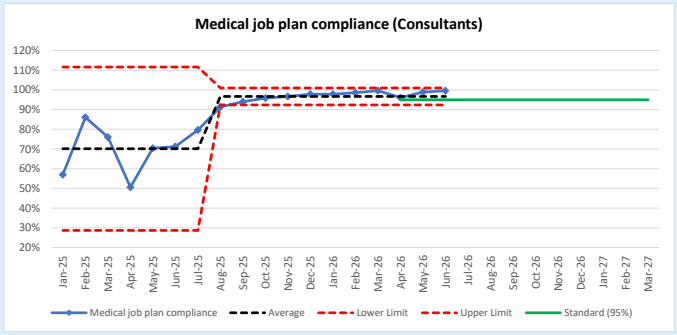


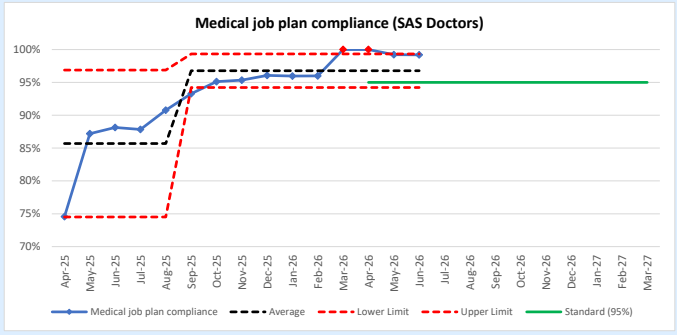
Appraisals

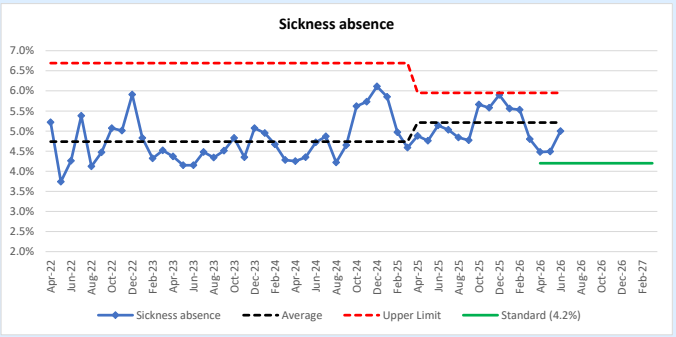


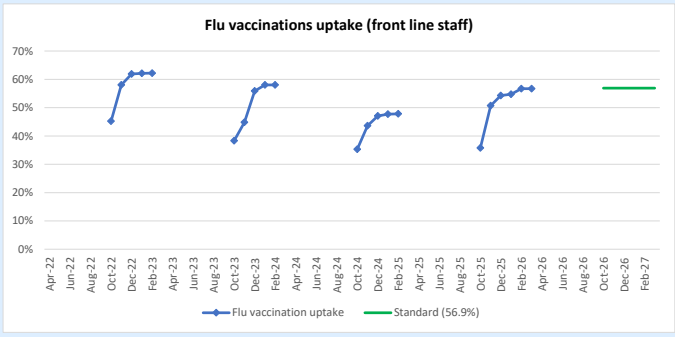
Mandatory & statutory training

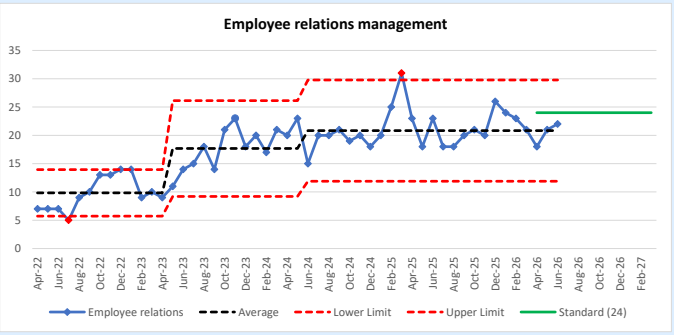


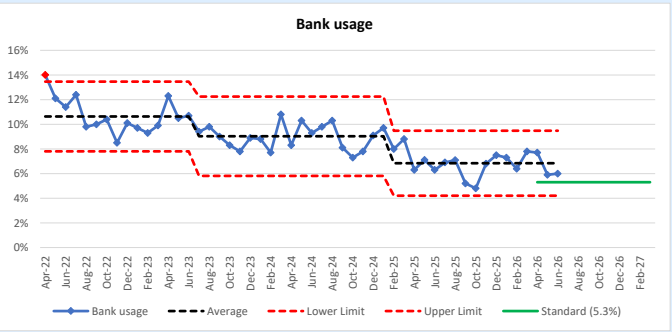

Medical job plan compliance (Consultants)
Medical job plan compliance
Average
Lower Limit
Upper Limit
Standard (95%)

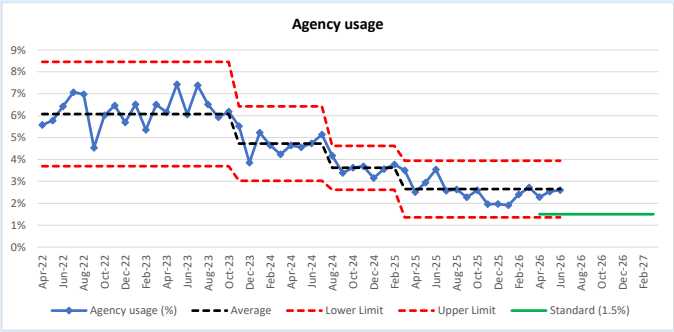

Medical job plan compliance (SAS Doctors)
Medical job plan compliance
Average
Lower Limit
Upper Limit
Standard (95%)

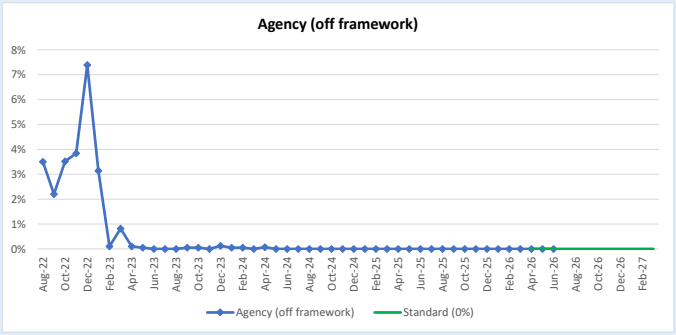

Sickness absence
Sickness absence
Average
Upper Limit
Standard (4.2%)

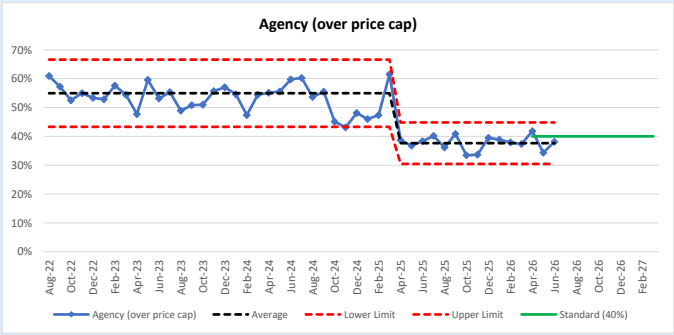

Flu vaccinations uptake (front line staff)
Flu vaccination uptake
Standard (56.9%)


Employee relations management
Employee relations
Average
Lower Limit
Upper Limit
Standard (24)


Bank usage
Bank usage
Average
Lower Limit
Upper Limit
Standard (5.3%)

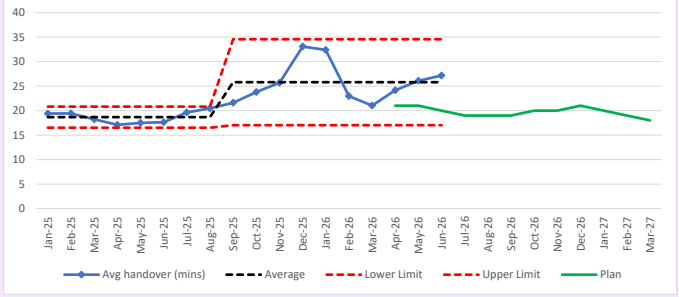

Agency usage
Agency usage (%)
Average
Lower Limit
Upper Limit
Standard (1.5%)


Agency (off framework)
Agency (off framework)
Standard (0%)

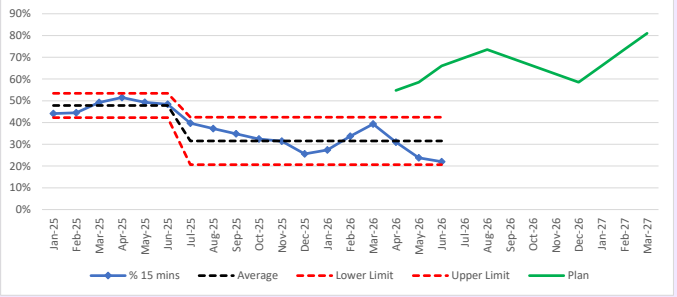

Agency (over price cap)
Agency (over price cap)
Average
Lower Limit
Upper Limit
Standard (40%)

Timely Care

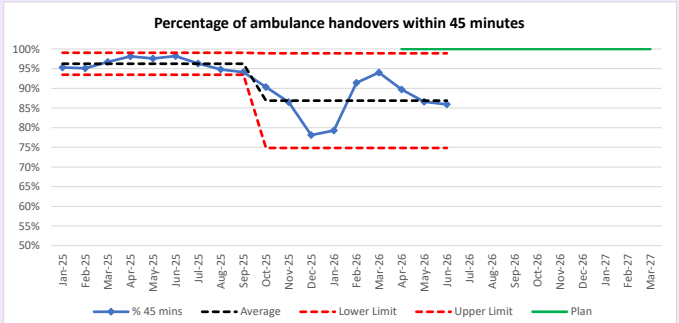
Average ambulance handover time (mins)



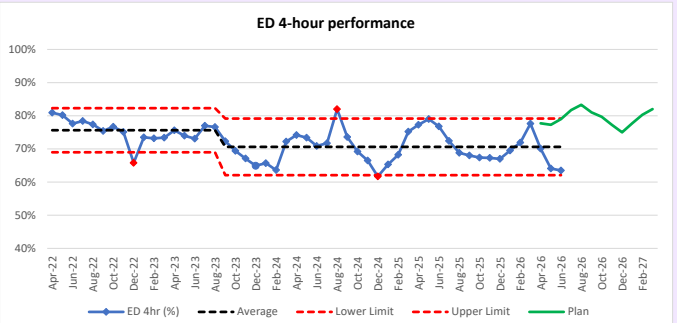
Percentage of ambulance handovers within 15 minutes



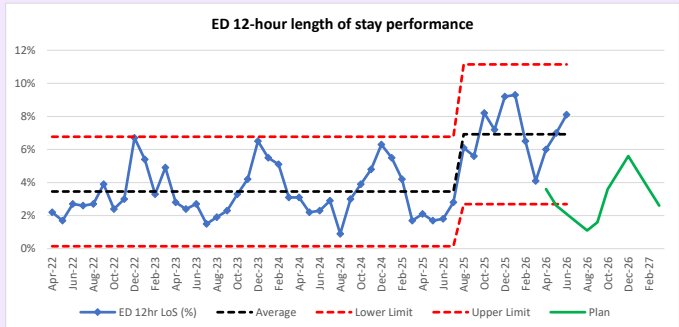
Percentage of ambulance handovers within 45 minutes



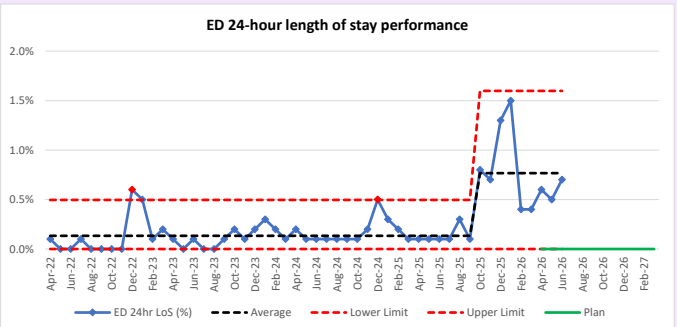
ED 4-hour performance



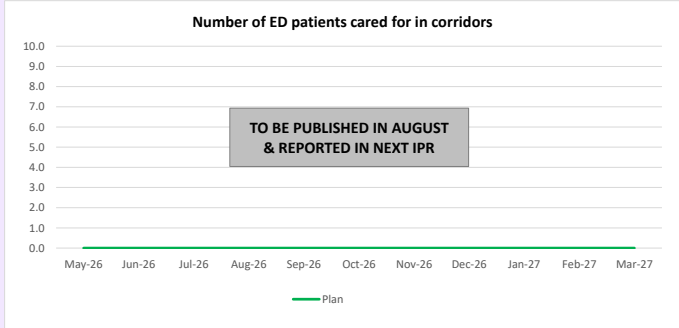
ED 12-hour length of stay performance



ED 24-hour length of stay performance

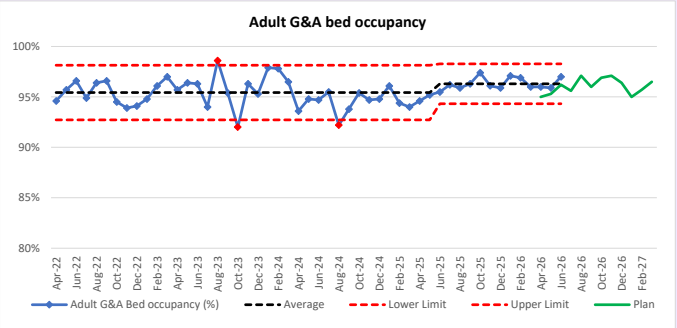


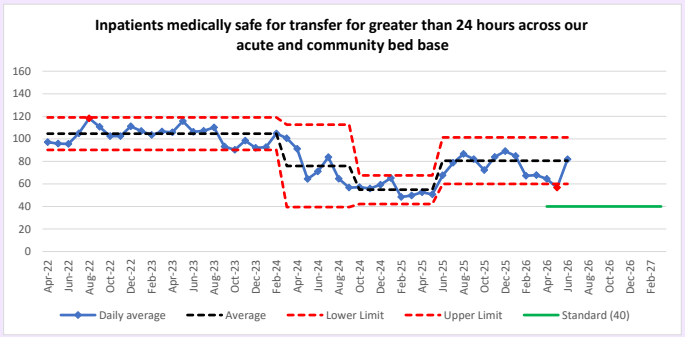
Number of ED patients cared for in corridors

