KPMG

Well-Led Governance Review

Sherwood Forest Hospitals NHS Foundation Trust

FINAL REPORT

December 2018

Important notice

Our work commenced 10 October 2018 and our fieldwork was completed on 7 December 2018. We have not undertaken to update our report for events or circumstances arising after that date.

As part of Well-Led reviews we would usually undertake meetings with the Divisional Triumvirate teams and conduct staff focus groups, however due to the fact that the CQC has only recently undertaken its inspection, including its Well-Led review, where the Trust was rated as 'Good', we were asked to exclude these elements. However we did interview the Clinical Chairs. Our views do not therefore include those of staff working within the Divisional services apart from views expressed by the Clinical Chairs.

In preparing our report, our primary source has been internal management information and representations made to us by management. We do not accept responsibility for such information, which remains the responsibility of management. A list of individuals with whom we held discussions with is also set out on page 69. We have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information that was made available to us in the course of our work in accordance with the terms of our Engagement Letter. We have not, however, sought to establish the reliability of the sources by reference to other evidence.

Our engagement is not an assurance engagement conducted in accordance with any generally accepted assurance standards and consequently no assurance opinion is expressed.

Our report is for the benefit and information of the addressee only and should not be copied, referred to or disclosed, in whole or in part, without our prior written consent, except as specifically permitted in our contract letter. The scope of work for this report included has been agreed by the addressee and to the fullest extent permitted by law we will not accept responsibility or liability to any other party (including the addressee's legal and other professional advisors) in respect of our work or the report.

Contents

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Introduction

Background

Sherwood Forest Hospitals NHS Foundation Trust ('the Trust') procured this review in line with NHSI's 'Well-Led framework for governance reviews: guidance for NHS foundation trusts'. Trusts are required to commission an independent governance review at least every three years for the following reasons:

– Good governance is essential in addressing the challenges the NHS faces;

– Oversight of governance systems is the responsibility of NHS FT Boards;

– Governance issues are increasing across the sector as a cause of organisational failure; and

– Regular reviews can provide assurance that systems are fit for purpose.

Boards are responsible for all aspects of performance and governance of the organisation. The role of the Board is to set strategy, lead the organisation and oversee operations, and to be accountable to stakeholders in an open and effective manner. The Francis report led to major changes in the regulatory regime. It has also resulted in even closer working relationships between the bodies responsible for regulation and oversight of FTs, particularly around the sharing of information and intelligence. It is in this spirit regulators have committed to developing an aligned framework for making judgements about how well led NHS providers are. The 'Well-Led framework for governance reviews' considers eight key questions:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning continuous improvement and innovation?

This Well-Led review is an important assessment for the Trust, not only because trusts are expected to advise NHSI 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 you to fully understand the strengths and weaknesses of your current governance arrangements and implement actions at an appropriate pace. We recognise the need for this formal report and assurance, but also for informal feedback from our observations throughout our engagement with you. In addition we presented our interim findings to you at a Board of Director's Time-Out event on November 9th 2018.

Introduction

For each of the eight key questions we have assessed the Trust and assigned a rating using the four point scoring methodology detailed below.

Well-Led Framework Scoring Methodology		
Rating	**Definition**	**Evidence**
Green	Meets or exceeds expectations.	Many elements of good practice and there are no major omissions.
Amber/Green	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable time frame.	Some elements of good practice, has no major omissions and robust action plans to address perceived short falls with proven track record of delivery.
Amber/Red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable time frame.	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in an early stage of development with limited evidence of track record of delivery.
Red	Does not meet expectations.	Major omission in quality governance identified. Significant volume of action plans required and concerns on management capacity to deliver.

Acknowledgement

We would like to thank all of the individuals at the Trust who have supported the completion of this review.

Executive Summary

Conclusion

Overall we have raised 20 recommendations consisting of:

— 10 medium priority recommendations – these recommendations address potentially significant or medium level weakness in the governance arrangements in place at the Trust. Addressing these issues will be key to developing the Trust score for each of the key questions of the Well-Led Governance Framework.

— 10 low priority recommendations – which could improve the efficiency and/or the effectiveness of the governance arrangements in place at the Trust. These are generally issues of good practice which we consider would achieve better outcomes.

The table below summarises our assessment of the Trust's performance against the eight key lines of enquiry outlined in NHS Improvement's Well-led Framework.

NHSI Well-Led Framework		
#	**Question**	**KPMG rating**
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	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
3	Is there a culture of high quality sustainable care?	Amber / Green
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Amber / Green
5	Are there clear and effective processes for managing risks, issues and performance?	Green
6	Is appropriate and accurate information being effectively processed, challenged and acted on?	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
8	Are there robust systems and processes for learning continuous improvement and innovation?	Amber / Green

Executive Summary

In this section we summarise our key findings under each of the 8 questions from NHSI's 'Well-Led' framework methodology. We have assigned a rating to each question and the descriptors are listed on page 5 of this report.

KPMG Rating	NHSI's Well-Led Framework
Green	**Key Question 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?** After a significant period of instability all Board positions are substantive appointments. People spoke positively regarding the stability, capacity and capability of the Board members. There is clear role definition amongst all members and good awareness responsibilities and accountabilities. All Board members spoke knowledgeably and consistently regarding issues and risks the organisation face, across the various portfolios. There is a good breadth of skills in the Non Executive Director (NED) group. NED membership has been strengthened by the recent appointments of two new NEDs, one with a clinical background, who has already been working with the Trust in the capacity of Board advisor, and the other with experience in leading organisational strategy, partnership working and engagement. Once both new NEDs are in post the Board should undertake a formal skills assessment as this has not been undertaken since 2014. Results of this assessment should be used to direct the future content of the Board Development Programme. During Committee meetings and at the Board meeting we found the level of challenge from the NEDs to Executive Directors to be robust whilst maintaining professionalism. We also saw appropriate levels of Executive to Executive challenge in other meetings. We did not witness defensive behaviours in the Board room or at Committees, and mutual respect between colleagues was evident. The Trust has developed a clinical leadership model and Clinical Chairs are the accountable officers in each of the five Clinical Divisions. These appointments were made earlier this year and the model is maturing well. In meetings we attended the Clinical Chairs provided information across all areas of responsibility, e.g. finance, (including their ability to meet the financial improvement programme); workforce; clinical; quality; and patient safety. A post-implementation review of this model should be undertaken to ensure the time allocated to the role is sufficient and sustainable. The Trust has a significant underlying financial deficit and the Board has recognised that in order to meet the challenging FIP targets a more transformational approach is required. External support is now in place to maintain consistency, pace and grip of the overall process and the Divisional Triumvirate teams are involved in weekly meetings to discuss progresses of individual schemes. Leadership programmes are in place to support leaders and Executive Directors have attended the Senior Leadership Programme, however some staff we interviewed suggested the Divisional Triumvirate teams would benefit from targeted team development, and this should be considered. The visibility and accessibility of the Board members is good. Formal and informal activities and meetings are in place, ensuring exposure to a wide range of staff/services.

Executive Summary

KPMG Rating	NHSI's Well-Led Framework
Amber / Green	**Key Question 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?** The Trust's strategy is being revised and is currently out to consultation. The launch is scheduled for April 2019. Significant work has been undertaken by the Head of Communications and Board members in the communication of this strategy across the Trust's services, Governors and its membership. A Public Involvement and Engagement Plan is in place to allow the public opportunities to inform and be involved in and influence the Trust's plans and services. A two year Forward View document has been circulated to all staff clearly stating the main focus of the Trust over the next two years, internally and externally, including the need to increase partnership working. The Trust is heavily involved in working with its partners through the Nottingham and Nottinghamshire Sustainability and Transformation Partnership (STP). The Trust has been working over three years on the Better Together programme that brings together the local Trusts; CCGs in Newark and Sherwood and Mansfield and Ashfield; Nottinghamshire County Council and other partners to look at how the health economy can join up health and social care services more effectively in the future. The Trust are aware of the significant work that needs to be undertaken within the health economy to develop services that will meet the future needs of its local population. The Trust's Vision and values are well presented and understood by staff. At the last inspection CQC found staff were aware of the Trust's vision and values and were focused on constant improvement and delivering outstanding care to patients. The strategic objectives are contained within the Board Assurance Framework and this is considered at Board each month. Each of the five strategic objectives are aligned to the various sub-committees of the Board, (Quality and Finance) and the Risk Committee.

