Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	External Well-led Review – Recommendations, Progress Report	**Date**: 2nd February 2023	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Shirley A Higginbotham, Director of Corporate Affairs		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
The purpose of this paper is for the Board to receive assurance regarding progress against the achievement of the recommendations identified in the final report from the Grant Thornton Well Led Review March 2022		**Approval**	
		Assurance	x
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x		x	x	

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

Committees/groups where this item has been presented before
Executive Team

Executive Summary

Grant Thornton undertook an external Well-led review of the organisation, delivering its final report to the Trust in March 2022.

The Well-Led review is an important assessment for the Trust, not only because trusts are expected to advise NHSE/I of any material governance concerns that have arisen from the review and the action plan in response to those concerns, but more importantly because it provides the opportunity for the Trust to fully understand the strengths and weaknesses of its current governance arrangements and implement actions at an appropriate pace.

The initial report detailing the 15 recommendations was presented to Board in April 2022 and a further update in August 2022.

This report provides progress against those recommendations, noting 11 are complete and four remain outstanding, progress reports are provided for those which remain outstanding.

Recommendation 8 – Requires further discussion and agreement by Board

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This Well-Led review was undertaken during the Covid-19 pandemic. All interviews and meeting observations were undertaken virtually using MS Teams.

The Well-Led framework for governance reviews considers 8 key lines of enquiry (KLOEs):

The table below summarises the assessment of the Trust's performance against the 8 key lines of enquiry outlined in NHSI's Well-Led framework. The 2018 Well-Led report ratings for comparison.

NHSI Well-Led framework			
#	KLOE	2018 rating	GT rating
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	GREEN	AMBER/GREEN
2	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	AMBER/GREEN	AMBER/GREEN
3	Is there a culture of high quality sustainable care?	AMBER/GREEN	AMBER/GREEN
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	AMBER/GREEN	GREEN
5	Are they clear and effective processes for managing risk, issues and performance?	GREEN	GREEN
6	Is appropriate and accurate information being effectively processed, challenged and acted on?	AMBER/GREEN	AMBER/GREEN
7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	AMBER/GREEN	GREEN
8	Are there robust systems and processes for learning continuous improvement and innovation?	AMBER/GREEN	AMBER/RED

Overall, 15 recommendations, were identified in the report, there were no high-level recommendation; three medium level recommendations; and 12 low level recommendations

This report provides progress against those recommendations, noting 11 are complete and four remain outstanding, progress reports are provided for those which remain outstanding.

Recommendation 8:

The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.

This has been included in the FTSU reports to Board, however the system used to collate the Guardian of Safe Working Hours report does not have the facility to record ethnicity and gender data, which would mean a manual investigation via ESR for each exception report, which would be very time consuming. This data is included in the Medical Workforce Report. Board are asked to discuss and agree if this recommendation can be closed.

No.	Risk	Recommendation	Action	Lead		Timeline
KLOE 1. – Is there the leadership capacity and capability to deliver high quality, sustainable care?						
1	**Medium**	**Internal v external priorities** The Director of Human Resources is a joint post with Nottinghamshire Healthcare NHS Foundation Trust. However, due to the way the portfolio of work is arranged and the existence of a strong deputy this appears to and is reported to work well. The Director of HR is also prominent in the Integrated Care System (ICS) leading the people agenda and this workload needs to be regularly reviewed to ensure it remains manageable. **Recommendation:** As external priorities become more apparent in the establishment of the ICS a watching brief should be reviewed to ensure executives continue to have sufficient bandwidth to undertake their portfolio of work.	All joint posts with Nottinghamshire Healthcare have ceased **Complete**	Chief Executive Officer	**Complete**	June 2022
2	**Low**	**Succession planning** The Trust had undertaken a formal succession planning exercise for its executive roles in 2019, and this is best practice. It is important to refresh this periodically and this	A report will be presented to the Nomination and Remuneration Committee **Progress update:** Draft report presented to	Chief Executive Officer	**Complete**	September 2022