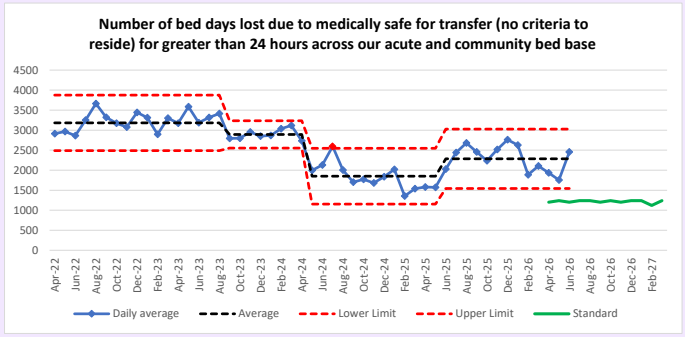


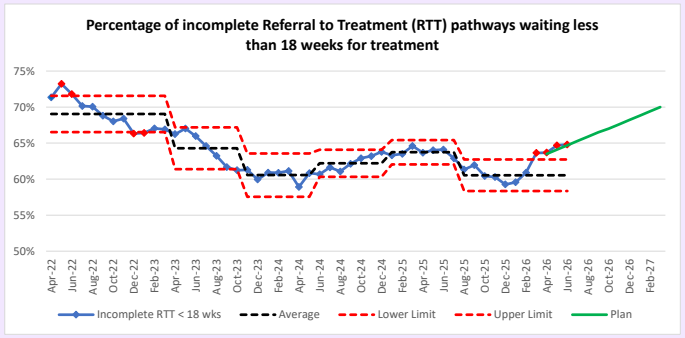
TO BE PUBLISHED IN AUGUST & REPORTED IN NEXT IPR

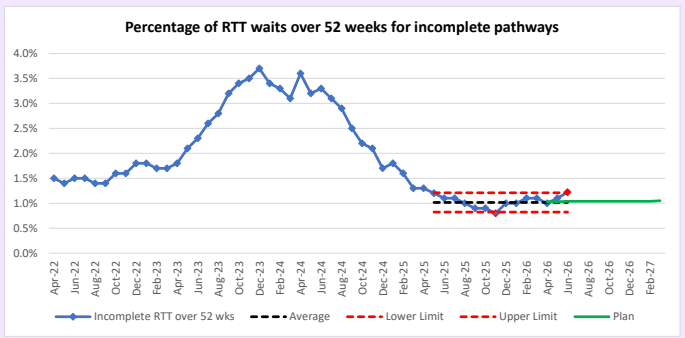
Adult G&A bed occupancy

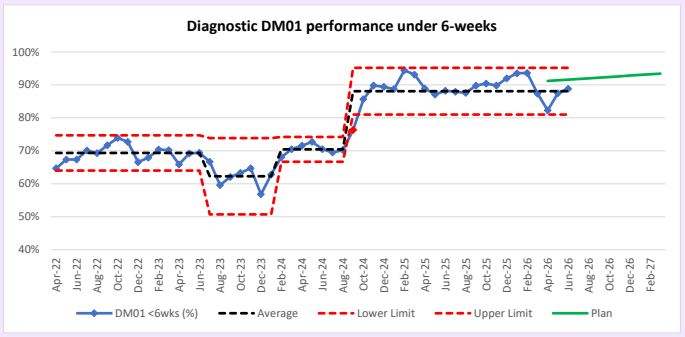


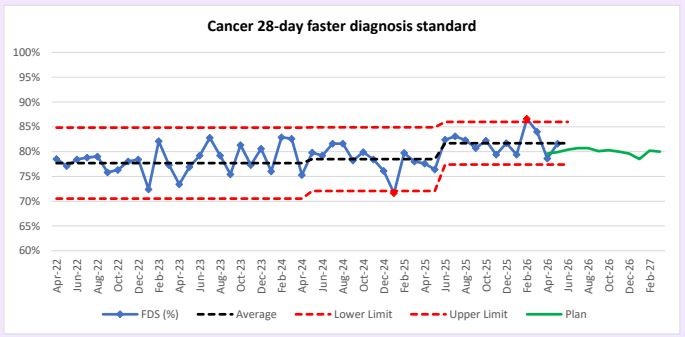

Inpatients medically safe for transfer for greater than 24 hours across our acute and community bed base
Daily average
Average
Lower Limit
Upper Limit
Standard (40)

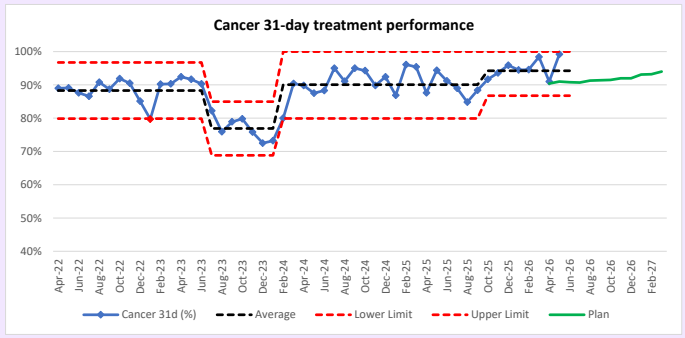

Number of bed days lost due to medically safe for transfer (no criteria to reside) for greater than 24 hours across our acute and community bed base
Daily average
Average
Lower Limit
Upper Limit
Standard

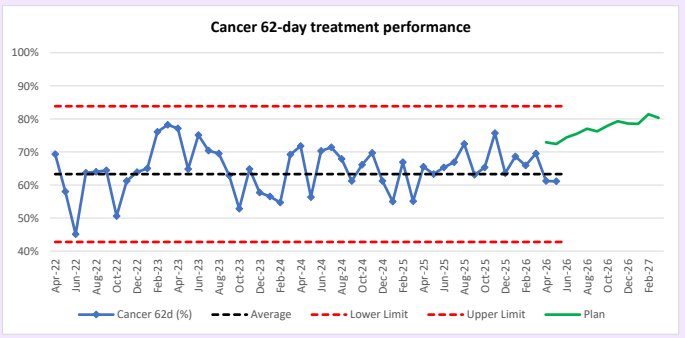

Percentage of incomplete Referral to Treatment (RTT) pathways waiting less than 18 weeks for treatment
Incomplete RTT < 18 wks
Average
Lower Limit
Upper Limit
Plan


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


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

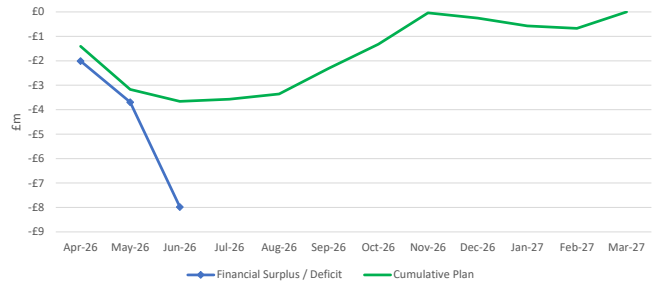

Cancer 28-day faster diagnosis standard
FDS (%)
Average
Lower Limit
Upper Limit
Plan


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

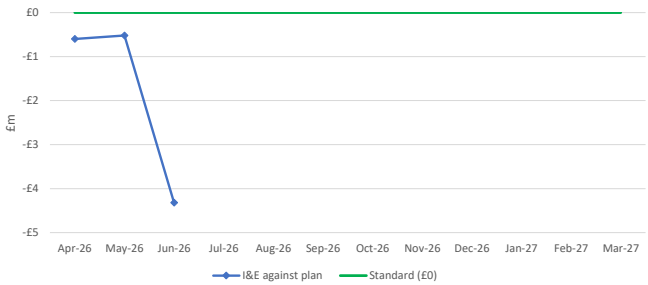

Cancer 62-day treatment performance
Cancer 62d (%)
Average
Lower Limit
Upper Limit
Plan

Best Value Care

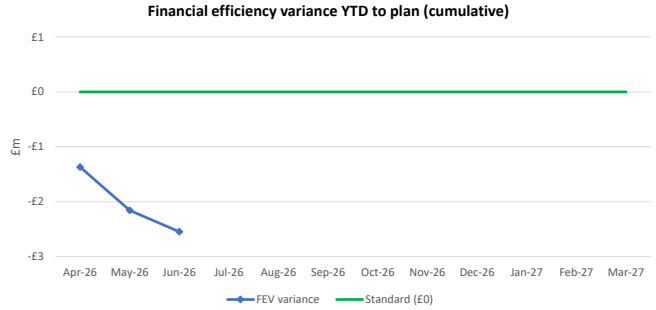
Financial Surplus / Deficit (cumulative)



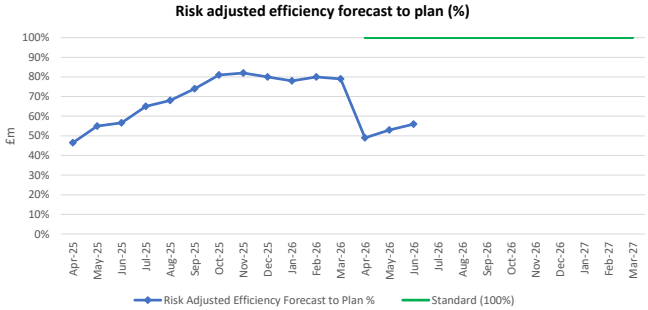
Variance YTD to financial plan (cumulative)



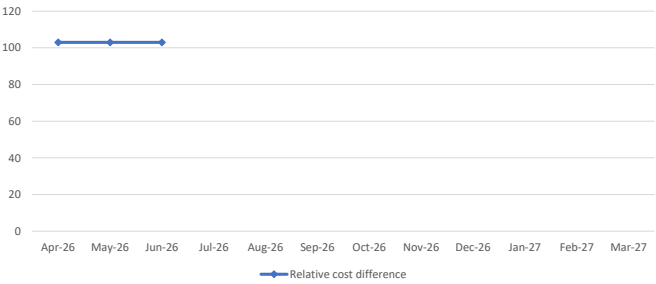
Financial efficiency variance YTD to plan (cumulative)



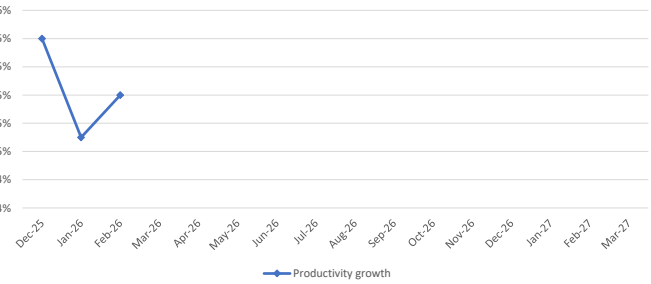
Risk adjusted efficiency forecast to plan (%)



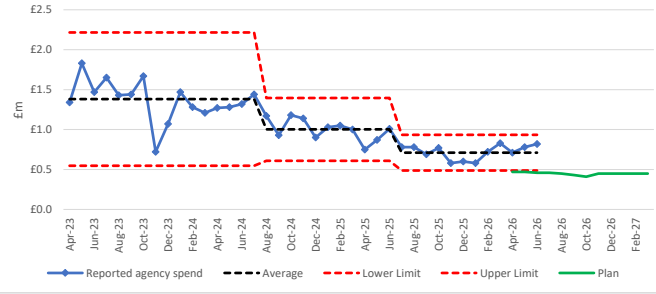
Relative cost difference (National Cost Collection Index)



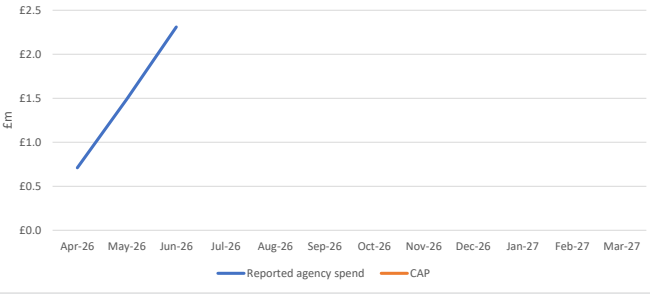
Implied productivity growth (YTD compared to last year)