Executive Summary

KPMG Rating	NHSI's Well-Led Framework
Amber / Green	**Key Question 3. Is there a culture of high quality sustainable care?** At the Trust's last inspection, CQC found a demonstrable culture of high quality, sustainable care that was delivered across the Trust's services. CQC found that managers across the Trust promoted a positive culture, that supported and valued staff, creating a common purpose based on shared values. The Trust has a Freedom to Speak Up/Raising Concerns - Whistleblowing Policy, outlining the process for raising concerns internally and externally, roles and responsibilities and the support available for staff. We have made some recommendations for the Trust to reassess its current arrangements, including lines of accountability for the Freedom to Speak Up (FTSU) Guardian. The Trust currently has four Guardians and one supporting 'champion', and we have recommended appointing one FTSU Guardian supported by a number of 'champions' or 'listeners' of varying levels and disciplines, to ensure staff feel they are accessible by locality and grade. The Trust promotes an open culture for incident reporting, encouraging staff to report all incidents and near misses. 'No' or 'low harm' incidents consistently account for approximately 99% of the total incidents reported. A Patient Safety Quality Group meets monthly. This has a high clinical representation from Divisions and corporate function staff. The Medical Director chairs this group, and the Chief Nurse and Chief Operating Officer are also members. This is a high functioning meeting with a clear agenda, and focussed and monitored actions. The Trust is using the NHS Improvement / Kings Fund Culture and Leadership toolkit to undertake a diagnosis of the Trust's current and desired culture and leadership style. The results and analysis of the discovery phase will be used to inform the Trust's future leadership and organisational development work. A new appraisal system was launched in April 2018 and includes talent conversations. Appraisal rates are high with overall compliance at 95%. The Trust provides training for appraisers and appraisees, however a trust-wide process in is not in place to review the quality of appraisals on a regular basis. The Board is undertaking work to address its position in relation to the number of staff from a BME background. Currently less than 9% of staff are from a BME background, and are underrepresented in senior AfC pay bands.

Executive Summary

KPMG Rating	NHSI's Well-Led Framework
Amber / Green	**Key Question 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?** CQC found the effectiveness of the Board had developed into a positive team working ethic, with appropriate levels of challenge, debate and support. The Trust has developed its structure, processes and systems of accountability. There is a suite of Board sub-committees. Committees are well organised with papers that are appropriate, well written and well presented. The Trust does not have a workforce sub-committee of the Board, and there was considerable debate at the Board meeting generated by the NEDs with regard to workforce issues. At a time where the workforce agenda is significant in terms of recruitment and organisation development, reinstating the Workforce Committee as a sub committee of the Board should be considered. The Quality Committee meets bi-monthly. This is a well chaired and important Committee for the Trust to gain assurance over its patient safety and quality agenda. Chairing responsibilities are being reorganised due to the appointment of a new NED with a clinical background. The Trust is considering changing the frequency of the Quality Committee to quarterly. The Trust has undertaken considerable improvement work across its services from being placed in special measures in 2013, and has recently improved its CQC rating from 'Inadequate' in 2015 to 'Good' in 2018. We recommend that the Trust maintains the bi-monthly frequency of its Quality Committee with a view to reviewing this once the new Chair has been in post 12 months. Monthly Divisional Performance Review meetings are in place. These are chaired by the Chief Operating Officer and attended by many of the Executives. although on occasions Executives are unable to attend or send representation, and this is an area for improvement. Information gained during our interviews and our observations at meetings supported a mature and embedded governance processes, with good ownership at both Corporate and Divisional level. The CCG also commented that governance was 'rigorous'. Divisions are appropriately held to account through these structures.

Executive Summary

KPMG Rating	NHSI's Well-Led Framework
Green	**Key Question 5. Are there clear and effective processes for managing risks, issues and performance?** The Trust has a Risk Committee which reports to the Board and has the responsibility to systematically review, scrutinise and challenge risk profiles across all Divisions and Corporate functions ensuring the correct strategy is adopted for managing each key risk. This Committee is chaired by the CEO, which brings appropriate focus and challenge to this forum. The Board Assurance Framework (BAF) includes regular updates to Key Risk Indicators (KRIs), which are a series of indicators that highlight performance of the Trust in mitigating the impact of a potential risk. It is clear that the financial position of the Trust is a key challenge and has significant focus and scrutiny across the Trust. The impact on service quality is considered in meetings and by a formalised process of Quality Impact Assessments. The Trust has responded to the financial pressures by engaging external support to review FIP plans and processes and identify schemes to meet this challenge. Monitoring is in place to track the progress and pace of these schemes. In addition to the statutory Audit Assurance and Remuneration Committees, the Trust also has a Quality Committee and a Finance Committee. The Trust's governance structures and performance management framework provide a platform to manage current and future performance. The Trust has reviewed the effectiveness of its committee structure and made changes where it has deemed necessary. The Trust has established a process of monthly Divisional Performance meetings. These meetings are chaired by the COO and attended by the General Manager, Finance Manager and Clinical Chair for each Division as well as other Executive Directors. These meetings are a useful tool to drive frontline performance and are held in a constructive manner. The Divisions feel held to account by these meetings and the discussions are evidence led and focused on the actions required to improve or maintain performance. There is scope to improve attendance at these meetings by some members of the Executive team. The Trust has established a Single Oversight Framework (SOF) in order to report performance in one place. This report is well designed and comprehensive – a short executive summary is supported by a dashboard which sets out performance and trends for a suite of KPIs. The Trust's clinical audit plan is on track and progress reported to the Clinical Audit and Effectiveness Group, with regular updates reported to the Patient Safety and Quality Group. However the report does not consider the tangible benefits resulting from these reviews and this should be considered.

Executive Summary

KPMG Rating	NHSI's Well-Led Framework
Amber / Green	**Key Question 6. Is appropriate and accurate information being effectively processed, challenged and acted on?** The Trust's Single Oversight Framework provides a ward-to-board reporting and monitoring structure. Routine reports are issued on a monthly basis from a single data source to ensure consistency of reporting and interpretation. At Board level, quality and sustainability is reported through the Patient Safety and Quality Group to the Quality Committee. Whilst available data is detailed and offers significant granularity, the Trust are working to add a self serve process at Divisional level. The Trust's Single Oversight Framework focuses on in-year (operational and financial) monitoring, working alongside the Quality Committee (quality) Finance Committee (financial planning and business cases) and Workforce Planning Group in respect of HR indicators. This focus avoids duplication of data across committees. In the Trust's last CQC inspection, CQC stated that information systems were working for the Trust, providing good quality, timely data which is appropriately reported. The Trust has a Data Quality Strategy that considers its strengths and weaknesses in regard to data quality. In order to address these issues the Trust established a Data Quality Oversight Group that reports to the Risk Committee, chaired by the Executive Medical Director. The Trust has prepared a Data Quality Improvement Plan, which seeks to improve overall data quality. This plan has clear ownership for each action, a timeline for achievement and a RAG rating to confirm progress. The Trust has an Information Governance Framework in place and has during the year updated its Cyber Security Plan as overseen by the Cyber Security Delivery Group. The Trust has responded to the General Data Protection Regulation (GDPR) landscape with a GDPR group reporting into the Trust's governance structures. This is subject to Internal Audit with audits planned for the overall Data Quality Framework, DSP Toolkit and Cyber Security during the 2018/19 year.

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KPMG Rating	NHSI's Well-Led Framework
Amber / Green	**Key Question 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?** The Trust Board opens with a patient story and the Board encourages a full and diverse range of patient/carer views and concerns to be heard and acted on. The 2017 NHS National Staff Survey response rate was 57%, which is in the highest 20% of acute trusts in England (44%), and compares with a response rate of 41% at the Trust in the 2016 survey. The survey highlighted many areas, including overall staff engagement, that had shown a significant change since the previous year. The top five ranking scores were all in the best 20% of acute Trusts in England. The Trust has developed an action plan to address any emerging themes and regular 'pulse checks are undertaken to continually gauge the views of staff. The Trust can demonstrate multiple activities and events to engage and support staff. Board members and Divisional Clinical Chairs were able to cite examples where patient feedback had been effectively used to shape services and the culture of delivery. Executive to Executive meeting of Sherwood Forest Hospitals NHS FT and Newark and Sherwood CCG and Mansfield and Ashfield CCG occurs regularly, usually weekly. Meetings alternate by site and chairing responsibilities. Commissioner relationships are reported to be good. Our interview with Commissioners confirmed a positive culture within the Trust and a willingness to learn and escalate issues as appropriate. The CCG views the governance structure within the Trust as 'rigorous'. The Trust works well on engagement with its Council of Governors (CoG). A number of best practice initiatives are in place, for example two Governors attend each Board sub-committee although there is variance of how this operates in practice and this requires further clarification and a more rigorous and consistent approach. The Board should consider re-establishing the NED / Governor buddy scheme to assist with introducing consistency in the role. Further training for Governors should be undertaken to define the role, its value and expectation.

Executive Summary

KPMG Rating	NHSI's Well-Led Framework
Amber / Green	**Key Question 8. Are there robust systems and processes for learning continuous improvement and innovation?** The Trust's 'Journey to Outstanding' is a compelling story and resonates throughout its various financial, improvement, quality and safety plans. There are many examples of continuous learning with tangible outcomes, including significant work around reducing mortality; management of sepsis; and management of the deteriorating patient. The Trust has recently won a number of prestigious awards in areas such as enhancing care for people with learning disabilities; management of waste; and for its work in the development of a clinical phycology cancer service. The Trust is working towards developing and training staff in a single Quality Improvement (QI) methodology, and for this to be rolled out across the organisation. The QI programme will require implementation and embedding across the Trust's services. The Trust has sought external advice from its peers in various areas and also supports other Trusts requesting advice or external review. The Trust benchmarks its performance in many areas with Trusts of a similar type and also within its local health community.