		should be completed following the appointment of the CEO. Some Trusts include the NED skills in this exercise as this can help to identify any gaps and target skill sets of future appointments. **Recommendation:** Following the appointment of the Chief Executive post the Trust should refresh its succession planning and consider extending the exercise to include NEDs and Divisional triumvirate team members	the CEO – to be further discussed with the Executive Team in August 2022, once all Executives are in post. Final succession planning report presented to RemCom in October 2022			
3	**Low**	**Structured visits programme** The structured quality visit programme where NEDs and Executive Directors undertake more formal visits to the services has been suspended and is planned to be reinstated when the Covid -19 restrictions on access to clinical areas allow. This will be particularly helpful to the new NEDs as they familiarise themselves with the Trust's services. **Recommendation:** As soon as Covid 19 restrictions allow the Board should reinstate its structured visits programme to its	Visits did commence once restrictions were lifted unfortunately these have now been paused due to the increase in COVID infections across the Trust. Visits will re-commence as soon as current restrictions are lifted, schedules for visits have been developed and are in place. **Complete**	Chief Nurse	**Complete**	June 2022

		services. This will be particularly beneficial to the new NEDs and existing NEDs who have missed the opportunities to undertake face to face activities				
	KLOE 2 – is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?					
4	**Low**	**Quality Strategy** A new Quality Strategy is in development. A working draft version was presented at the November 2021 Quality Committee. The new strategy will run from 2022-2025 and has four campaigns on delivery quality care: 1. Create a positive practice environment to support the delivery of safest and most effective care 2. Excellent patient experience for users and the wider community 3. Strengthen and sustain a culture of continuous quality improvement and learning 4. Deliver high quality care through kindness and supporting each other It is not clear however how the third campaign links to the improvement techniques and training that are currently being rolled out in the Trust and this should be made more explicit **Recommendation**	Updated Quality Strategy approved by Quality Committee in September 2022, to include quality improvement methodology and linkages to the People, Culture and Improvement Strategy. Indicators provided in the Advancing Quality Programme will track delivery of the strategy	Chief Nurse	**Complete**	September 2022

		The Quality Strategy should more explicitly document the quality improvement methodology that is being rolled out within its campaign to strengthen and sustain a culture of continuous quality improvement and learning.				
	KLOE 3 – Is there a culture of high quality sustainable care?					
5.	**Low**	**Freedom to Speak up Guardian meetings with Divisions** The Guardian has regular meetings within one Division as these were established by her predecessor however does not regularly meet with all of the Divisional triumvirates, generally only meeting with them to discuss specific cases. **Recommendation:** The FTSU Guardian should schedule regular meetings with the Divisional triumvirate teams to develop relationships and establish a more proactive approach	Regular meetings with all triumvirates have been scheduled **Complete**	Director of Corporate Affairs	**Complete**	June 2022
6.	**Low**	**Freedom to Speak Up Guardian meetings with the Guardian of Safe Working Hours** Nationally the data suggests medical staff tend not to use FTSU mechanisms to raise concerns and in	Regular meetings with the Guardian of Safe Working Hours have been scheduled **Complete**	Director of Corporate Affairs	**Complete**	June 2022

		some trusts we see the Guardian of Safe Working Hours used to raise a broad range of issues. The Trust has successfully recruited a doctor to a FTSU Champion role and this may encourage medical staff to speak up if they have concerns. The FTSU Guardian does not meet with the Guardian of Safe Working Hours and this would be a useful link. **Recommendation:** The FTSU Guarding should arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles.				
7.	**Low**	**Awareness of detriment** It is important to ensure that people do not suffer detriment as a result of speaking up. Currently, following the closure of a case, the FTSU Guardian sends out a short four question email to staff who have raised concerns, however the response rate is low and the questions do not adequately assess if there has been any detriment. **Recommendation:** The FTSU Guardian should formalise a process to contact staff who have	A formal process to contact staff who have raised concerns to ascertain if they have suffered detriment has been developed and implemented **Complete**	Director of Corporate Affairs	**Complete**	June 2022

		raised concerns three to six months following closure of the case to discuss how they are and if they have suffered detriment as a result of speaking up				
8.	**Low**	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation:** The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.	**Progress update February 2023**: Included in the FTSU report to Board in August 2022. Complex to include in Guardian of Safe Working Hours report, is included in Medical Workforce Report	Director of Corporate Affairs and Executive Medical Director	**Board to Agree if accept recommendation completed**	September 2022
KLOE 4 – Are there clear responsibilities, roles and systems of accountability to support good governance and management?						
9.	**Low**	**Highlight report to the Board of Directors** There is variance in the quality of reporting the work of the Committees to the Board. A more common approach using a quadrant style	A quadrant template has been developed and has been implemented from April Committees. **Complete**	Director of Corporate Affairs	**Complete**	June 2022