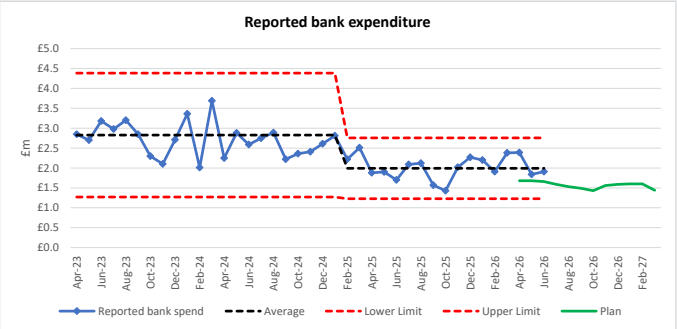


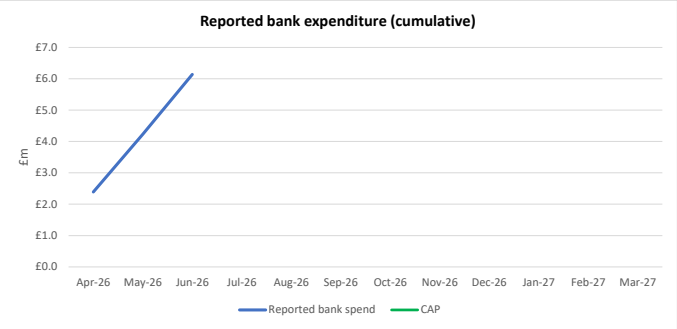
Reported agency expenditure

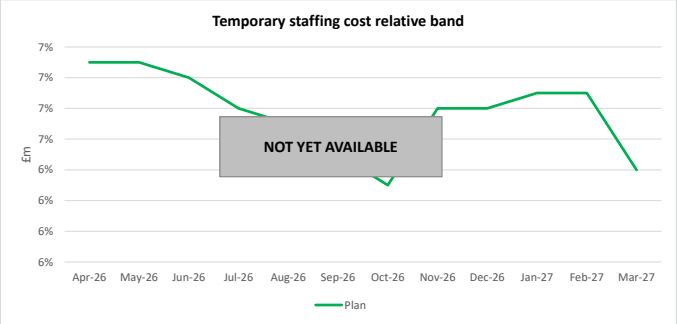


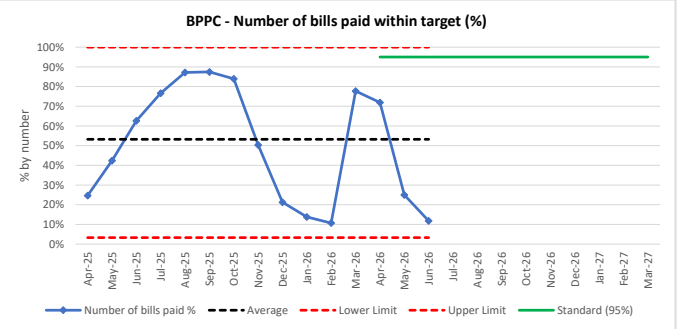
Reported agency expenditure (cumulative)

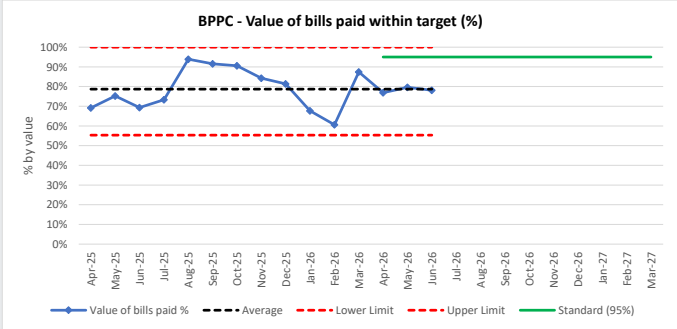


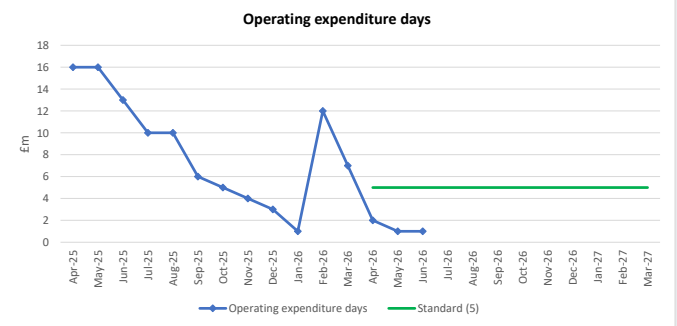

Reported bank expenditure
£m
Reported bank spend
Average
Lower Limit
Upper Limit
Plan

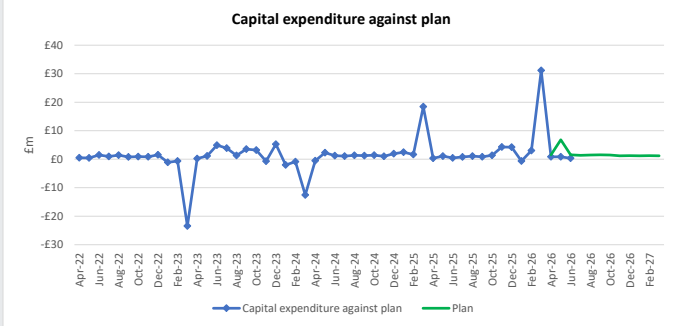

Reported bank expenditure (cumulative)
£m
Reported bank spend
CAP


Temporary staffing cost relative band
£m
NOT YET AVAILABLE
Plan


BPPC - Number of bills paid within target (%)
% by number
Number of bills paid %
Average
Lower Limit
Upper Limit
Standard (95%)

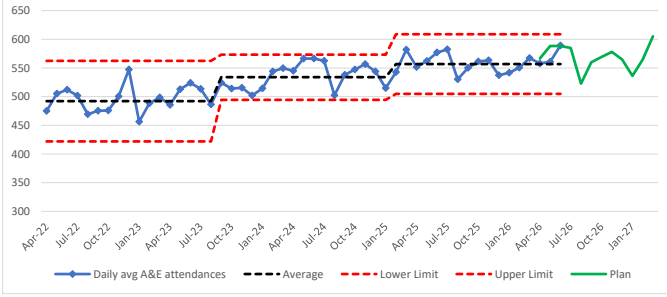

BPPC - Value of bills paid within target (%)
% by value
Value of bills paid %
Average
Lower Limit
Upper Limit
Standard (95%)


Operating expenditure days
£m
Operating expenditure days
Standard (5)

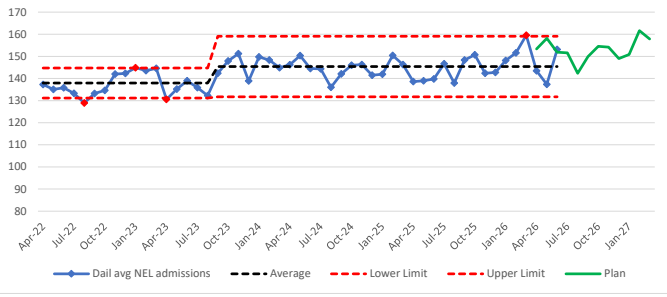

Capital expenditure against plan
£m
Capital expenditure against plan
Plan

Activity (for context)

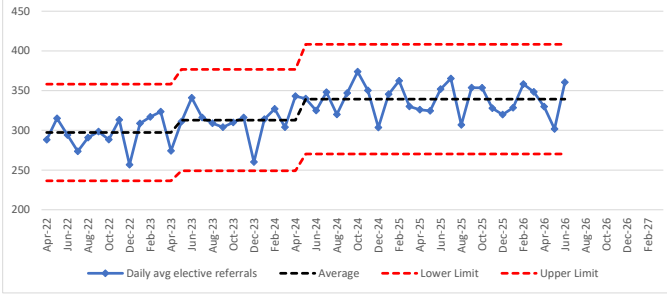
Daily average A&E attendances (inc. PC24)



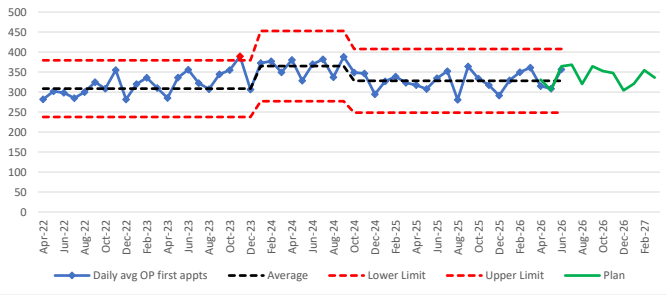
Daily average non-elective admissions



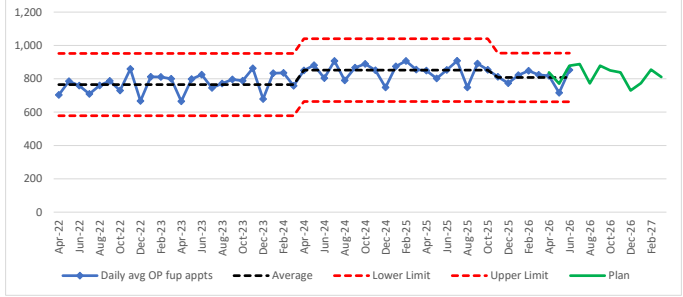
Average daily elective referrals



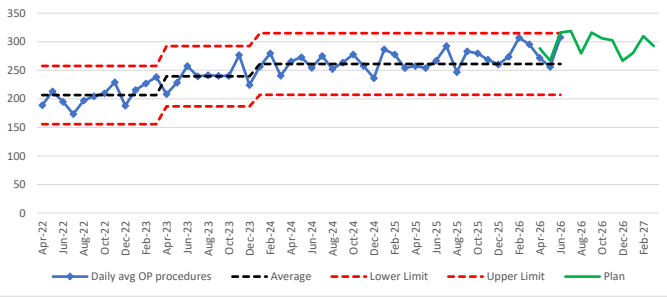
Daily average outpatient first appointments



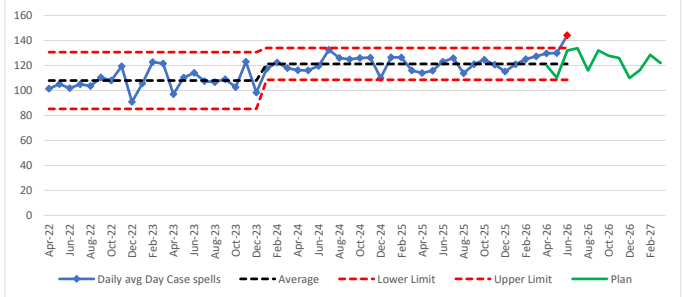
Daily average outpatient follow-ups



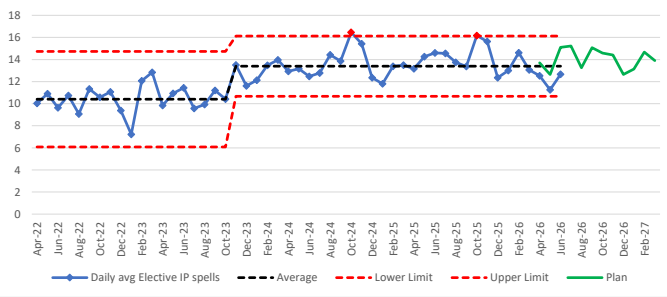
Daily average outpatient procedures



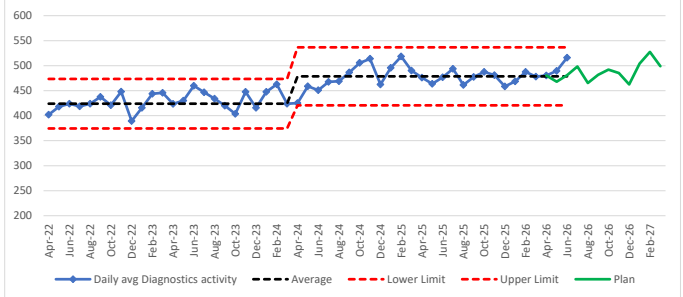
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

June 2026 (Qtr 1)

Cover Page | Charts | Definitions | P+C Scorecard | P+C Benchmarking Charts

People & Culture Benchmarking

Apr-26

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period
Belonging	Engagement Score	NHS Staff Survey	6.7	66	121	6	2025
Growing the future	Turnover in month	NHS Hospital and Community Health Services (HCHS) monthly workforce statistics	0.9%	55	118	5	Apr-26
Looking after our People	Sickness absence	NHS Sickness Absence Rates	4.9%	52	118	5	Mar-26
New Ways of Working	Bank usage	Model Hospital	7.3%	119	195	7	Feb-26
	Agency usage	Model Hospital	1.9%	158	193	9	Feb-26

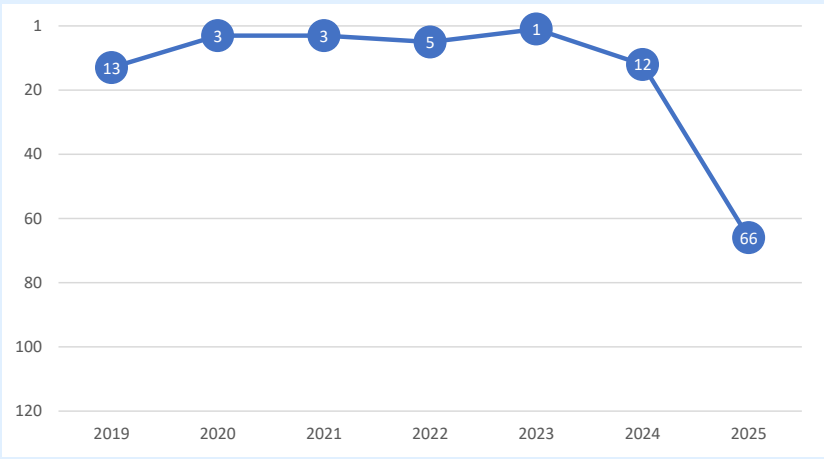
Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

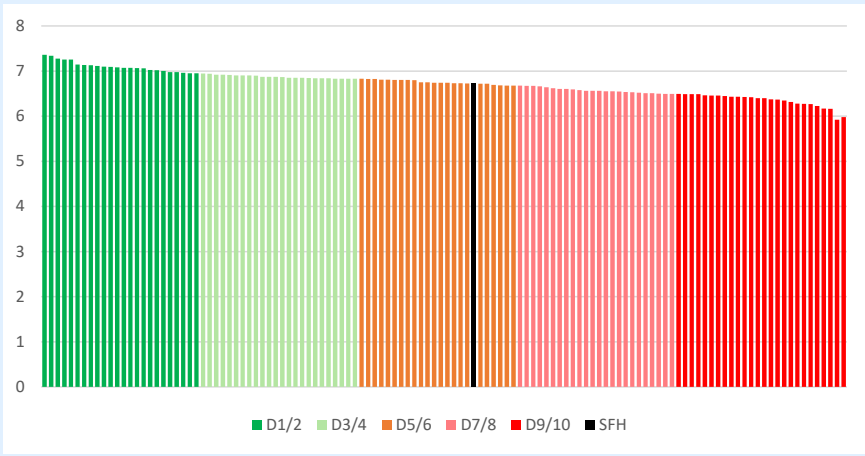
June 2026 (Qtr 1)