KPMG

Section two

Detailed findings

Detailed findings

Detailed Findings

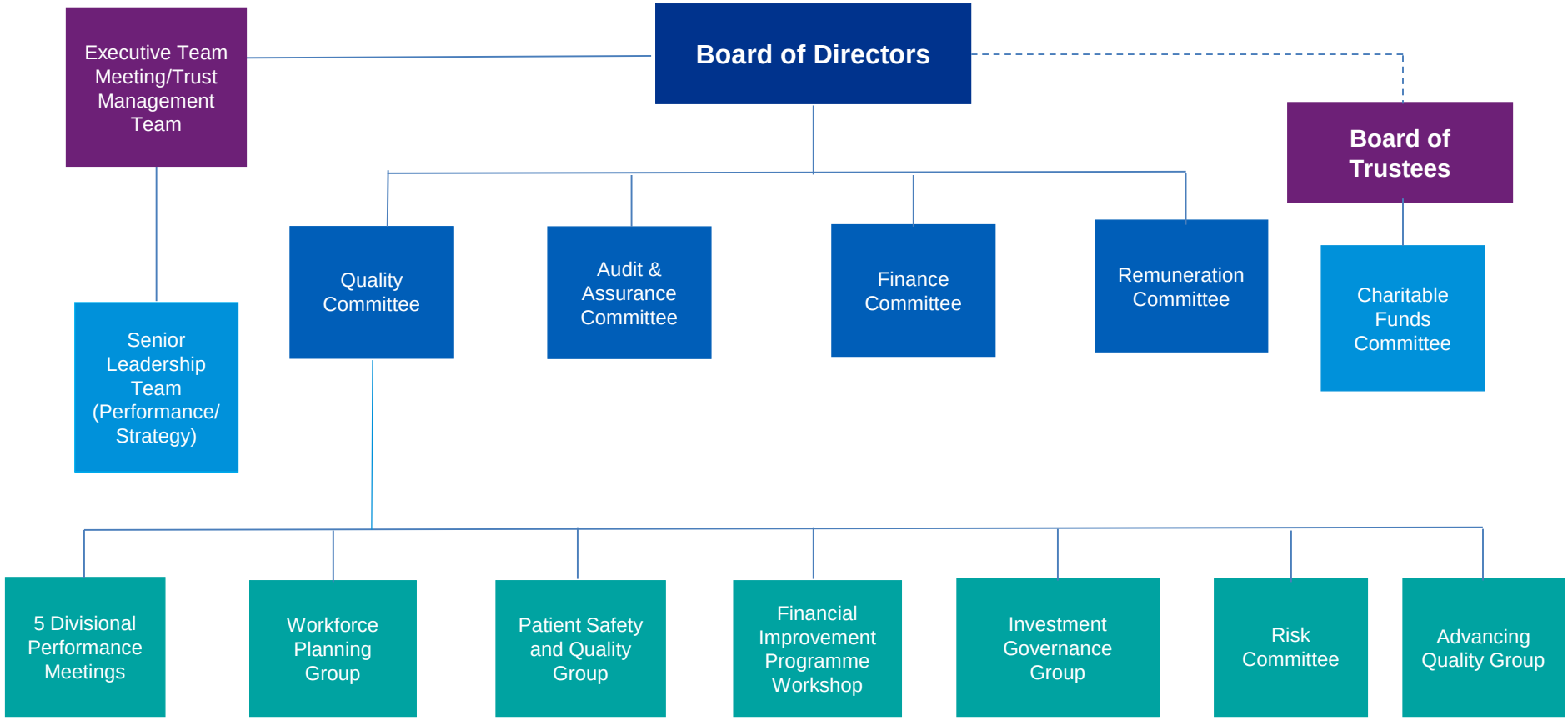
This section sets out our detailed findings in relation to our work. We have reported the Board survey results followed by our findings for each of the eight key questions, in accordance with NHSI's Well-Led Framework for Governance Reviews.

Question 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?	**Question 2** Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	**Question 3** Is there a culture of high quality sustainable care?
Question 4 Are there clear responsibilities, roles and systems of accountability to support good governance and management?	**Are services well-led?**	**Question 5** Are there clear and effective processes for managing risks, issues and performance?
Question 6 Is appropriate and accurate information being effectively processed, challenged and acted on?	**Question 7** Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	**Question 8** Are there robust systems and processes for learning continuous improvement and innovation?

Detailed findings

Trust governance structure

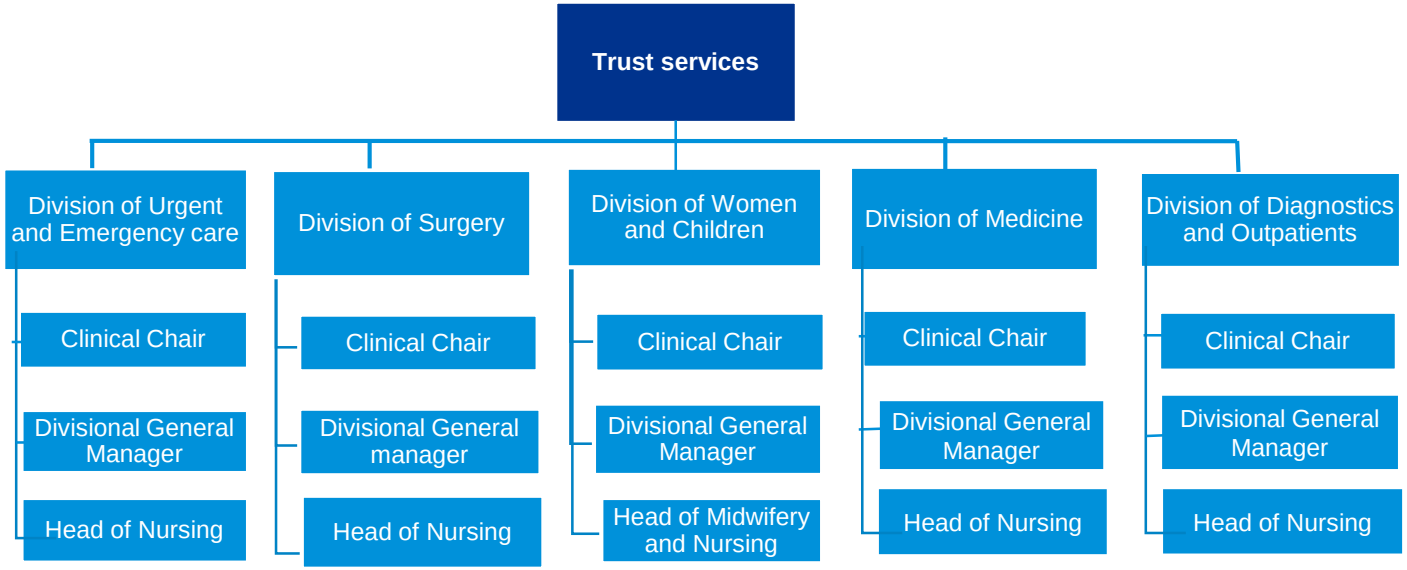
We outline below an extract of the Trust's governance structure.



Detailed findings

Trust's operational structure

The Trust is organised in five Clinical Divisions.



Detailed findings

Board survey results

In total we received12 responses to the Board survey out of a possible 15. The survey consisted of 130 short questions across the eight well-led key lines of enquiry. For each of the eight themes we asked respondents to provide an overall confidence rating using a four point scale from green to red as described in the key below.

Rating	Descriptor
Green	Meets or exceeds expectations.
Amber/Green	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable time frame.
Amber/Red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable time frame.
Red	Does not meet expectations and requires further work.

The overall results are presented in the table below:

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
	Leadership	Vision and Strategy	Culture	Roles and Accountability	Risk and Performance	Information	People and Partners	Learning and Innovation
Overall rating	Amber/Green	Amber/Green	Green	Green	Green	Green	Amber/Green	Amber/Green

The detailed survey results have been presented by question at:

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Summary of our findings	KPMG rating	GREEN

Do leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

In addition to the Trust Chair the Board includes 14 members – eight Executive Directors and five Non Executive Directors (NEDs). A new NED has been appointed but has not yet started in post.

The Board positions are all substantive appointments, and this is something that has been viewed positively by every person we interviewed. People spoke of the Board stability, capacity and capability. There is clear role definition amongst all members and all were aware of their roles, responsibilities and accountabilities. All Board members spoke knowledgeably regarding issues the organisation face, across the various portfolios.

Executives Directors are all now established in their roles. Staff at Divisional level spoke to us regarding the positivity that the Executive has collectively brought to the Trust. People spoke of the "profound effect" and commented that "attitudes and behaviours generate loyalty".

Most Executive Directors are supported by deputies and these positions are well defined to ensure that aspects of the portfolios are appropriately covered e.g. revalidation.

Additionally there is a good breadth of skills in the NED group. NED membership has been recently strengthened by the addition of two new NEDs, one with a clinical background, who has already been working in the capacity of Board advisor, and the other with experience in leading organisational strategy, partnership working and engagement.

The Non-Executive Directors (NEDs) have diverse backgrounds, including relevant clinical, finance and business experience. A gap analysis of skills in the existing NED group had been made and this directed the recruitment of the two new NED appointments.