		reporting could more effectively identify key issues and action taken. **Recommendation:** Committee Chairs should consider the use of a quadrant style report to present at the Board meeting. Headings of the 4 quadrants are commonly: • Matters of concern or key risks to escalate • Major actions commissioned / work underway • Positive assurances to provide • Decisions made				
10.	**Low**	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation:** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.	Committee Chairs have observed all key meetings which feed into their committee	Director of Corporate Affairs	**Complete**	September 2022
11.	**Low**	**People, Culture and Improvement**				

		Committee The Chair of the Committee does not routinely meet with the Lead Executive for this Committee, more ad-hoc arrangements occur. Setting up a scheduled arrangement would be beneficial to allow for regular discussion of progress, current issues and the identification of areas where further work my b indicated **Recommendation:** The Chair of the People, Culture and Improvement Committee should set up regular meetings with the lead Executive Directors	A schedule of regular meetings prior to committee meeting will be developed and implemented **Complete**	Director of People	**Complete**	June 2022
	KLOE 5. – Are there clear and effective processes for managing risks, issues and performance?					
12.	**Low**	**Divisional Performance Reviews** We attended the November 2021 round of Performance Reviews for all five clinical Divisions. The Performance Review meetings are well organised and mutually supportive. We note that Urgent and Emergency Care Division presented an informative HR performance report and whilst other Divisions talk about their HR issues, they did not include a presentation of metrics. HR	All future Divisional Performance Reviews will include the presentation of their HR Performance report. All divisions now have an HR report which they present monthly within their DPRs **Complete**	Chief Operating Officer	**Complete**	June 2022

		performance reports are routinely created and supplied to Divisions via the HR Business Partner, and these should be presented at each Division Performance Review. **Recommendation:** All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.				
	KLOE 6 – Is appropriate and accurate information being effectively processed, challenged and acted on					
13.	**Medium**	**Data Quality Strategy** The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However, the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore, the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. The Trust is currently in the process of moving to a more integrated approach, where data quality is		Executive Medical Director		December 2022

		owned and monitored across the wider governance structure. It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework, but this process is not yet fully documented, and roles and responsibilities need to be clarified. It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed. **Recommendation :** Once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.	The Trust has established a Patient Information and Data Assurance Group (PIDAG). This has been chaired by the Chief Digital Information Officer. The group has: • Begun to develop a workplan relating to data quality issues • Capture and track NHS Data Set Change Notices • Reviewed the initial work relating to 'kitemarking' of key data sets • Begun to consider the importance of the data quality lifecycle in relation to all the above			
14.	**Low**	**Data Quality Assurance Indicators** The Trust does not at present utilise a Data Quality Assurance Indicator. A data quality traffic light or kite mark		Director of Corporate Affairs	**On-Going**	On-Going

		could be used to appear next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based **Recommendation:** The Trust should consider the use of Data Quality Assurance Indicators to inform users of any data quality risks attached to the data that might impact decision making.	The initial work of the group will address the Information management sign off and governance in relation to data and its quality.			
	KLOE 7. – Are people who use services, the public, staff and external partner engaged and involved to support high quality sustainable services?					
	We have not made any recommendations in this area as the Trust is already working on issues identified.					
	KLOE 8. – Are there robust systems and processes for learning, continuous improvement and innovation?					
15.	**Medium**	**Continuous Improvement** The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a	**Progress update February 2023** There are currently 32 improvement projects recorded on AMAT since the module went live in July 2022, and this is available to colleagues across the organisation as a knowledge	Director of Strategy and Partnerships	**On-Going**	September 2022

		Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation:** Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.	management resource. Learning from projects has been shared at various forums over 2022 – the Improvement and Learning sub cabinet, the Senior Leadership team meeting, the People, Culture and Improvement Committee and the Improvement and Clinical Audit Group (all minuted/recorded). Over 2023, the aim is to focus all Improvement resources under a single Improvement Faculty, which should further amplify the visibility, focus and learning from Improvement at SFH. This will also clarify the 'Improvement Production System' on how we undertake Improvement at SFH, in line with national learning from the Virginia Mason NHS experience and the proposed NHSE national Improvement Framework.			