People + Culture Benchmarking

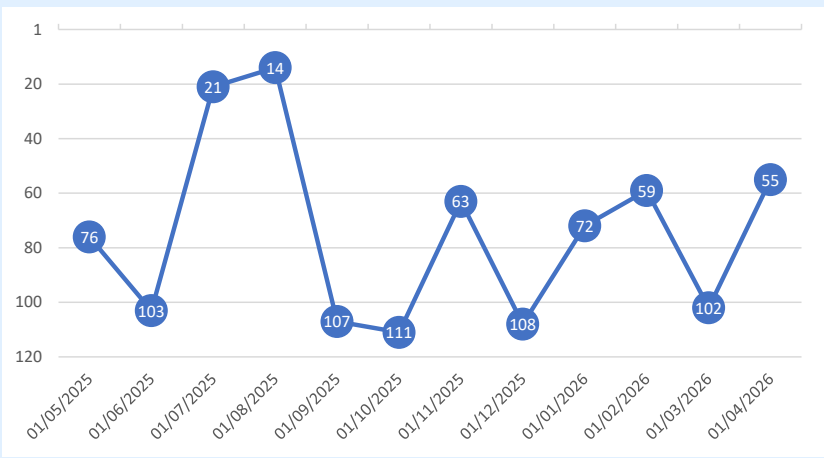
Overall Staff Engagement (NSS)



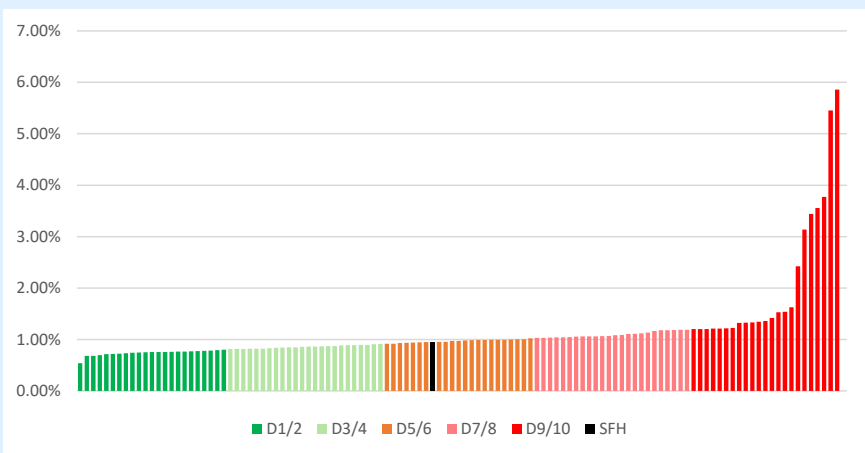
2025 Position



Turnover in month

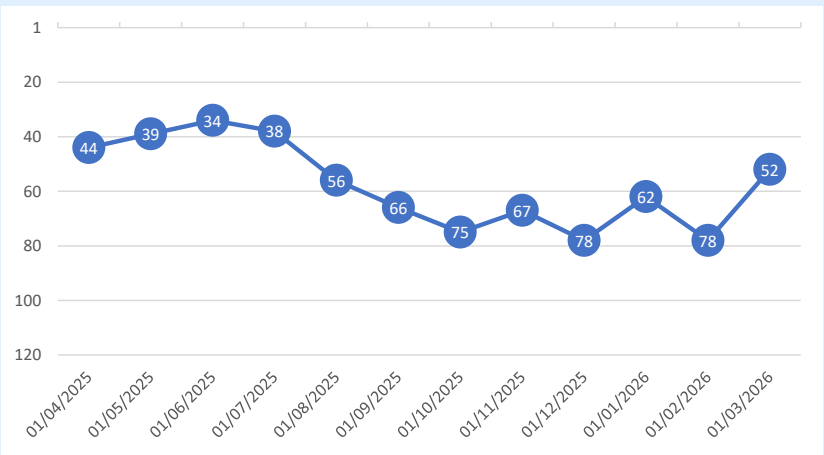


Apr-26 Position

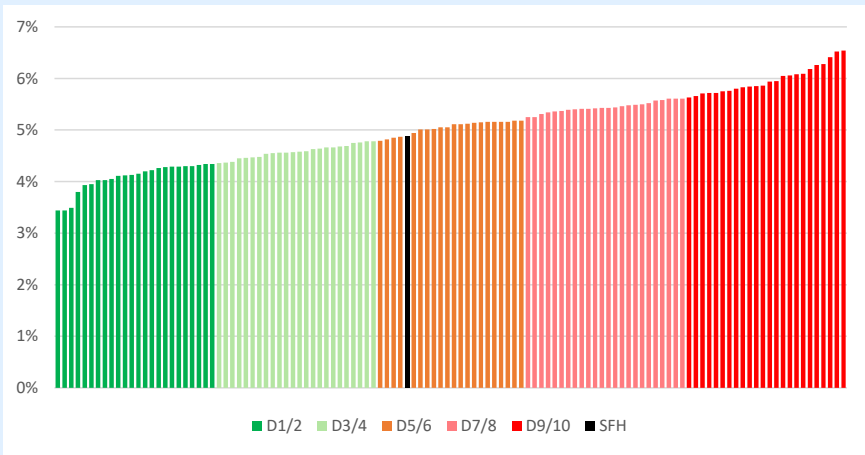


NB: Benchmark not published for March 25

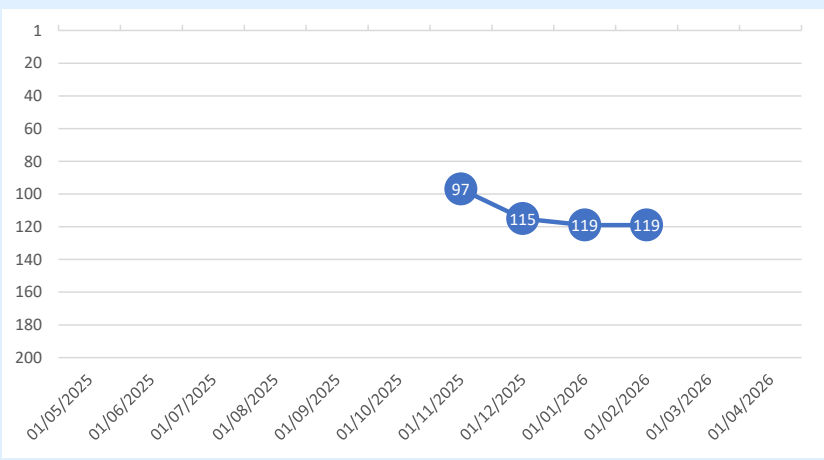
Sickness Absence



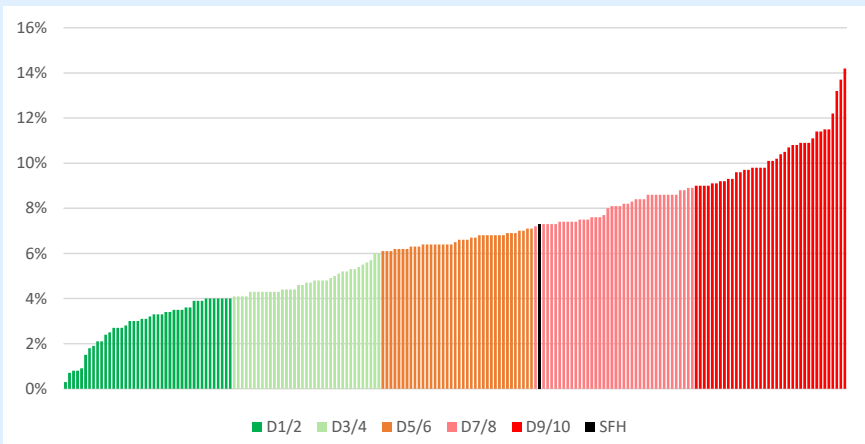
Mar-26 Position



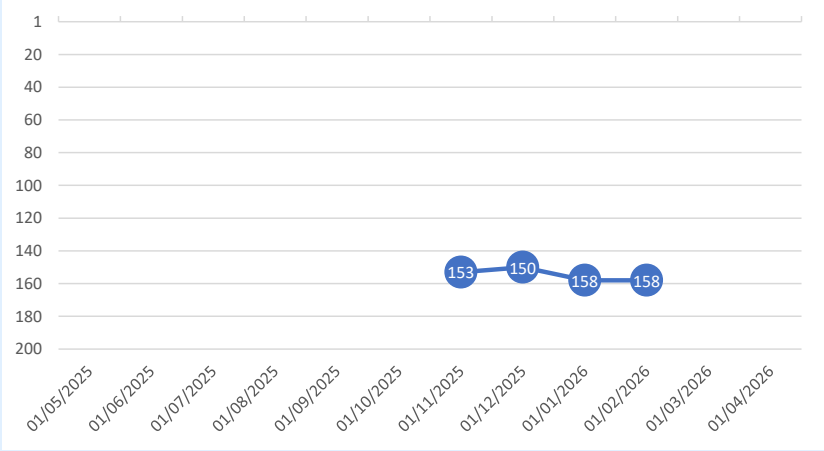
Bank usage



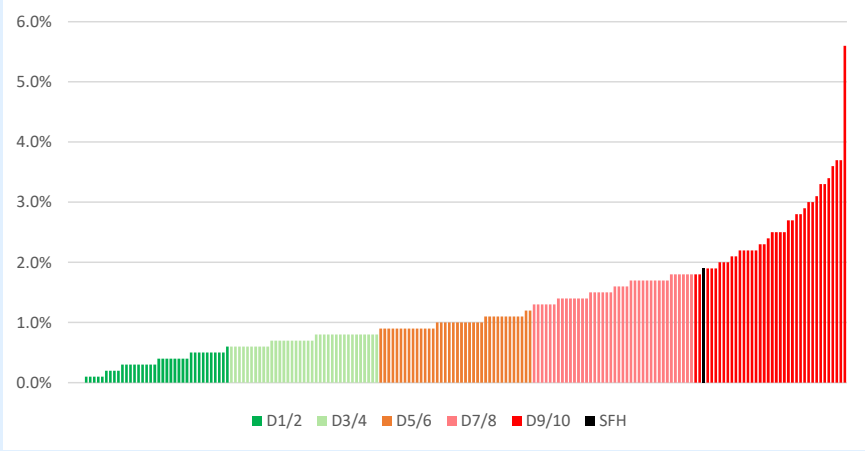
Feb-26 position



Agency usage



Feb-26 position



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

June 2026 (Qtr 1)

Cover Page | Charts | Definitions | TC Scorecard | TC Benchmarking Charts

Timely Care Benchmarking

May-26

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period
Urgent Care	Ambulance turnaround times <15 mins	Summary Emergency Department Indicator Table (SEDIT)	24.1%	125	174	8	May-26
	Average ambulance handover time (mins)	EMAS Handover and Turnaround Report	00:26:06	4	15	1	May-26
	Percentage of ambulance handovers within 45 minutes	EMAS Handover and Turnaround Report	86.6%	5	15	1	May-26
	ED 4-hour performance	A&E Attendances & Emergency Admission monthly statistics	64.1%	124	140	9	May-26
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	10.1%	83	177	5	May-26
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	94.2%	80	177	5	May-26
Electives	Elective RTT 18-Week Performance	RTT waiting times data	64.7%	88	148	6	May-26
	Incomplete RTT pathways +52 weeks	RTT waiting times data	1.1%	77	148	6	May-26
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	87.5%	45	135	4	May-26
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	81.6%	49	127	4	May-26
	Cancer 31-day treatment performance	Cancer Waiting Times standards	99.2%	26	134	2	May-26
	Cancer 62-day treatment performance	Cancer Waiting Times standards	61.1%	112	130	9	May-26

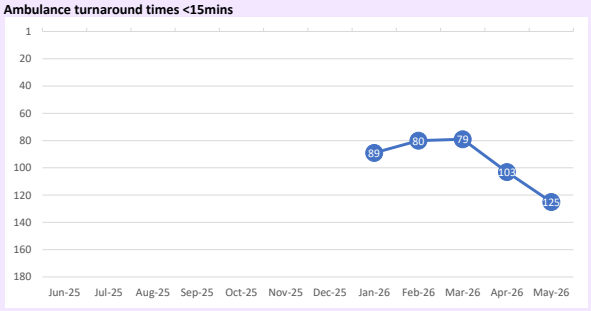
Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2026/27

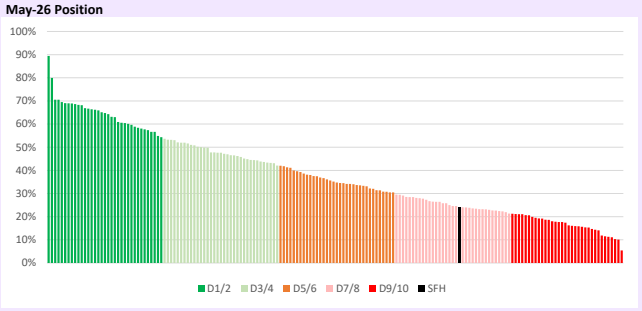
June 2026 (Qtr 1)