Although the Board has time-out away days a formal skills assessment has not been undertaken since 2014. As all Board positions are recruited this would be a good time to undertake this and base any subsequent Board development sessions on the findings. **(Recommendation 1)**

The Board level Committees are well managed and membership is clearly defined. There is some 'cross attendance' at Committees and this is helpful to allow areas of collective understanding and that decisions are not made in exclusion of associated agendas e.g. finance and quality.

Board and Committee effectiveness is regularly evaluated and action taken to address any emergent issues. The Trust reviews the effectiveness of its Committees utilising a Committee Health Check, a self-assessment tool which has been designed as a practical resource to assist the Trust's committees in demonstrating their good governance practices and identifying areas for improvement.

It is based on the National Audit Office document and is divided into 5 sections:

- Role and responsibilities;
- Membership and independence;
- Skills and experience;
- Scope of work; and
- Communication.

We found the level of challenge from the NEDs to Executive Directors to be robust whilst maintaining professionalism. We also saw Executive to Executive challenge in other meetings. We did not witness any defensive behaviours in the Board room or at Committees, and the mutual respect between colleagues was evident.

The Trust has a clinical leadership model with Clinical Chairs being the accountable officer in each of the five Clinical Divisions. The appointments to these roles were made earlier this year. This has matured over time and we saw Clinical Chairs able to provide information across all areas of responsibility, e.g. finance, workforce, clinical quality and patient safety etc.

Each Clinical Chair has four programmed activity (PAs) sessions allocated to undertaking the role. Some Clinical Chairs have maintained their on-call rota responsibilities and this has impacted on their capacity to undertake all aspects of the roles in the time allocated. Clinical Chairs do not have an appointed deputy, usually the Divisional General Manager and head of Nursing/Midwifery deputise in their absence. The Trust should undertake a post implementation review of the Clinical Chair role to establish the capacity of the post holders. **(Recommendation 2)**

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care? (cont.)

Is the leadership knowledgeable about issues and priorities for the quality and sustainability of services, understand what the challenges are and take action to address them?

From our Board member interviews there was a common understanding of the key risks, issues and priorities for the Trust. The issues are documented on the Board Assurance Framework and the Trust's Corporate Risk Register. Clinical Chairs were able to describe their top risks and the processes in place to manage them.

From our attendance at the Board-level committees and the Board meeting, it was clear that the Trust's key issues are being discussed on a timely basis. Action logs are well maintained and staff came prepared to discuss any due actions. At our attendance at the Patient Safety Quality Group an update was not available from one of the Clinical Chair and this was dealt with appropriately in the meetings. Expectations are clear.

The Trust has a significant underlying financial deficit and the Board has recognised that in order to meet the challenging CIP targets a more transformational approach is required. External support is now in place to maintain consistency, pace and grip of the overall process and the Divisional Triumvirate teams are involved in weekly meetings to discuss progresses of individual schemes. When interviewed the Clinical Chairs were all confident that whilst the financial improvement programme (FIP) is challenging, their Division would meet their control target and CIP schemes were progressing well.

Is compassionate, inclusive and effective leadership sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.

The Board has undertaken development sessions, some of which have been externally facilitated, impactful and helpful.

There are a number of leadership programmes aimed at various staff levels and disciplines throughout the organisation. This includes a well evaluated Senior leadership Programme that Executive Directors attended.

Some staff we interviewed stated the Divisional Triumvirate teams would benefit from a targeted team development programme and this should be considered. **(Recommendation 3)**

The Chief Executive has undertaken work regarding succession planning, focussed on post holders that may retire within the next two years. Some Trusts we have worked with have addressed succession plans in a detailed way, assessing each Executive Director with contingency plans in the event of an immediate absence, plans if given 3-6 months notice and plans for scheduled retirement. **(Recommendation 4)**

Talent succession planning is in place and materials have been produced to assist with these local leadership conversations.

Are leaders at every level are visible and approachable.

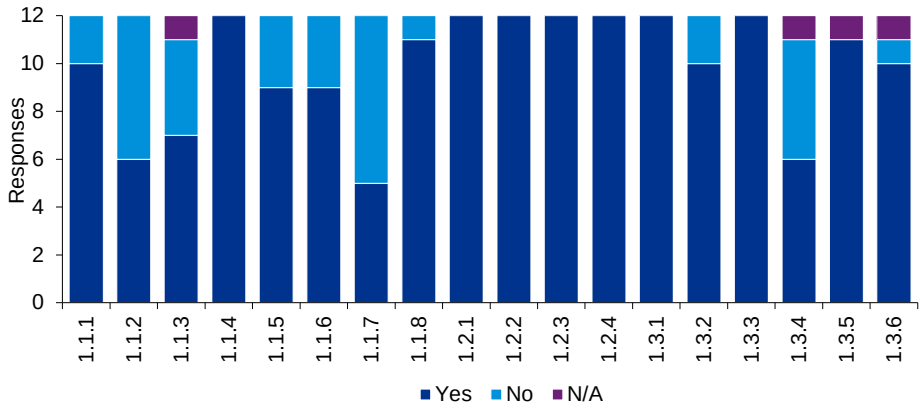
The Board are described as visible and accessible. An open door policy is evident.

There is good Executive Director attendance at key meetings such as the Patient Safety Quality Group and Trust Management Team etc where Divisional representatives are present. In a addition there are a series of 15 steps visits where the NEDs accompany staff on visits to services and the findings of these are reported through the Quality Committee. All Executives plan to engage with a different service area each week and this is displayed on a white board so others know which services are being visited to avoid unnecessary duplication. Some Executives have joined ward board rounds and this assists them in their understanding of some of the key challenges across the Trust's services.

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care? (cont.)

Board survey results

Overall respondents rated this domain as **AMBER-GREEN**



What do you see as the key piece of assurance that the Trust receives as to the capacity and capability of leadership to deliver high-quality, sustainable care?

- Staff survey results
- Annual Training report
- Maximising our Potential reports
- Executive appraisal outputs
- Workforce Strategic update
- External Reports from inspectors
- Feedback from stakeholders

#	Question
1.1	Are all posts filled?
1.1.2	Is an update to the Board skills assessment and training plan in place?
1.1.3	Are succession plans in place for appropriate roles?
1.1.4	Are appraisals and PDPs in place and reviewed?
1.1.5	Have Board working relationships been reviewed?
1.1.6	Has skills based training been provided to the Council of Governors?
1.1.7	Have the skills and capabilities within the Trust assigned to the STP process been assessed?
1.1.8	Is there a clear, defined and documented leadership and team structure for all parts of the Trust?
1.2.1	Are routine communications from the Board made to all staff on key priorities including quality, safety, operational, financial and human resources matters?
1.2.2	Are the board briefed on routine matters and escalation of matters arising from divisions on an ongoing basis?
1.2.3	Do the leaders of the Trust have an action plan to address issues identified in the annual staff survey?
1.2.4	Do staff have multiple forums to raise concerns directly with leaders of the Trust?
1.3.1	Has the Board approved a comprehensive workforce strategy for the Trust?
1.3.2	Has the Trust developed an education and training strategy for all relevant staff groups within the Trust?
1.3.3	Have sub-strategies or plans for particular workforce groups been developed, for example a Nursing Staff Strategy?
1.3.4	Has the Board considered succession planning for critical senior posts outside of Board members?
1.3.5	Does the Board invite specialists or relevant professionals to support their operations when necessary?
1.3.6	Has a senior staff development programme been put in place for senior staff outside the Board?

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Summary of our findings	KPMG rating	AMBER/GREEN

Is there a clear statement of vision and values, driven by quality and sustainability.? Has it been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant?

The Trust has developed a strategy that was well understood by everyone we spoke to. The strategy is currently being revised and is currently out to consultation. The launch is April 2019. A significant amount of work has been undertaken by the Head of Communications and Board members in the communication of this strategy across the Trust's services, Governors and its membership.

A two year Forward View document has been circulated to all staff and clearly states the main focus of the Trust over the next two years:

- Working with partners to promote health and wellbeing and supporting people in their homes for as a long as possible.
- Providing safe, personalised care through all Trust sites, in particular on the emergency pathway.
- Working with partners to discharge patients in a safe, timely way.

The Trust has also developed its Quality Strategy and aims to provide not just good care, but the best care that can be provided.

Areas of focus include:

- Improving the management of patients with mental health needs and learning disabilities;
- Ensuring the appropriate and safe management of medicines;
- Improving the support provided to patients nearing the end of their life;.
- Improving access to the full range of diagnostic and treatment services on every day of the week; and
- Maternity services - ensuring that women-centred care is delivered, that is safe, personalised, kind, professional and family friendly.

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? (cont.)

Is the strategy aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population?

The work of the Nottingham and Nottinghamshire Sustainability and Transformation Partnership (STP) and the selection of Greater Nottingham to be the early focus of an accelerator site for the development of an accountable care system affords the Trust the chance to work across the health economy to develop services that will meet the future needs of its local population.

The Trust has been working over three years on the Better Together programme and the Trust's Chairman is the Chairman of that Board, which brings together the NHS in Newark and Sherwood, Mansfield and Ashfield and Nottinghamshire County Council and other partners to look at how the health economy can join up health and social care services more effectively in the future.

Several of the Trust Executives are actively engaged in these partnership activities, and this is viewed as positive in terms of the impact it will have on the system and subsequent benefit the Trust's patients in the redesign of services.