Timely Care Benchmarking

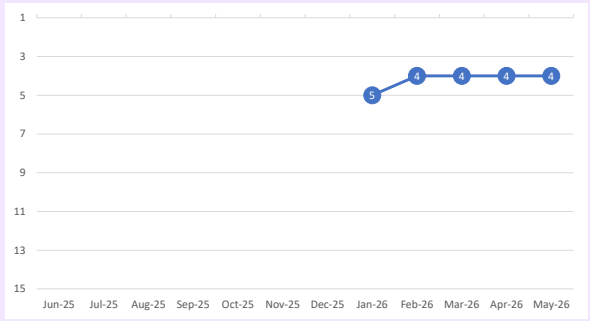
Ambulance turnaround times <15mins



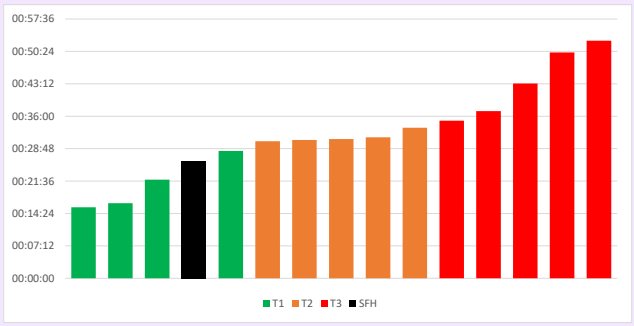
May-26 Position



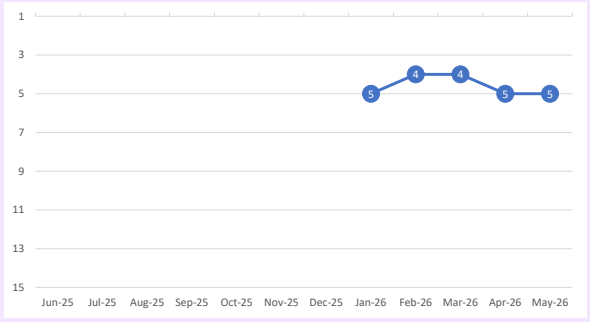
Average ambulance handover time (mins) - Local Benchmarks only, data sourced from EMAS



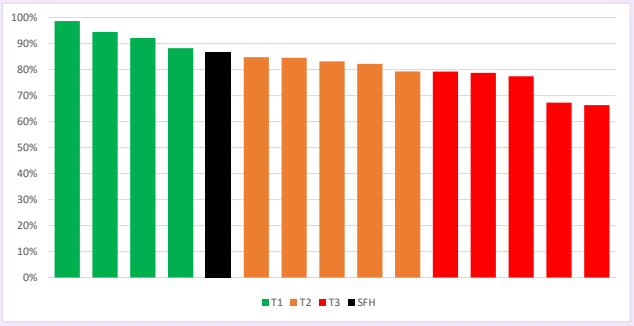
May-26 Position



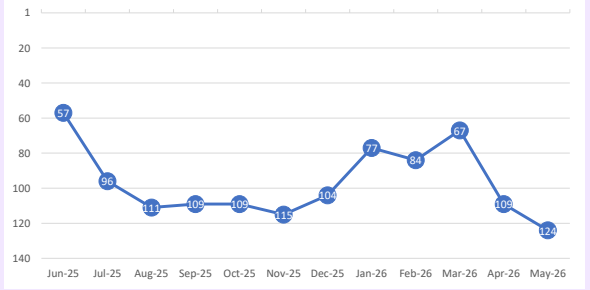
Percentage of ambulance handovers within 45 minutes - Local Benchmarks only, data sourced from EMAS



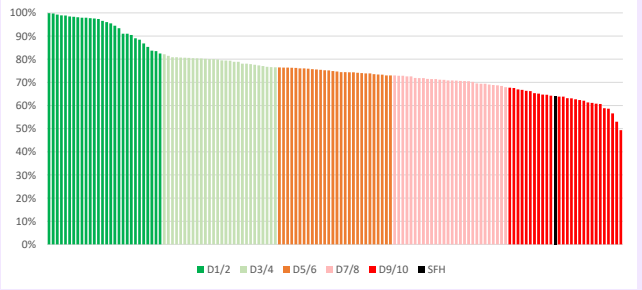
May-26 Position



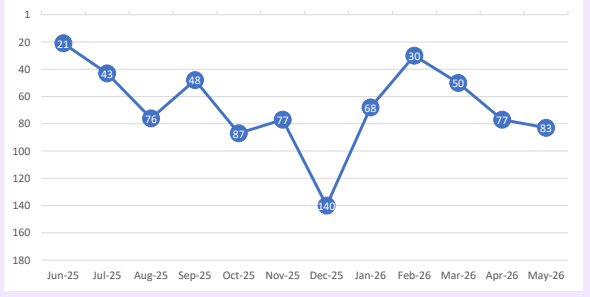
ED 4-hour performance



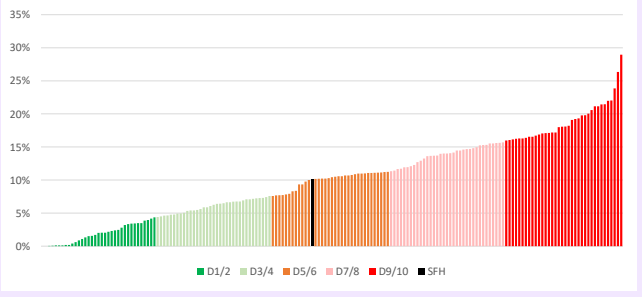
May-26 Position



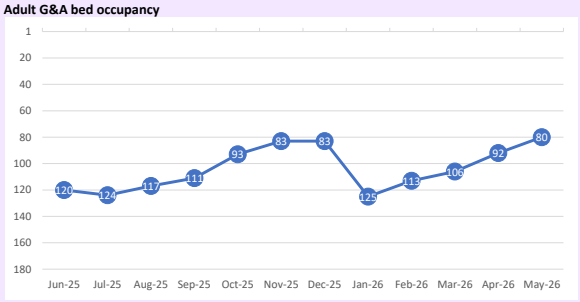
ED 12-hour length of stay performance



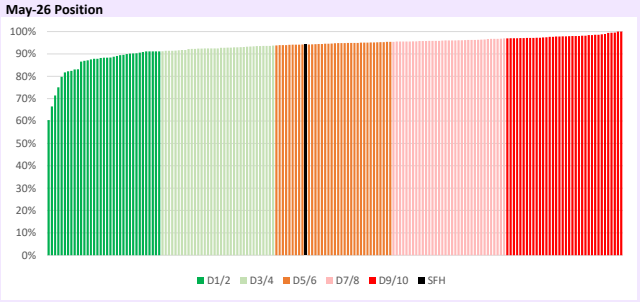
May-26 Position



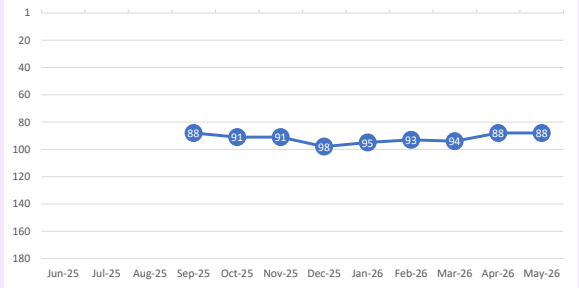
Adult G&A bed occupancy



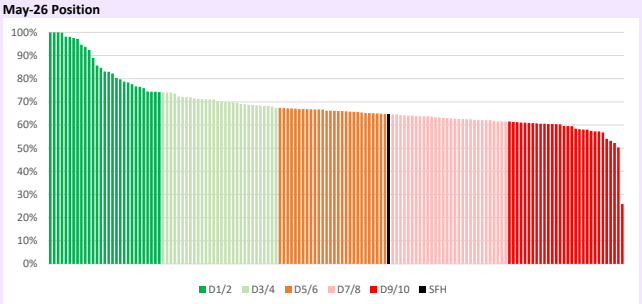
May-26 Position



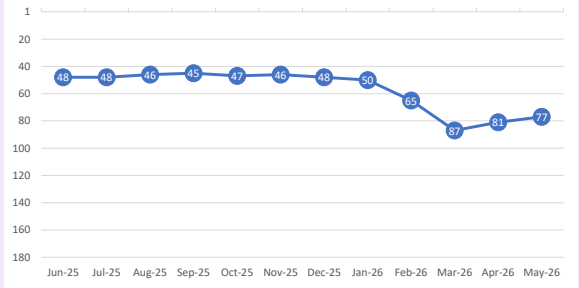
Elective RTT 18-Week Performance



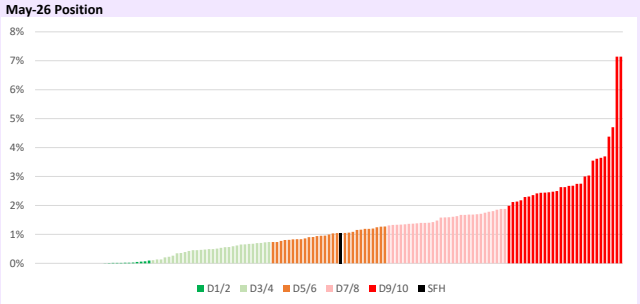
May-26 Position



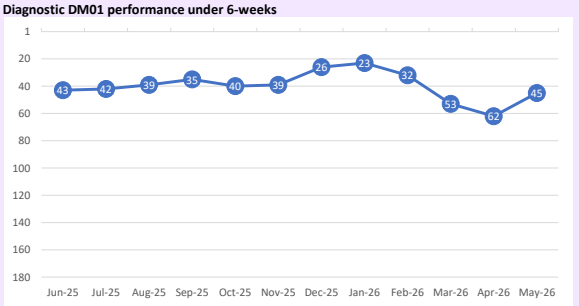
Incomplete RTT pathways +52 weeks



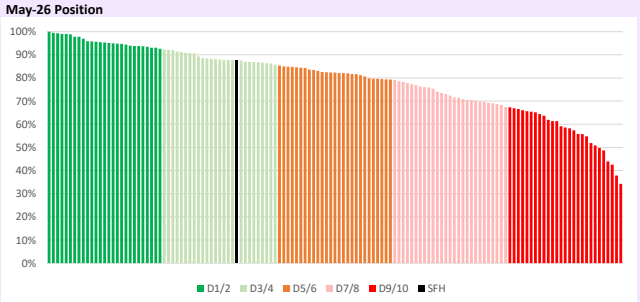
May-26 Position



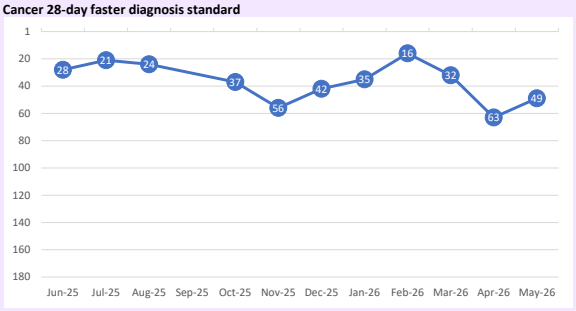
Diagnostic DM01 performance under 6-weeks



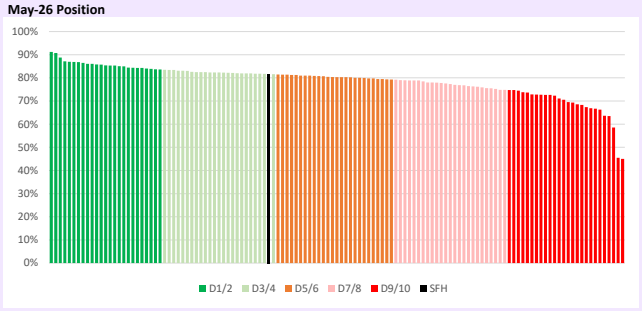
May-26 Position



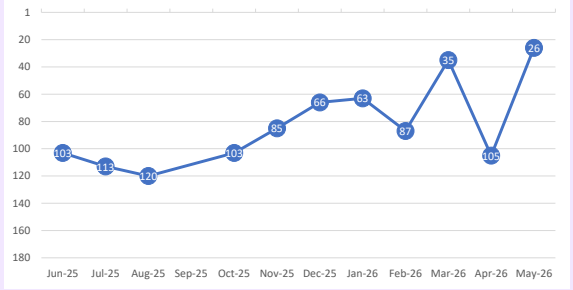
Cancer 28-day faster diagnosis standard



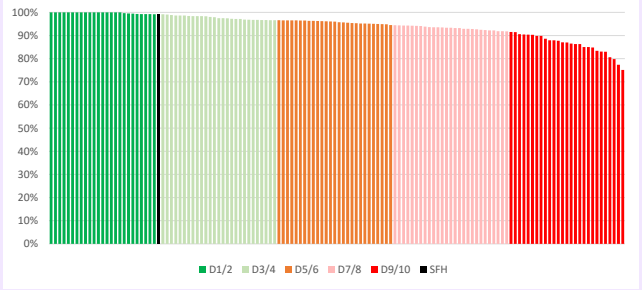
May-26 Position



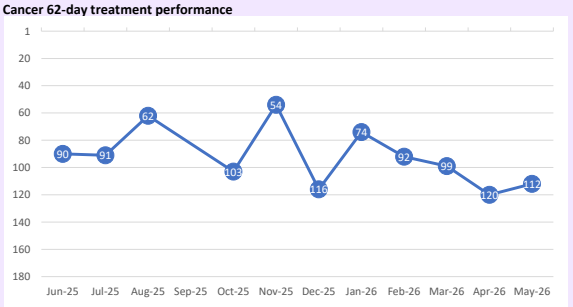
Cancer 31-day treatment performance



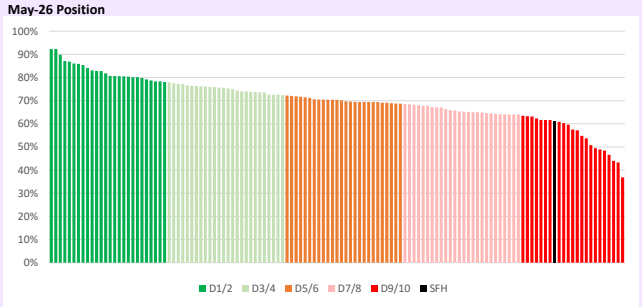
May-26 Position



Cancer 62-day treatment performance



May-26 Position



Board of Directors Meeting in Public

Subject:	Fit & Proper Person Annual Compliance Report 2025-26	Date:	6th August 2026
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To provide assurance to the Board of Directors of full compliance with the NHSE Fit and Proper Person (FPP) Framework requirements for the reporting year ended 30th June 2026.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Recommendation

That the Council of Governors:

• takes assurance from the details in this paper describing the management and completion of the FPP Framework process for the period ended 30th June 2026 and be assured the Trust has met the 2026 FPP requirements in a full and timely manner, and
• notes the FPP requirements continue to be extended on a non-mandated basis to Executive Directors' designated deputies.