Do staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them?

There is evidence of a variety of good communications with staff throughout the Trust's services. During the last regulatory inspection, CQC found all staff were aware of the Trust's vision and values and were focused on constant improvement and delivering outstanding care to patients.

In our Board survey only 50% of respondents agreed that the strategy included a clear vision for the Trust, and underpinning values and priorities. This may be because the strategy is currently being consulted upon and therefore not finalised. However this should be discussed to ensure the strategy is explicit and easily understood. **(Recommendation 5)**

Has the vision, values and strategy been developed through a structured planning process in collaboration with people who use the service, staff and external partners?

The Trust's strategy and the vision and values were developed following consultation with staff. The Council of Governors also receive updates on the strategy and outcomes of the consultation.

The Trust recognises that it is important to include the voices and views of the public in its plans. However it also acknowledges that there is more work it can do to make it easier for the public to engage.

As a result it has produced a Public Involvement and Engagement Plan, to run from 2017-2021. The aim of this is to ensure the public have the opportunities to inform (and become informed), be involved in and influence the Trust's plans and services. It has two key objectives:

- To ensure there are regular opportunities for the public to be involved and influence plans.
- To ensure there are regular channels that inform the public and information aimed at the public has been reviewed by the public.

As a result of this a Forum for Public Involvement was established, and held its first meeting in November 2017. Foundation Trust members and members of the public were invited to participate which resulted in an interested group of 46. Terms of reference have been established and the group meets monthly with every fourth meetings at Newark Hospital.

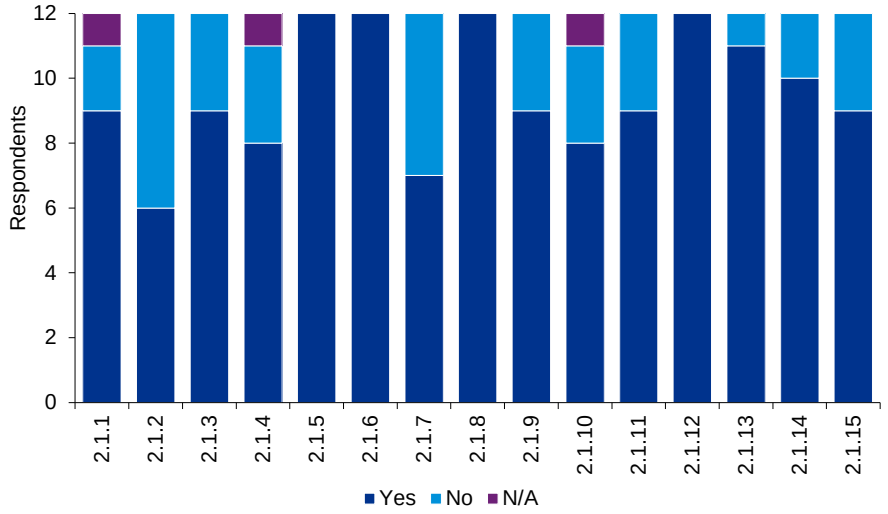
Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

The strategic objectives are contained within the Board Assurance Framework and this is considered at Board each month. Each of the five strategic objectives are aligned to the various sub-committees of the Board, (Quality and Finance) and the Risk Committee.

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? (cont.)

Board survey results

Overall respondents rated this domain as **AMBER-GREEN**



What has been the most effective tool used to communicate the strategy and vision to staff?
– Weekly newsletter from the CEO
– Face to face staff briefings
– Communication across different media
– Team briefings for individual service lines

#	Question
2.1.1	Is the strategy up to date?
2.1.2	Does the strategy include a clear vision for the Trust, and underpinning values and priorities?
2.1.3	Was it formulated involving appropriate stakeholder input (ie. commissioners, local authorities, neighbouring providers, education partners, voluntary sector)?
2.1.4	Does it have a clear communication plan internally and externally?
2.1.5	Was the strategy rooted in a clear assessment of past achievements?
2.1.6	Did the strategy employ techniques, such as SWOT, to aid its development?
2.1.7	Does the strategy mix national as well as local priorities?
2.1.8	Has the strategy been cascaded into goals for staff within the Trust?
2.1.9	Do different elements of the strategy have clear time frames for their achievement?
2.1.10	Has the strategy resulted in targets for divisions?
2.1.11	Has the strategy been linked to outcome based performance metrics for the Board?
2.1.12	Has the strategy been used as a reference point for business cases within the last 12 months?
2.1.13	Does the strategy include stretch objectives as well as those which are more achievable?
2.1.14	Has the strategy, vision, priorities and values of the Trust been regularly communicated and updated to staff?
2.1.15	Have the risks to the strategy been captured in a Board Assurance Framework or equivalent?

KLOE 3. Is there a culture of high quality sustainable care?

Summary of our findings	KPMG rating	AMBER/GREEN

Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.

All staff we spoke to at various levels of seniority displayed the Trust's values. It was clear that there are many activities in place to communicate with staff and support staff to undertake their roles.

The CQC visited many of the Trust's services and spoke to staff both formally and informally. They found a demonstrable culture of high quality, sustainable care that was delivered across Divisions, specialties, Trust locations and staff groups. CQC found that managers across the Trust promoted a positive culture which supported and valued staff, creating a common purpose based on shared values.

CQC found there was a strong and palpable culture of team work and staff felt valued, with different disciplines working alongside each other and showing respect for each other's opinion.

The Trust holds a number of schemes whereby staff can nominate others for awards – star of the month, Chief Nurse awards etc.

The Trust has recently run a series of Culture and Leadership focus groups for staff, across all grades and disciplines. The Trust is running the NHS Improvement Culture and Leadership programme, to support the type of leadership and culture that aims to deliver high quality, continuously improving, compassionate care. Through this the Trust aims to improve the health and wellbeing of its staff, leading to better health outcomes for patients.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on.

The Trust has a Freedom to Speak Up/Raising Concerns - Whistleblowing Policy, and this is primarily for concerns where the public interest is at risk, which includes a risk to the wider public, patients, staff or the Trust itself. The policy outlines the Trust's process for raising concerns internally and externally, roles and responsibilities and the support available for staff. However during the course of this review there are some personnel changes to reporting lines and these, along with the adoption of our recommendations will need to be reflected in an revised policy.

The Trust recognises that it needs to reassess its current arrangements for its Freedom to Speak Up Guardian. It currently has four Guardians and one supporting 'champion' and reporting lines are formally through Human Resources. We have discussed the appropriateness of this with the Trust and a change has recently been made and the role now reports to the Director of Corporate Affairs. Common practice would be to have one FTSU Guardian supported throughout the Trust's services by a number of 'champions' or 'listeners'. These should be of varying levels and disciplines to ensure staff feel they are accessible by locality and grade. **(Recommendation 6)**

The Trust has recently undertaken a self review of its Freedom to Speak Up processes, using the NHSI's tool. This was reported at Trust Board in September 2018. The following areas were identified for action:

- Consideration of the model for the FTSU Guardians, currently this is on a voluntary basis across 4 guardians;
- The current guardians do not reflect the diversity of the organisation;
- There is a requirement for a FTSU strategy which aligns with the Trusts vision, values and strategic objectives;
- More focus is required on understanding the barriers to speaking up in the organisation;
- There should be a more formal approach to auditing of FTSU concerns and process; and
- A review of case studies from within and external to the organisation to be reported to the Board 6 monthly by the FTSU guardians.

The FTSU Guardian reports to the Board each quarter, via the workforce culture and leadership report.

KLOE 3. Is there a culture of high quality sustainable care?

The Trust has an incident reporting policy. The policy outlines the Trust's requirements for reporting incidents and identifying serious incidents. It also details the investigation process and key roles and responsibilities of staff. There is also a Serious Incident Review and Sign-off Group to promote a consistent approach for the reporting, managing and monitoring of serious incidents. The group has a terms of reference.

The Trust uses an electronic incident reporting system, (Datix) to manage the incident reporting process.

In our interviews staff reported a good incident reporting culture across the Trust. 'No' or 'low harm' incidents consistently account for approximately 99% of the total incidents reported.

Incident reporting by level of harm

Reporting period	Incidents reported per 1000 bed days	No harm	Low harm	Moderate harm	Severe harm	Death
April 16-Sept 16	32.82	80.1%	19.3%	0.5%	0.2%	0%
April 17-Sept 17	34.09	78.3%	20.9%	0.7%	0.1%	0%
Oct 17-March 18	32.64	79.6%	19.6%	0.5%	0.3%	0%

The Trust are slightly lower than average reporter of incidents when compared to all non-specialist acute hospitals (median average incident rate per 1000 bed days = 40.1). However the National Reporting and Learning System (NRLS) do not consider the Trust's incident reporting rate to be indicative of under reporting.