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Trust Board

Acronyms

FPP/T – Fit and Proper Person/Test
SID – Senior Independent Director

Executive Summary

This report is the third annual update to the Board of Directors following the introduction of the new FPPT Framework requirements in force from 30th September 2023. The initial paper presented to the Board of Directors 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 to implement the FPP Framework process. The Board of

Directors took assurance from the details in that paper and agreed to extend FPP testing to Executive Directors' designated deputies.

Since then, work has continued 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 for the 2025-26 reporting period with no adverse findings. This enabled the annual submission on the outcomes of the FPP assessments to be prepared for review by Graham Ward, the outgoing Trust Chair prior to the end of his final term of office and Barbara Brady, the SID. The resulting return (containing information as of 19th May 2026) was scrutinised and signed off by the SID (in respect of the Chair) and the Chair in relation to the rest of the Board of Directors on 19th May 2026. The completed return was sent to the NHSE Regional Director on 20th May 2026 with receipt acknowledged on his behalf on 26th May 2026 to complete the process.

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

Internal Audit

In 2025 further assurance was 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. 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.

Both actions were signed off by 360 Assurance, Internal Auditors, as completed in the agreed timescale. These additional checks have been integrated into the suite of FPP checks and are now completed on an annual basis, including for the most recent assessment and reporting period ended 30th June 2026.

A follow up Fit and Proper Person Test Audit is planned on a three-year cycle meaning it will be included in the draft Internal Audit Plan for 2027/28, subject to Audit and Assurance Committee and Board approval.

Separately, beyond the scope of the new Framework, and with the approval of the Board in May 2024 as noted above, 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.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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

Subject:	Quality Committee	**Date**	**Monday 27th July 2026**
Prepared By:	Esther Smith, PA to Chief Nurse Office		
Approved By:	Lisa Maclean, Non-Executive Director/Committee Chair		
Presented By:	Lisa Maclean, Non-Executive Director		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Mental health system pressures and delayed packages of care continued to impact patient flow, with patients waiting in inappropriate environments and associated quality, safety, staffing and patient experience concerns. **Corridor care remained a key area of concern, with continued focus required on reducing and ultimately eliminating corridor care whilst balancing wider operational, clinical and financial risks.** **CSSD fragility was escalated following a business continuity incident which resulted in cancelled procedures and highlighted ongoing risks relating to storage, air handling and instrument tray replacement.** **Cancer 62-day performance remained the principal cancer performance challenge, impacted by diagnostic capacity, oncology capacity, tertiary pathway dependencies and specialty-level variation.**	Board-level escalation supported for mental health system pressures, delayed packages of care and the quality impact of patients waiting in environments not appropriate to their needs. Continued governance oversight commissioned for corridor care through Quality Committee and Board, including prevalence, associated harm, improvement actions and wider risk trade-offs. CSSD recovery work continues through the established recovery group, with harm reviews underway, clinically urgent and cancer patients prioritised, a modular sterile services unit planned, and procurement work ongoing regarding instrument tray replacement. Further work commissioned through Patient Safety Committee to review infection metrics and clarify the relationship between regional thresholds, peer data and Model Hospital data for Board reporting. Future updates requested on dementia improvements made in response to previous family feedback, including closing the loop with the Elgie family. Consideration to be given to complaints policy and website wording where use of AI-generated correspondence may require clarification and affect response times.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Positive assurance was received regarding planned care progress, including achievement of the June RTT plan, reduction in the cancer 62-day backlog and improvement in ED four-hour performance compared with June.	The Committee APPROVED the minutes of the meeting held on 29 June 2026 as a true and accurate record.

The Committee received assurance from the AQuA improvement review and the actions underway to strengthen the Trust's improvement model, access to support, QI capability, prioritisation and divisional business partner approach. Safeguarding assurance was received regarding work with the local authority to improve referral outcome feedback loops, strengthened governance for outstanding AMaT audit actions and ongoing work to improve safeguarding supervision uptake. Positive assurance was received from the dementia update, including the success of dementia drop-in sessions, strengthened best-interest support in outpatient settings, progress following the lorazepam PSII and ongoing work to improve documentation and carer engagement. The Cancer Services Annual Report provided assurance on strong Faster Diagnosis Standard performance, improved 31-day performance, strengthened governance and positive patient experience. Further positive assurance was received through the Nursing, Midwifery and AHP Strategy update, Patient Experience Committee report and Patient Safety Committee report.	The Committee APPROVED Principal Risk 1 and Principal Risk 5 remaining at their current risk scores, noting the need to refine the risk narrative to reflect operational and improvement-related developments. The Committee supported escalation to Board regarding mental health system pressures, delayed packages of care, corridor care, CSSD fragility and relevant BAF considerations. The Committee confirmed interim Quality Committee Vice Chair arrangements, with Manjeet Gill acting as interim Vice Chair in the absence of Barbara Brady, to be reviewed monthly. The Committee APPROVED the IPR for Quality of Care ahead of presentation to BOD.
Comments on effectiveness of the meeting	
LM thanked contributors for the quality of the papers and discussion, noting the level of engagement, constructive challenge and effective scrutiny across a broad range of quality, safety, operational and patient experience issues. The meeting enabled appropriate escalation of key risks while also recognising areas of positive assurance and improvement. Feedback on the meeting was welcomed either during or after the meeting.	
Items recommended for consideration by other Committees	
Patient Safety Committee to undertake further review of infection metrics and benchmarking to support consistent interpretation within Board reporting. Patient Safety Committee to continue oversight of IPC, UEC governance, SHOT incidents, neonatal peer review outcomes and theatres leadership. Trust Board to consider corridor care, mental health system pressures, delayed packages of care, CSSD fragility and related Board Assurance Framework considerations. Private Board to receive the corridor care paper and consider the triangulation of associated risks and options available to reduce corridor care.	
Progress with Actions	
Number of actions considered at the meeting – 8 Number of actions closed at the meeting – 5 Number of actions carried forward - 3 Any concerns with progress of actions – No If Yes, please describe –	

Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

Charitable Funds Committee Chair's Highlight Report to the Board of Directors

Subject:	Charitable Funds Committee Meeting	**Date:**	6 August 2026
Prepared By:	Emma Musgrove, Community Involvement Coordinator		
Approved By:	Steve Banks, Non-Executive Director (Deputising for Committee Chair)		
Presented By:	Steve Banks, Non-Executive Director		
Purpose:			
To provide an overview of the key discussion items from the Charitable Funds Committee held on 21st July 2026			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• Update on the charity lottery showed that whilst significant unrestricted income had been generated there has been a decline in active ticket numbers by 28% due to natural attrition and reduced promotional activity. The committee supported further exploration of investment options and the establishment of appropriate communications and engagement arrangements to ensure the long-term sustainability and growth of the lottery. The committee recognised that the existing charity strategy requires updating and supported convening a strategic planning session to review the future direction of the charity, fundraising priorities, governance arrangements, committee structure and opportunities for growth to support long-term sustainability. • The external funding for the Opus Music programme concludes in December 2026 with no alternative funding source currently identified. The committee acknowledged the positive impact of the programme to date. • Supported for further development of proposals for a memorial and reflection space for staff, patients and families. Whilst there was broad support for the concept, further work is required regarding design, stakeholder engagement, costs, governance arrangements and ongoing maintenance.	• Explore trustee refresher training options, including potential funding routes and external providers. • Arrange annual investment update and trustee training session toward year-end (potentially November/December). • Bring charity accounting standards impact paper to the next committee meeting. • Develop a lottery subgroup and identify arrangements for communications, supporter engagement and governance. • Contact The Fundraising Foundry to obtain examples of innovative approaches used by other NHS charities.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
• The committee reviewed the action tracker,closed several completed actions and received assurance through routine governance reporting. • Newly introduced project evaluation process positively received; providing enhanced assurance regarding the impact and benefits delivered through charitable expenditure. • Positive assurance on the financial position of the charity, including strong investment performance during Q1. Charitable funds continue to be managed appropriately, with robust scrutiny of funding requests and expenditure. • Positive fundraising and volunteering activity, including significant donations, fundraising events, expansion of volunteer services and recognition of long-serving volunteers. The charity continues to demonstrate meaningful impact for patients, staff and services. • Work is progressing to develop a formal charity strategy, strengthen lottery sustainability and explore future fundraising opportunities, supporting the long-term development of the Charity, noting the very lean staffing model.	• Approval to support the purchase of ophthalmology equipment for use in SSDEC. • Take memorial garden/reflection space proposal to Executive Team and propose next steps.

Comments on effectiveness of the meeting

Positive engagement and discussion continued despite the meeting not being quorate throughout. The Committee was grateful to Non-Executive Director Manjeet Gill who joined for an agenda item to approve a request for charitable funding.

Items recommended for consideration by other Committees

Corporate Trustee – approval of further investment in charity lottery
Executive Team – proposal for memorial garden/reflection space

Progress with Actions

Please answer the following regarding progress on actions:
Number of actions considered at the meeting - 4
Number of actions closed at the meeting – 4
Number of actions carried forward - 0
Any concerns with progress of actions – No
If Yes, please describe –

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

Board of Directors Meeting in Public

Subject:	Information Governance, Cyber Security and DSPT Assurance 2025/26	**Date:**	6th August 2026
Prepared By:	Jacqueline Widdowson, Head of Data Security and Privacy/ DPO		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs/SIRO, Nikki Turner, CDIO.		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs /SIRO,		

Purpose

To provide the Public Board with the outcome of the independent DSPT audit, an overview of the Trust's information governance assurance position, report to SIRO, and oversight of the top three data and cyber risks, including areas of positive assurance, areas requiring improvement, and the governance arrangements in place to monitor delivery.	**Approval**	**x**
	Assurance	**x**
	Update	
	Consider	

Recommendation

The Public Board is asked to:

1. **Note** the positive independent DSPT audit outcome, including the low-risk assurance opinion and high confidence rating received for the Trust's 2025/26 submission.
2. **Receive assurance** that the Trust achieved full compliance with all applicable DSPT requirements and recorded no reportable data security or confidentiality SIRIs during 2025/26.
3. **Support** the delivery of the DSPT improvement actions identified through the independent audit, including completion of essential function mapping, implementation of periodic access reviews, cyber exercise action tracking and National Data Opt-Out awareness activities.
4. **Endorse** the continued development of the Trust-wide Information Asset Register, data flow mapping and essential function mapping programme to strengthen organisational resilience, business continuity planning and Cyber Assessment Framework compliance.
5. **Note** the ongoing challenges in Freedom of Information compliance and support the implementation of targeted actions to improve performance against statutory response times.
6. **Receive assurance** that the Trust's Top Three Data and Cyber Risks continue to be actively monitored and managed through established governance and risk management arrangements.
7. **Support** continued oversight through the Information Governance Working Group, Data Protection and Cyber Security Committee, Senior Information Risk Owner (SIRO) and Trust Board governance structure.

Strategic Objectives

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

Identify which Principal Risk this report relates to:

PR1	Significant deterioration in standards of safety and care	**x**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	

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

Committees/groups where this item has been presented before

This item has previously been presented to TMT, Audit Committee. Related assurance and oversight have been considered through the Information Governance Working Group and Data Protection and Cyber Security Committee.

Acronyms

Explained at first use

Executive Summary

The Trust has maintained a positive information governance and data security assurance position during 2025/26. This is evidenced by full compliance with the Data Security and Protection Toolkit (DSPT), a low-risk assurance opinion and high confidence rating from the independent DSPT audit, and no reportable Serious Incidents Requiring Investigation (SIRIs) relating to data security or confidentiality.

The independent audit confirmed that the Trust's self-assessment was accurate and identified no high or medium-risk findings. Four low-risk improvement actions were identified to further strengthen access governance, cyber resilience, essential function mapping, and National Data Opt-Out awareness. A structured improvement programme is in place to address these actions.

The Trust continues to strengthen its information asset management, data flow mapping and essential function identification arrangements to improve organisational resilience and understanding of critical system dependencies. Whilst progress has been made, further work is required to achieve full organisational coverage and alignment between information assets, data flows and business-critical functions.

Subject Access Request performance remains strong, with 4,650 requests managed during the year and no complaints escalated to the Information Commissioner's Office. Freedom of Information performance remains challenged due to operational pressures and increasing demand, and a focused improvement programme will be required to improve compliance with statutory response times.

The Trust's principal data and cyber risks are cyber security attacks, vulnerabilities and system weaknesses, and inappropriate disclosure of confidential information. These risks are managed through technical controls, policies, assurance processes and governance oversight through the Information Governance Working Group and Data Protection and Cyber Security Committee.

Overall, the assurance position remains positive, and the Trust can take reasonable assurance that appropriate arrangements are in place to manage information governance, cyber security and data protection risks whilst continuing to mature its resilience and compliance framework.

DSPT Independent Audit Outcome
The independent audit of the Trust's 2025/26 Data Security and Protection Toolkit self-assessment has been completed by 360 Assurance. The review assessed 12 outcomes across the five objectives of the Cyber Assessment Framework-aligned DSPT, including the nine mandatory outcomes set by NHS England and three additional outcomes selected by the Trust.

The independent DSPT audit provides positive assurance on the Trust's data security and protection arrangements. The audit confirmed an overall low-risk assurance rating, high confidence in the Trust's self-assessment, and no high or medium-risk findings. The four low-risk actions identified are practical improvements to strengthen resilience, access governance, cyber exercise follow-up and National Data Opt-Out awareness.

The accompanying report provides further detail on the assessment.

Audit Action Plan

Action	Lead	Due Date
Complete mapping of essential functions to supporting networks, systems, technologies and key interdependencies, ensuring alignment between the Information Asset Register and DSPT essential functions template.	CDIO / Director of NHIS	28th February 2027
Implement a documented user access review process at defined intervals, with system owners validating access rights and removing access no longer required	Head of Data Security & Privacy/DPO	31st December 2026
Ensure actions arising from cyber exercises are documented, assigned to named responsible officers and given implementation dates.	Emergency Planning & Business Continuity Officer	28th February 2027
Make National Data Opt-Out training available to relevant staff through the Trust's training system and monitor completion.	Head of Data Security & Privacy/DPO	28th February 2027

The four low-risk DSPT audit actions have been assigned to accountable leads with target completion dates. Progress should be monitored through the Information Governance Working Group and reported to the Data Protection and Cyber Security Committee, with escalation to the SIRO and TMT where delivery is at risk.

Top 3 Data and Cyber Risks

The Trust recognises three primary information and cyber risks. The highest risk is a successful cyber-attack, which could affect the availability, integrity or confidentiality of critical systems and data, with potential consequences for patient safety and service delivery.

Closely related, but distinct, is the risk arising from vulnerabilities and system weaknesses. This includes unsupported systems, patching gaps, and infrastructure limitations. These represent the underlying conditions that may increase the likelihood or impact of a cyber-attack and are therefore managed separately in line with the CAF framework.

The third key risk is inappropriate disclosure of personal or confidential information. This may arise through human error, inappropriate access to systems or process failure and may result in regulatory, legal, or reputational impact. Taken together, these risks reflect both the external threat landscape and the internal control environment, and are managed through a combination of technical controls, organisational processes and policies and governance oversight.

The Trust recognises that its risk appetite for cyber security and vulnerabilities is low, reflecting the potential impact on patient safety and service delivery. In contrast, while the risk of inappropriate data disclosure cannot be eliminated, it is managed through established controls, training, and governance processes to ensure risks remain within acceptable tolerance levels.

This risk profile is also consistent with National Cyber Security Centre (NCSC) guidance, which identifies vulnerability management and system weaknesses as key factors influencing the likelihood and impact of successful cyber-attacks.

Assurance over the top three data and cyber risks is provided through established governance routes. Operational oversight is maintained through NHIS cyber security arrangements, the Information Governance Working Group and Data Protection and Cyber Security Committee. Executive accountability is provided through the SIRO and CDIO, with escalation to TMT and Board where risks move outside agreed tolerance or where delivery of improvement actions is off track.

Risk Overview and DSPT Alignment

Risk Area	Description	Current Risk Rating	DSPT/CAF Alignment
Cyber security attack risk	Loss of availability, integrity or confidentiality of systems and data due to cyber-attacks such as ransomware or phishing.	16	CAF B, C, D
Vulnerability and system weakness risk	Exposure to vulnerabilities in systems, software or configurations that could be exploited.	16	CAF B
Inappropriate data disclosure risk	Unauthorised or inappropriate disclosure of personal or confidential information.	9	DSPT Standard E

Cyber Security Attack
A successful ransomware, phishing or cyber-attack could compromise system availability, integrity or confidentiality impacting patient care and Trust operations.

Current Controls in place

- Cyber Security Operations managed through NHIS
- Multi-Factor Authentication implemented for remote access
- Microsoft security tooling and endpoint protection
- Backup and disaster recovery arrangements
- Cyber incident response procedures
- Cyber security awareness training
- Regular penetration testing and vulnerability scanning
- Data Protection and Cyber Security Committee oversight
- Tabletop exercises conducted periodically
- Phishing exercises periodically undertaken

Further Mitigation

- Complete remediation of identified audit actions
- Increase frequency of cyber response exercises
- Develop CAF-aligned assurance reporting
- Expand monitoring of privileged access accounts
- Complete essential function dependency mapping to support recovery priorities

Vulnerability and System Weakness
Unsupported systems, delayed patching or infrastructure weaknesses increase susceptibility to cyber compromise.

Current Controls in place

- Vulnerability scanning programme
- Patch management processes
- IT change management controls
- NHS England cyber alerts monitoring
- System lifecycle management

Further Mitigation

- Reduction of legacy technology dependencies
- Risk-based patching programme
- Enhance asset inventory completeness in Corestream
- Link system resilience plans to essential function mapping
- Introduce quarterly access review assurance reporting

Inappropriate Disclosure of Personal Information

Personal information may be disclosed through human error, inappropriate access or process failure.

Current Controls in Place

- Mandatory IG training
- Confidentiality Code of Conduct
- Imprivata FairWarning monitoring arrangements
- Data Protection Impact Assessment process
- Subject Access Request governance controls
- Breach management procedures

Further Mitigation

- Expand use of audit and monitoring tools
- Introduce targeted training for high-risk departments
- Strengthen manager oversight of access permissions
- Annual information asset review programme
- National Data Opt-Out awareness training

2025/26 Annual Senior Information Risk Owner Report

Information Governance Assurance Position

To document the Trust's compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Freedom of Information Act 2000, the Data Protection Act 2018 and the General Data Protection Regulations.

To document the Trust's compliance with the Data Security & Protection Toolkit and provide assurance of progress in relation to the completion of its mandated requirements.

To inform the Trust Board about any Serious Incidents Requiring Investigation (SIRI) during the year, relating to any losses of personal data or breaches of confidentiality.

Assurance Framework

The Data Protection and Cyber Security Committee meets monthly to assess risks to security and integrity of information and the management of confidential information. The Committee monitors the completion of the Data Security & Protection Toolkit submission, data flow mapping, and information asset registers. The Committee also ensures the Trust has effective policies, processes, and management arrangements in place.
All DSPT standards have been completed, and the final toolkit submission confirms full compliance. The Trust received a low-risk rating and high confidence assurance from the internal auditors.

Data Flow Mapping & Information Asset Registers

To be legally compliant with data protection legislation, the Trust must keep a register of all the different types of information it stores, shares, and receives. The register also needs to detail all the digital and physical places where personal and sensitive information is stored, and how it is kept safe.

The SIRO is responsible for the development and implementation of the organisation's Information Risk agenda. To support compliance with data protection legislation and national requirements, the Trust maintains Information Asset Registers (IARs) that record the information it processes,

including where data is stored, received and shared, and the controls used to protect it across digital and physical environments.

The Trust has also undertaken targeted work to improve its understanding of essential functions and the systems and data that support them, aligned to the Data Security and Protection Toolkit Cyber Assessment Framework A3.a. This has involved working with key departments to identify critical services, restoration requirements and the order in which systems would need to be recovered following disruption.

Activities completed to date include:

- recording selected information assets and supporting systems in Corestream
- updating data flow information in some departments using Excel-based mapping
- mapping essential functions for key departments, including MEMD, Pathology, NHIS and the Digital Transformation Unit.

This provides an initial baseline for understanding system dependencies, although coverage is not yet complete or consistent across the organisation.

Although a full organisation-wide data flow mapping exercise has not yet been completed this year, work has focused on critical areas to support essential function mapping and resilience planning.

The independent DSPT audit 2025/26 recognised progress in mapping essential functions to supporting systems but identified that further work is needed to confirm completeness and fully document interdependencies. The audit recommended completing the mapping of all essential functions to supporting networks, systems, technologies and key interdependencies, and ensuring alignment between Information Asset Registers and essential function mapping outputs.

In response, a structured improvement plan is being developed to:

- complete essential function mapping across all areas
- expand use of Corestream and improve consistency in asset and system documentation
- strengthen documentation of data flows and interdependencies
- align Information Asset Registers with essential function mapping outputs

Progressing a comprehensive organisation-wide approach has been challenging due to operational pressures and capacity constraints. However, the programme will remain a priority to strengthen understanding of system dependencies and support resilience planning.

Progress will be monitored through the Information Governance Working Group, with risks and assurance gaps escalated to the Data Protection and Cyber Security Committee and reported onward to the SIRO and Board as appropriate.

Serious Incidents Requiring Investigation (SIRI)
As part of the Annual Governance Statement, the Trust is required to report on any Serious Incidents (SIRIs) or Cyber Incidents which are notified on the Data Security & Protection Toolkit and then reported through to the ICO.

To date, there have been no data security or confidentiality incidents reported through the Data Security and Protection Toolkit during 2025/26, and no incidents required further investigation by the ICO.

Risk Management and Assurance
The SIRO is responsible for the development and implementation of the organisation's Information Risk agenda. During 2025/26 the Head of Data Security & Privacy has reviewed the current top 3 data risks in conjunction with the risk register. These have been identified as cyber security attack, vulnerability and system weakness and inappropriate data disclosure.

Freedom of Information (FOI)
During 2025/26 the Trust processed a total of 668 FOI requests. This function is managed by the IG Team; the activity is demonstrated in the table below. The team continue to monitor the number of requests and compliance is monitored by the Data Protection and Cyber Security Committee.

Total	Breached timeframe of 20 days	Escalated to ICO
668	454	0

Freedom of Information performance remains below the expected statutory standard, with 454 of 668 requests breaching the 20-working-day timeframe during 2025/26. This represents a material compliance weakness and limits the level of assurance that can be taken in this area. No FOI cases were escalated to the ICO, and a recovery plan is in place covering resource review, escalation arrangements, executive oversight, divisional reporting and monthly performance monitoring through the Data Protection and Cyber Security Committee.

FOI Recovery Plan
The Head of Data Protection and Security/ DPO recognises that FOI compliance remains below the expected standard due to sustained operational pressures and increasing request volumes.

Actions underway include:

- Review of resource requirements within the Information Governance Team.
- Improved escalation arrangements for overdue responses.
- Greater executive oversight of recurring delays.
- Enhanced reporting to Divisional Management Teams.
- Development of a performance improvement plan with monthly monitoring.

The effectiveness of these measures will be monitored through the Data Protection and Cyber Security Committee.

Subject Access Requests

The Trust received 4,650 requests for access to patient records during 2025/26. These requests were processed in line with national guidance, and many involved hundreds of pages of information requiring careful review to ensure appropriate release. There were no complaints to the Information Commissioner arising from the responses provided, and any patient requests for local review of record content were resolved locally. The department received around 940 more requests than in the previous year.

Type	01/04/25 to 31/03/26	Completed within 30 days
Total Requests	4650	4289

Conclusion and Assurance

The Trust has achieved a positive assurance position for 2025/26, evidenced through full DSPT compliance, independent low-risk audit assurance, no reportable data security incidents, and strong Subject Access Request performance. The Trust Board can take reasonable assurance that core information governance, cyber security and data protection controls are operating effectively. This assurance is qualified by two areas requiring continued focus: recovery of Freedom of Information performance and completion of essential function mapping to strengthen organisational resilience. The low-risk DSPT audit actions are being managed through established governance arrangements, with progress monitored through the Information Governance Working Group, Data Protection and Cyber Security Committee, SIRO and onward reporting as appropriate.

Data Security and Protection Toolkit

Sherwood Forest Hospitals NHS Foundation Trust

29 June 2026

2627/SFHFT/01

Final Report

Contents

Distribution

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

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 that 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, the 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.

Executive summary

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 nine mandatory outcomes, these being as follows:

Executive summary

NHS England mandated in-scope outcomes for 2025/26 – NHS trusts, ICBs, CSUs and ALBs only	
A1.a	You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.
B1.a	You have developed and continue to improve a set of information assurance and resilience policies, processes and procedures that manage and mitigate the risk of adverse impact on your essential function(s).
B4.a	You design security into the network and information systems that support the operation of your essential function(s). You minimise their attack surface and ensure that the operation of your essential function(s) should not be impacted by the exploitation of any single vulnerability.
B5.a	You are prepared to restore the operation of your essential function(s) following adverse impact.
B5.c	You hold accessible and secured current backups of data and information needed to recover 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.
D2.a	When an incident or near miss occurs, steps are taken to understand its root causes and ensure appropriate remediating action is taken.
E2.a	You appropriately assess and manage information rights requests such as subject access, rectification and objections.
E2.c	A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation

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

B2.d You closely manage and maintain identity and access control for users, devices and systems accessing the network and information systems supporting your essential function(s).

D1.b You have the capability to enact your incident response plan, including effective limitation of impact on the operation of your essential function(s). During an incident, you have access to timely information on which to base your response decisions.

D1.c Your organisation carries out exercises to test response plans, using past incidents that affected your (and other) organisation, and scenarios that draw on threat intelligence and your risk assessment.

Executive summary

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 did not provide assurance that the entire DSPT return is accurate and complete. Our work did not include detailed testing of IT systems and did not cover 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 mandated nine outcomes to be audited for 2025/26; organisations were required to select a further three outcomes to be audited which should be approved by Sherwood Forest Hospitals NHS Foundation Trus's Board. The scope of the audit has been approved by Sherwood Forest Hospitals NHS Foundation Trust and the independent assessor.

We produced this report as an output of this review. As a result of our evidence assessment and interviews with key stakeholders, we have identified four actions in total for the Trust, all low risk. 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 2025/26)	High	Medium	Low	Outcome result	Minimum achievement level met?	Overall risk assurance
A	A1.a	Achieved	-	-	-	Achieved	Met	Low
B	B1.a	Partially achieved	-	-	-	Partially Achieved	Met	
	B4.a	Partially achieved	-	-	-	Partially Achieved	Met	
	B5.a	Partially achieved	-	-	PA#1	Partially Achieved	Met	
	B5.c	Achieved	-	-	-	Achieved	Met	

Executive summary

Objective	Outcome	Minimum achievement level (as per the profile set for 2025/26)	High	Medium	Low	Outcome result	Minimum achievement level met?	Overall risk assurance
C	C1.b	Partially achieved	-	-	-	Partially Achieved	Met	
D	D2.a	Achieved	-	-	-	Achieved	Met	
E	E2.a	Achieved	-	-	-	Achieved	Met	
	E2.c	Achieved	-		A#3	Achieved	Met	
B	B2.d	Partially Achieved	-	-	PA#2, PA#3, A#2	Partially Achieved	Met	
D	D1.b	Achieved	-	-	-	Achieved	Met	
	D1.c	Achieved	-	-	A#2	Achieved	Met	

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

This means that no outcomes were rated as not meeting minimum achievement levels.