A Patient Safety Quality Group meets monthly. This has a broad membership with a high clinical representation from Divisions and corporate function staff. The Medical Director chairs this group, and the Chief Nurse and Chief Operating Officer are also members. This is a high functioning meeting with a clear agenda and focussed and monitored actions. We spoke to staff who attend, all of which found this a worthwhile and essential meeting to attend.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

The Trust is using the NHS Improvement / Kings Fund Culture and Leadership toolkit to undertake a diagnosis of the Trust's current and desired culture and leadership style. The Trust Board interviews are complete and the Trust has undertaken the Leadership Behaviours Survey and a series of Culture Focus Groups. The focus groups were widely advertised on posters, in the staff bulletin, through leaflet drops, through twitter, targeted emails to managers and promoted to attendees to encourage their colleagues to attend. The results and analysis of the discovery phase will be used to inform the Trust's future leadership and organisational development work.

There are multiple leadership development opportunities and talent management processes. Programmes include in-house programmes supported by NHS Elect, and external programmes such as the Mary Secole leadership programme.

A new appraisal system was launched in April 2018 and includes talent conversations. Appraisal rates are high with overall compliance at the Trust's target of 95%.

All nursing and midwifery staff incorporate aspects of the Trust's strategy within their appraisal, and agree their pledges for delivery. The Trust provides training for appraisers and appraisees but a trust-wide process in is not regularly in place to review the quality of the appraisals. **(Recommendation 7)**

The overall average statutory and mandatory training compliance rate is 94%, and is consistently above the Trust's target of 90%.

KLOE 3. Is there a culture of high quality sustainable care? (cont.)

Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their well being.

The Trust provides a number of processes to support the well being agenda. Staff are able to benefit from health and well being drop-in sessions that are provided across its locations. These are staffed by Occupational Health, and staff are invited to come and discuss any health or well being issues they may have.

The Trust had a good response rate to the 2017 national staff survey. Over 2500 staff responded, giving a response rate of 57%. This was the highest in the East Midlands and joint 7th highest in England for acute NHS Trusts, where the average response was 44%. The 57% response rate in 2017 compared well with the 41% Trust response rate in 2016.

The overall indicator of staff engagement for the Trust was 3.87, which was above average of 3.79 when compared to trusts of a similar type.

Staff experience had improved in areas including:

- % of staff experiencing physical violence from staff in the last 12 months;
- Support from immediate managers;
- % of staff reporting good communication between senior management and staff.

Staff experience had deteriorated in the following area:

- % of staff witnessing potentially harmful errors, near misses or incidents in the last month.

The Trust has an action plan in place to address issues arising from the staff survey. The Trust has undertaken benchmarking od staff survey results with other local acute trusts.

Results of the staff survey were discussed at the Staff Communication and Engagement Forum. Divisions have developed local action plans that are monitored centrally. The Trust has tailored its quarterly 'pulse' survey to include a series of follow-up questions to assist in monitoring progress against the key issues that emerged from the national survey.

There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility shared.

Staff were able to give some good examples where they have dealt with areas of conflict with good outcomes. Staff told us that poor behaviours are not tolerated and will be dealt with appropriately.

Relationships between staff appear good, although we have had limited exposure to the Trust's clinical teams during this review. However Divisional leaders interviewed demonstrated a passion for developing their services and had a positive attitude despite the financial and operational challenges the Trust is facing.

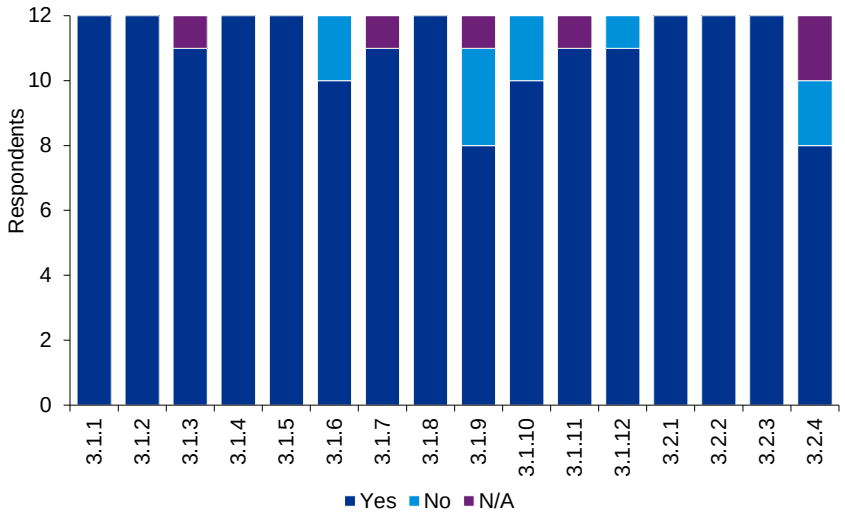
Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

The Trust considers its Workforce Race Equality Standard data at its Organisational Development and Workforce Committee. This is not however a sub-committee of the Board. The Board is aware that further work is required on its position in relation to its number of staff from a BME background. Currently less than 9% of staff are from a BME background and are underrepresented in senior AfC pay bands. **(Recommendation 8)**

KLOE 3. Is there a culture of high quality sustainable care? (cont.)

Board survey results

Overall respondents rated this domain as **GREEN**



What do you consider to be the most important measure of quality which is viewed at Board level?

- SOF
- Patient Story
- A&E wait times
- Access standards and safety reports (e.g. staffing levels)
- Patient Feedback
- Report from Quality Committee

#	Question
3.1.1	Is quality considered at every Board meeting?
3.1.2	Is quality given prominence in staff induction?
3.1.3	Are sufficient policies and procedures in place to support safe and effective working?
3.1.4	Does the Board effectively engage with external stakeholders?
3.1.5	Are raising concerns at work processes understood by the Board?
3.1.6	Are raising concerns at work processes understood by staff?
3.1.7	Are the results of clinical audit and quality reviews published to all relevant staff?
3.1.8	Are national enquiries and recommendations considered by the Board?
3.1.9	Does the Board understand the views of Health Watch on their services?
3.1.10	Does the Trust regularly review the availability and scope of volunteers to work with the Trust?
3.1.11	Does the Trust provide sufficient support for its volunteers?
3.1.12	Do Board members have sufficient informal interaction with staff?
3.2.1	Does the Trust regularly take action to review the cultural drivers of change at the Trust?
3.2.2	Is a culture of openness and transparency emphasised such as through freedom to speak up processes?
3.2.3	Do performance evaluations operate at all levels of the Trust?
3.2.4	Do performance evaluations include a review of the behaviours and relationships with staff at the Trust?

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Summary of our findings	KPMG rating	AMBER/GREEN

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services are clearly set out, understood and effective.

CQC found the effectiveness of the Board had developed into a positive team working ethic, with appropriate levels of challenge, debate and support. We attended the Board meeting and found it to be well organised with good quality papers. It was well chaired and allowed for an appropriate level of challenge and debate.

The Trust does not have a workforce sub-committee of the Board, and there was considerable debate at the Board meeting with regard to workforce issues. This, is part, was due to a number of papers that were scheduled to report at Board for that meeting, However the challenge and questions from the NEDs was significant, and this is perhaps due to the fact that none of the NEDs had been in forums to debate the detail of these reports. At a time where the workforce agenda is significant in terms of recruitment and organisation development, the Trust's Chairman and Chief Executive should consider reinstating the Workforce Committee as a sub committee of the Board. **(Recommendation 9)**

The Board and other levels of governance in the organisation function effectively and interact with each other appropriately.

The Trust has developed its structure, processes and systems of accountability. There is a suite of Board sub-committees. Committees are well organised with papers that are appropriate, well written and well presented.

Whilst the administration of Board sub-committees is good, there may be scope to ensure timetabling allows all Committees time to input their 'highlight' report to Board. For example the Finance Committee had to report verbally to the October Board due to the Committee being held earlier that week. **(Recommendation 10)**

We attended the majority of the sub-committees and the Board meeting. All meetings were well chaired. We saw appropriate levels of challenge between NEDs and Executive Directors and in some meetings Executive to Executive challenge. All challenge was undertaken in a professional manner and was responded to in a non defensive style.

The Quality Committee meets bi-monthly. This is a well chaired and important Committee for the Trust to gain assurance over its patient safety and quality agenda. The meeting operates well. We were informed that there is some discussion with regard to changing the frequency of the Quality Committee to quarterly. The Trust has undertaken considerable improvement work across its services from being placed in special measures in 2013, and has recently improved its CQC rating from Inadequate in 2015 to Good in 2018. Due to the appointment of two new NEDs, the Chair of the Quality Committee has recommended that one of the new NEDs, who is a clinician by background, is appointed as the new Chair, and this was approved at Board. We would recommend that, in line with most other Trusts that meet monthly or bi-monthly, the Trust maintains the bi-monthly frequency of its Quality Committee with a view to reviewing this once the new Chair has been in post 12 months. **(Recommendation 11)**

The Trust holds monthly Divisional Performance Review meetings where the Divisions are appropriately held to account. These are chaired by the Chief Operating Officer and attended by many of the Executives. The Director of Nursing, Medical Director, Director of Human Resources and Finance Director are all invited, although on occasions they are unable to attend or send representation and this is an area for improvement. **(Recommendation 12)**

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management? (cont.)

Information gained during our interviews and our observations at meetings supported a mature and embedded governance processes, with good ownership at both Corporate and Divisional level. Divisions reported feeling appropriately held to account through their performance reviews and other Committees/meetings they attend. However the overriding culture is stated to be supportive, and Divisions report good relationships and accessibility to the Executive Directors.