Assessing the veracity of your DSPT self-assessment

We have assessed 12 outcomes, and found that, for all 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 DSPT self-assessment is therefore High.

Areas of good practice

- The Trust has clearly documented information governance and security policies and has clear reporting to Board on discussions regarding information governance, systems and networks.
- The Trust holds log data securely and grants appropriate access only to accounts with business need.

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 Data Security and Protection Toolkit:

- ensure that all actions arising from exercises are assigned to responsible officers and have implementation dates
- ensure that the National Data Opt-Out training is made available to relevant staff and a Standard Operating Procedure is developed and made available to staff
- document the order and interdependencies for restoring systems.

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

Executive summary

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, K10 Vision. 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.

B5.a **You are prepared to restore the operation of your essential function(s) following adverse impact.**	**Findings**
	The organisation has documented all networks, information systems and underlying technologies that are necessary to restore the operation of the essential function(s). (PA#1) The Trust has implemented a structured approach to mapping essential functions to the supporting networks, information systems, and technologies through its Corestream system and evidenced through the DSPT essential functions template. The evidence demonstrates that, where completed, functions are clearly linked to specific systems and technologies, indicating that the organisation is capable of identifying these relationships. The Trust acknowledged that there is further work to do to complete the mapping exercise and to fully understand all interdependencies, but that for all key/critical systems these are understood and documented.
Risk rating **Low** (Impact x Likelihood) **2 x 3**	**Risk**
	Where mapping of essential functions to supporting systems, technologies and interdependencies is incomplete, the Trust may not have a full understanding of the systems required to maintain or restore critical services. This could result in gaps in business continuity, disaster recovery and incident response arrangements, potentially delaying service restoration during a disruption.
	Recommendation
	The Trust should complete the mapping of all essential functions to the supporting networks, information systems, technologies and key interdependencies, ensuring the Information Asset Register and DSPT essential functions template are aligned.
	Evidence to confirm implementation
	Completed mapping exercise and Information Asset Register

	Responsible officer
	Nikki Turner, Chief Digital Information Officer
	Target date
	28 February 2027

B2.d **You closely manage and maintain identity and access control for users, devices and systems accessing the network and information systems supporting your essential function(s).**	**Findings**
	User access right review - Assess whether user access rights are reviewed regularly, with the expected frequency of review being clearly documented, and also when users change roles via the joiners, leavers and movers process. Obtain evidence that user access rights are reviewed regularly and when users change roles, and that access rights are updated as required. (PA#2, PA#3, A#2) NHIS has an isolation and disable process for inactive accounts which removes access at active directory level if an account has not been accessed for 60 days. Access for joiners, leavers and movers is reviewed on an event-driven basis. However, the Trust currently does not have a documented process for proactively reviewing user access rights for leavers and movers.
Risk rating **Low** (Impact x Likelihood) **2 x 3**	**Risk**
	Without periodic access reviews users may retain access for longer than needed, increasing the likelihood of unauthorised access, data breaches, and non-compliance with security and data protection requirements.
	Recommendation
	The Trust should implement a user access review process at defined intervals (eg quarterly), ensuring access rights are validated by system owners.

	Evidence to confirm implementation
	A documented process setting out the frequency and the user access right review, and evidence of completion of such reviews.
	Responsible officer
	Jacqueline Widdowson, Head of Data Security & Privacy
	Target date
	31 December 2026

D1.c **Your organisation carries out exercises to test response plans, using past incidents that affected your (and other) organisation, and scenarios that draw on threat intelligence and your risk assessment.**	**Findings**
	Exercise scenarios are documented, regularly reviewed, and validated. (A#2) The Trust has demonstrated that post-exercise reports are completed and include clearly defined learning points and areas for improvement. However, there is no consistent process in place to formally assign named owners and clear implementation timelines to actions.
Risk rating **Low** (Impact x Likelihood)	**Risk**
	Where cyber security actions arising from exercises do not have clear ownership or implementation timescales, there is a risk that lessons identified are not effectively implemented.

2 x 3	**Recommendation**
	The Trust should ensure that all actions arising from exercises are clearly documented, assigned to named responsible officers and have defined implementation dates.
	Evidence to confirm implementation
	Evidence of post exercise actions with named responsible officers and implementation dates.
	Responsible officer
	Lauren Ward, Emergency Planning and Business Continuity Officer
	Target date
	28 February 2027

E2.c A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation.	**Findings**
	You have robust procedures and an adequate technical solution in place to ensure opt-outs are correctly applied. (A#3) The Trust has documented its requirements for relevant staff to undertake training in respect of National Data Opt-Out and this is included in the Training Needs Analysis (TNS). However, the Trust, currently, does not have any training in place for staff to complete on National Data Opt-Out. The Trust commented that this is due to expected changes from NHSE occurring during the year. As per A#3, there is a requirement for training to be available for specified staff to complete on National Data Opt-Out.
Risk rating	**Risk**

Low (Impact x Likelihood) **2 x 3**	Where National Data Opt-Out training is not accessible to relevant staff, there is a risk that staff are not fully aware of their responsibilities in applying opt-outs. This may lead to non-compliance with national policy, inappropriate use or sharing of patient data, and potential breaches of data protection requirements.
	Recommendation
	The Trust should ensure that the National Data Opt-Out training package is uploaded to eAcademy and that all relevant staff are required to complete the training within a defined timeframe
	Evidence to confirm implementation
	National Data Opt-Out training to be added to the Trust's training system.
	Responsible officer
	Jacqueline Widdowson, Head of Data Security & Privacy
	Target date
	28 February 2027

Non-reportable items

The following observations are included for information purposes and relate to items where the risk exposure is calculated at a very low level. It is hoped that the inclusion of such observations is helpful in contextualising and remediating data security and data protection issues.

E2c A#1 A review of the Information Asset Register identified that completion of the National Data Opt-Out (NDOO) field has not been completed for all assets listed on the register.

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#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A1.a	You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.	A#1	Achieved	**Agree**	✓ Reviewed ownership and approach	**Agree**
		A#2	Achieved	**Agree**	✓ Reviewed board discussions	
		A#3	Achieved	**Agree**	✓ Reviewed board level accountability	
		A#4	Achieved	**Agree**	✓ Reviewed how board sets the direction	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B1.a	You have developed and continue to improve a set of information assurance and resilience policies, processes and procedures	PA#1	Partially Achieved	**Agree**	✓ Reviewed policies, processes and procedures	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Reviewed process for updating policies, processes and procedures in response to cyber security incidents	

	that manage and mitigate the risk of adverse impact on your essential function(s).	PA#3	Partially Achieved	Agree	✓ Verified IG policies, processes and procedures align to national policies and legal frameworks	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B4a	You design security into the network and information systems that support the operation of your essential function(s). You minimise their attack surface and ensure that the operation of your essential function(s) should not be impacted by the exploitation of any single vulnerability.	PA#1	Partially Achieved	Agree	✓ Reviewed network and information system design documentation	**Agree**
		PA#2	Partially Achieved	Agree	✓ Verified strong boundary differences in place	
		PA#3	Partially Achieved	Agree	✓ Reviewed data flow documentation.	
		PA#4	Partially Achieved	Agree	✓ Verified organisations design decisions	
		PA#5	Partially Achieved	Agree	✓ Verified that all inputs are checked/validated at the network boundary	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B5.a	You are prepared to restore the operation of your essential function(s) following adverse impact.	PA#1	Partially Achieved	Agree (low risk finding)	✓ Validated that all networks, information system and underlying technologies required for restoration are documented	**Agree**
		PA#2	Partially Achieved	Agree (low risk finding)	✓ Reviewed documentation that confirms the organisation understands the order in which networks can be brought back online	

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

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B5.c	You hold accessible and secured current backups of data and information needed to recover operation of your essential function(s).	A#1	Achieved	**Agree**	✓ Reviewed the organisations backup procedures and testing regime	**Agree**
		A#2	Achieved	**Agree**	✓ Verified that backup testing is regular conducted	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's 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 master copies of log data within an agreed retention period, after which it should be deleted.	PA#1	Partially Achieved	**Agree**	✓ Verified user access controls for logs.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ Sample tested authorised users to confirm controls operating as designed	
		PA#3	Partially Achieved	**Agree**	✓ Validated access to logs is monitored	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D2.a	When an incident or near miss occurs, steps must be taken to understand its root causes and ensure appropriate remediating action is taken.	A#1	Achieved	**Agree**	✓ Reviewed incident response policy and process to confirm inclusion of lessons learned and root cause analysis	**Agree**
		A#2	Achieved	**Agree**	✓ Confirmed the comprehensiveness of policy	
		A#3	Achieved	**Agree**	✓ Tested a sample of incidents and near misses to confirm lessons	

					learned and root cause analysis had been completed	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E2.a	You appropriately assess and manage information rights requests such as subject access, rectification and objections.	A#1	Achieved	**Agree**	✓ Reviewed documented process for responding to information rights requests	**Agree**
		A#2	Achieved	**Agree**	✓ Reviewed staff training material to confirm staff responsibilities adequately covered	
		A#3	Achieved	**Agree**	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E2.c	A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation.	A#1	Achieved	**Agree (low risk finding)**	✓ Reviewed internal Trust processes for national data opt out including recording on information assets and data flows	**Agree**
		A#2	Achieved	**Agree**	✓ Reviewed public facing guidance for national data opt out	
		A#3	Achieved	**Agree**	✓ Reviewed procedures to ensure that opt outs are correctly applied	

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

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B2.d	You closely manage and maintain identity and access control for users, devices and systems accessing the network and information systems supporting your essential function(s).	PA#1	Partially Achieved	**Agree**	✓ You follow a robust procedure to verify each user and issue the minimum required access rights.	**Agree**
		PA#2	Partially Achieved	**Agree**	✓ You regularly review access rights and those no longer needed are revoked.	
		PA#3	Partially Achieved	**Agree (low risk finding)**	✓ User access rights are reviewed when users change roles via your joiners, leavers and movers process.	
		PA#4	Partially Achieved	**Agree**	✓ All user, device and system access to the systems supporting the essential function(s) is logged and monitored, but it is not compared to other log data or access records.	
		PA#5	Partially Achieved	**Agree**	✓ When issues are raised about staff not having appropriate access to information, these are resolved without undue delay.	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D1.b	You have the capability to enact your incident response plan, including effective limitation of impact on the operation of your essential function(s). During an incident, you have access to timely information on which to	A#1	Achieved	**Agree**	✓ Understand the resources that will likely be needed to carry out any required response activities, and arrangements are in place to make these resources available.	**Agree**
		A#2	Achieved	**Agree**	✓ Understand the types of information that will likely be needed to inform response decisions and arrangements are in place to make this information available.	

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

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
	base your response decisions.	A#3	Achieved	Agree	✓ Response team members have the skills and knowledge required to decide on the response actions necessary to limit harm, and the authority to carry them out.	
		A#4	Achieved	Agree	✓ Key roles are duplicated, and operational delivery knowledge is shared with all individuals involved in the operations and recovery of the essential function(s).	
		A#5	Achieved	Agree	✓ Back-up mechanisms are available that can be readily activated to allow continued operation of your essential function(s) (although possibly at a reduced level) if primary networks and information systems fail or are unavailable.	
		A#6	Achieved	Agree	✓ Arrangements exist to augment your organisation's incident response capabilities with external support if necessary (such as specialist cyber incident responders).	

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D1.c	Your organisation carries out exercises to test response plans, using past incidents that affected your (and other) organisation, and scenarios	A#1	Achieved	Agree	✓ Exercise scenarios are based on incidents experienced by your and other organisations or are composed using experience or threat intelligence.	**Agree**
		A#2	Achieved	Agree (low risk finding)	✓ Exercise scenarios are documented, regularly reviewed, and validated.	

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

Req. #	Description	IGP#	Organisation's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
	that draw on threat intelligence and your risk assessment.	A#3	Achieved	Agree	✓ Exercises are routinely run, with the findings documented and used to refine incident response plans and protective security, in line with the lessons learned.	
		A#4	Achieved	Agree	✓ Exercises test all parts of your response cycle relating to your essential function(s) (for example restoration of normal function levels).	

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.

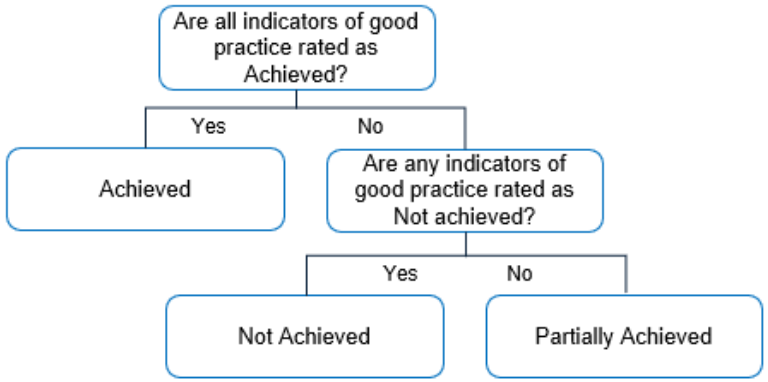
How to determine the outcome level achievement level

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

Leanne Hawkes, Director	
leanne.hawkes@nhs.net	07545 423040
Glynis Onley, Assistant Director	
glynis.onley@nhs.net	07500 572707
Claire Page, Client Manager	
claire.page9@nhs.net	07747 472858
Andrew Fooks, Assistant Client Manager	
andrew.fooks@nhs.net	07342 073053
Faheem Kara, Internal Auditor	
faheem.kara@nhs.net	07990 084851