Assurance reports are prepared after each Board sub-committee for presentation to the Board. The quality of these reports is good, highlighting the key areas for escalation.

Board agendas are structured around the following themes:

- Strategy;
- Operational;
- Delivery and risk; and
- Governance.

The Board undertakes the vast majority of its business at the public session and this demonstrates a high level of transparency. There is a confidential session and the items that are presented at this session are limited to those that would be classified as sensitive and confidential information.

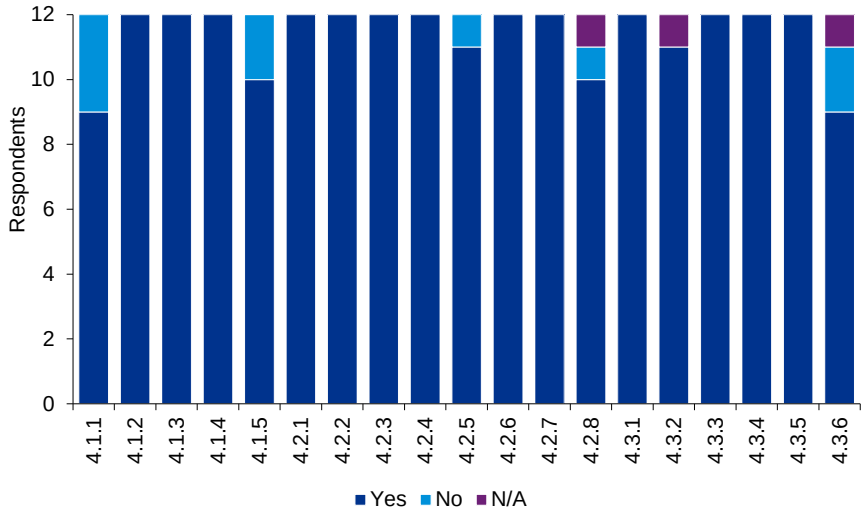
Staff are clear on their roles and accountabilities

The Clinical Chairs stated that the triumvirate teams and staff at service levels are clear on their roles and responsibilities. The Trust's vision and values are incorporated into the appraisal process and subsequent objective setting to ensure staff are clear on what is expected of them. In our interviews staff reported that they feel held to account.

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management? (cont.)

Board survey results

Overall respondents rated this domain as **GREEN**



Which area of activity do you believe has benefited most from scrutiny at the Board in terms of improving performance?

- Reduction in agency spend
- Access
- Quality metrics
- Patient Flow
- Financial Performance
- ED
- Deep dives in a broad number of subjects

#	Question
4.1.1	Is there a Board approved Trust wide Organisational Development plan or equivalent?
4.1.2	Is there a process for cascading lessons learned from complaints, compliments and incidents to all relevant parts of the Trust?
4.1.3	Is benchmarking or comparison always routinely used to drive improved performance?
4.1.4	Can the Board demonstrate action as a result of staff survey feedback?
4.1.5	Does the Board know how local services access their quality, operational and financial information?
4.2.1	Is the governance structure at Divisional Level clear to the Board?
4.2.2	Is the Board agenda setting process understood?
4.2.3	Is the Board clear about which responsibilities it has delegated?
4.2.4	Do all Committees focus with clear terms of reference, forward work plans and appropriate membership?
4.2.5	Have all Committees performed a periodic assessment of their effectiveness and reported this to the Board?
4.2.6	Are all governance documents (for example schemes of delegation) contemporary?
4.2.7	Are clear processes in place for Committees to refer matters to each other?
4.2.8	Has Board governance received positive assurance from previous independent review?
4.3.1	Are routine reports to the Board sufficient to cover quality, safety, operational, financial, estates and human resources matters?
4.3.2	Do routine reports to the Board include sufficient detail for disaggregation of data so that trends or areas of concern can be identified?
4.3.3	Are performance reports presented alongside proposed actions to address variances from expected performance?
4.3.4	Are performance reports periodically updated to ensure that the indicators and target remain relevant?
4.3.5	Are all relevant performance measures (financial AND operational) routinely forecast forwards alongside historic reporting?
4.3.6	Has the Board reached a collective view on what it regards as the tolerance for off target performance which should be reported and escalated outside of its meeting schedule?

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Summary of our findings	KPMG rating	GREEN

There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

The Trust has a Risk Committee that reports to the Board and has the responsibility to systematically review, scrutinise and challenge risk profiles across all Divisions and Corporate functions ensuring the correct strategy is adopted for managing each key risk. Committee members also have the role of verifying controls and confirming that action plans are in place and effective. This Committee is chaired by the CEO which brings appropriate focus and challenge to this forum.

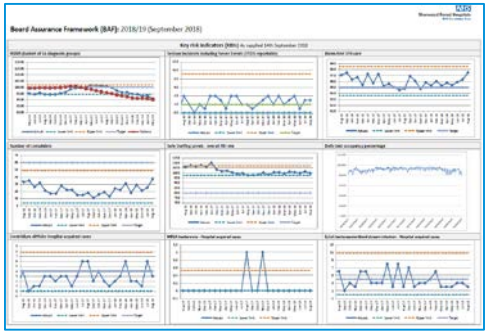
This Committee is part of a revised Risk Management Strategy and Policy introduced in January 2017, which has since then been given a positive assurance rating by Internal Audit and direction of travel positively commented on by the CQC.

Risk management processes are underpinned by:

- Divisional and Corporate Risk reports are taken to each Risk Committee which is supplemented by deep dives on hot topics at each meeting as required.
- BAF presentation to Audit Committee, Quality Committee and Trust Board. Each sub committee of the Board discusses and appraises the mitigations in place for the risks owned by that Committee.
- Updates on each of the Significant Risks (score of 15+) are reported to the Risk Committee at each meeting. KPIs assessing risk management performance are also reported.

The BAF includes regular updates to Key Risk Indicators (KRIs) which are a series of indicators which highlight a performance of the Trust in mitigating the impact of a potential risk.

This level of detail, which is regularly updated, is considered best practice and has the impact of making the BAF a live document which links strategic risk to operational performance.



Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.

From our interviews and meeting observations it is clear that the financial position of the Trust is a key challenge and has significant focus and scrutiny across the Trust. It is also clear that the impact on service quality is considered throughout these discussions. The Trust has responded to the financial pressures by engaging external support to review FIP plans and processes and identify schemes to meet this challenge. The Trust has an ongoing process to identify FIP schemes to help achieve an improvement in the underlying financial position of the Trust, in the context of the structural issues in place.

The Trust has a significant cost improvement programme requirement for 2018/19 of £17.3m. As at October 2018 the Trust are forecasting achievement of a £7.5m CIP. To mitigate this shortfall the Trust has agreed a Financial Recovery Plan (FRP) which outlines the actions required to achieve a further £8.9m improvement in the financial position and achieve its agreed control total.

As part of existing processes, the Trust has required Quality Impact Assessments (QIA) to be reviewed and approved by the relevant Directorate prior to review and sign-off by the Chief Nurse and Medical Director.

The organisation has the processes to manage current and future performance.

The Trust has four Committees. In addition to the statutory Audit and Assurance and Remuneration Committees, the Trust also has a Quality Committee and a Finance Committee. The Trust's governance structures and performance management framework provide a platform to manage current and future performance. The Trust has reviewed the effectiveness of its committee structures and made changes where it has deemed necessary. All groups have terms of reference in place.

In our discussions with the Executive team and from our observation of the Board we have noted that a significant portion of Board time is spent discussing performance issues. Elsewhere Trusts consider performance issues within a Finance and Performance Committee to allow Non-Executive Directors to challenge issues in that forum rather than the Board. We recommend that the Trust move to this structure to allow regular performance scrutiny to take place at the Committee level rather than at full Trust Board (**Recommendation 13**).

KLOE 5. Are there clear and effective processes for managing risks, issues and performance? (cont.)

Performance issues are escalated to the appropriate committees and the Board through clear structures and processes.

The Trust has established a process of Divisional Performance meetings which take place on a monthly basis. These meetings are chaired by the COO and attended by the General Manager, Finance Manager and Clinical Director for each Division as well as other Executive Directors. From our interviews all participants consider that these meetings are a useful tool to drive frontline performance and are held in a constructive manner. The Divisions feel held to account by these meetings and the discussions are evidence led and focused on the actions required to improve or maintain performance.

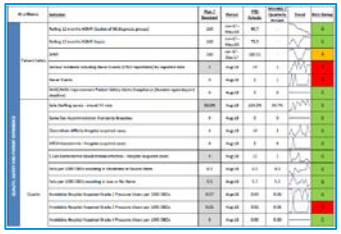
Each Executive Director has an area of challenge to focus on so the full team are involved in the scrutiny process of each Division. We have noted that attendance at these meetings by some members of the Executive is sporadic and we recommend that this is monitored and action taken if required in order to encourage regular attendance **(see Recommendation 12).**

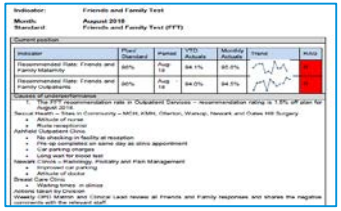
Whilst the current process works well our experience elsewhere tells us that similar meetings at other Trusts are not chaired by the COO in order to enable the meetings to be led outside of the operational team. We recommend that in future the Trust review who chairs these meetings to consider if an alternative approach may maintain the effectiveness of the process whist maintaining separation of duties. **(Recommendation 14).**

Single Oversight Framework (SOF)

The Trust has established a SOF in order to report performance in one place. This report is well designed and comprehensive – a short executive summary is supported by a dashboard which sets out performance and trends for a suite of KPIs.

This summary is then supported with a narrative report on key areas of operation of the Trust with further detail for any exceptions which occurred in the preceding period. For each exception a detailed explanation is included with mitigation actions outlined and target dates set for when compliance will be achieved.





Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

The Trust has an internal audit plan comprising of 310 days of input from an external provider. The plan covers financial and non financial areas. The Trust devotes part of the internal audit plan to data quality, including in 2017/18 a deep dive into part of the Single Oversight Framework in place at the Trust. The Trust received a *Significant Assurance* opinion in 2017/18 which provides *"that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently."*

The Trust has a recommendation tracking system in place, facilitated by internal audit, with progress reported to each Audit Committee meeting. Depending on the number and severity of actions, there may be a separate report to Committee in relation to a particular subject matter. We observed this at the September Audit Committee meeting in respect of the Costing Assurance Review where an update was given as part of the progress report as the actions were six months overdue.

In March 2018 the Local Counter Fraud Specialist Self Review Tool assessment was submitted on behalf of the Trust. Whilst the overall SRT assessment was a green score, an amber assessment was made against three of the four areas in the Inform and Involve domain. The main driver for these ratings is the low response rate for Trust staff completing survey set up to assess the level of staff awareness of anti-fraud arrangements at the Trust.

The Trust develops an annual Clinical Audit Programme that takes into account key national priorities, Trust priorities for quality improvement, and service priorities. Progress against the annual plan is monitored by the Clinical Audit and Effectiveness Group, with regular updates reported to the Patient Safety and Quality Group, and relevant updates provided to the Trust Board.

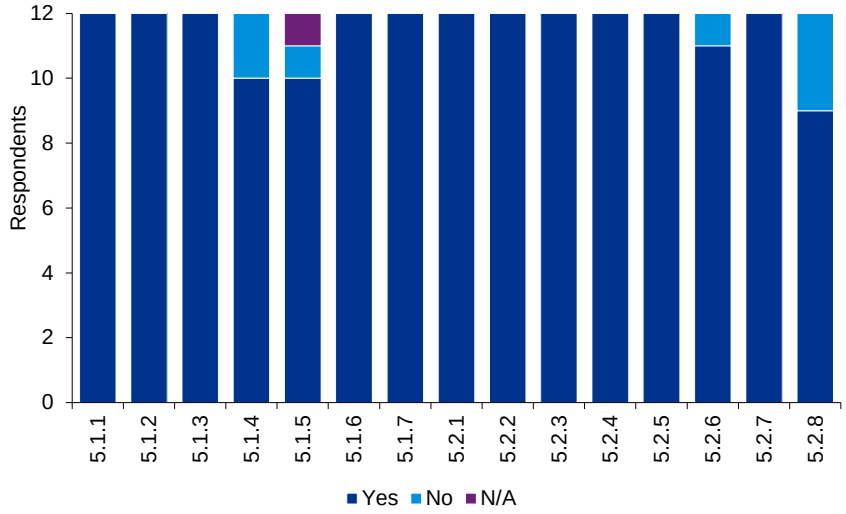
Progress of Clinical Audit : October 2018	
Completed	47%
Discontinued	5%
On Schedule	41%
Overdue	7%

As at October 2018 93% of audits were reported as on track, discontinued or complete however the report does not consider the benefits accruing to the Trust due to these reviews taking place (**Recommendation 15**).

KLOE 5. Are there clear and effective processes for managing risks, issues and performance? (cont.)

Board survey results

Overall respondents rated this domain as **GREEN**



What has been the most enduring single risk faced by the Trust?
– Financial position
– PFI financing
– Increasing demand for services
– Shortage of workforce
– STP system working

#	Question
5.1.1	Is there a clear set of Committees or forums for cascading and disaggregating reported performance?
5.1.2	Does reported performance include appropriate forecasts (on a rolling rather than fixed point basis) as well as historic data?
5.1.3	Is there an effective hierarchy and trigger for the escalation of variances in performance?
5.1.4	Is there clear distinction between risks which are generated by the external environment and those which are solely generated by Trust activity?
5.1.5	Are task and finish groups used to respond to risks?
5.1.6	Is the interface between operational risk registers and the Board Assurance Framework well defined and understood?
5.1.7	Is there clear accountability for actions arising on risk registers and are individuals held to account on a timely basis?
5.2.1	Do updates to risk registers exist for all relevant components of the Trusts operations?
5.2.2	Training is available to relevant staff on risk capture and escalation?
5.2.3	Does the Board use an Assurance Framework to routine review strategic risk?
5.2.4	Are business case processes well established for operational changes and investments?
5.2.5	Does the business case process include quality/service impacts assessments?
5.2.6	Is there a process for capturing risks raised by national bodies which might impact the Trust?
5.2.7	Is there any active programme of Board visits / interaction with services across the Trust?
5.2.8	Does the Board routinely review the risks and strategies of its main commissioners?

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

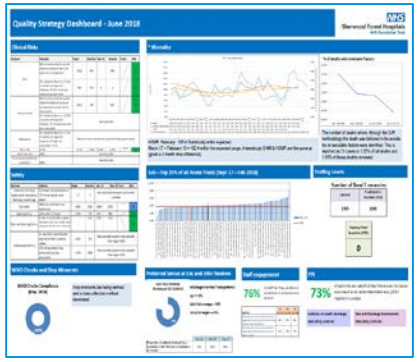
Summary of our findings	KPMG rating	AMBER/GREEN

Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.

The Trust's Single Oversight Framework provides a ward-to-board reporting and monitoring structure. Routine reports are issued on a monthly basis from a single data source to ensure consistency of reporting and interpretation. At Board level, quality and sustainability is reported through the Patient Safety and Quality Group (PSQG) to the Quality Committee.

Whilst issues are escalated appropriately with exception reporting undertaken as part of SOF reporting (see KLOE 5) there is a more detailed focus on specific issues at the PSQG.

For example the regular reporting of the Deteriorating Patient Dashboard which includes a breadth of data to help highlight how the Trust are performing when looking after the most acutely unwell.



At the Quality Committee data is again used to inform the assessment of performance with the Quality Strategy Dashboard highlighted performance by the Trust in mitigating clinical risk by assessing performance in key metrics such as mortality, falls, staffing vacancies and Serious Incidents.

Whilst the information presented to Committee is detailed the Trust are working to add a self serve process at the Divisional level.

Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.

The Trust's Single Oversight Framework focuses on in-year (operational and financial) monitoring, working alongside the Quality Committee (quality) Finance Committee (financial planning and business cases) and Workforce Planning Group in respect of HR indicators. This focus avoids duplication of data across Committees.

The Trust recognises that it has a significant amount of data but some staff interviewed consider it to be information poor. The Trust's SOF report information in respect of:

– in-month performance for a suite of key indicators (financial, quality and people issues);

– previous month performance; and

– direction of travel; and trend charting.

The integrated report is supplemented by a number of other dashboards capturing workforce and safety and quality information. Any exceptions are then expanded upon and discussed in more detail at Board.

In the Trust's last CQC inspection they stated that information systems were working for the Trust, providing good quality, timely data which is appropriately reported.

Performance information is used to hold management and staff to account.

The Trust's monthly Divisional performance meetings include a detailed review of the performance information. The information used as part of these discussion includes:

- Single Oversight Framework;
- Performance Exception Report;
- Diagnosis Indicators;
- Outpatient Dashboard;
- Avoidable Clinic Cancellation Dashboard; and;
- Outpatient Capacity Dashboard.

From our interviews with Clinical Chairs and the Executive team these discussions are reported as robust but supportive with the Divisional leadership held to account.

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on? (cont.)

The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

In accordance with best practice, the Trust has a Data Quality Strategy that facilitates testing by its internal auditors against the six dimensions of data quality (accuracy, validity, reliability, timeliness, relevance and completeness). Internal Audit reports are rated against these individual dimensions for each key performance indicator tested.

This strategy also considers the Trust's strengths and weaknesses in regard to data quality. In order to address these issues the Trust established a Data Quality Oversight Group (DQOG) in December 2017. This group reports through to the Risk Committee and is chaired by the Executive Medical Director and attended by the COO and all Divisional General Managers as well as members of the Information Team.

The key areas of focus for that group are:

- Referral Management – working to remove the backlog of open referral and improving the management of 'on hold' lists as well as improving the SOPs, staff training and reporting framework in this area;
- Real-time data capture – the Trust is aware that there is still some way to go to achieve real-time performance data across the Trust. In particular there is a focus on ED performance recorded on SystmOne and transition to wards recorded on Medway.
- The assurance and sign off processes for internal and external data. This group also oversaw the recent update to the Data Quality Strategy prior to approval by the Trust Board.

The Trust has prepared a Data Quality Improvement Plan which seeks to improve overall data quality at the Trust by considering the following areas:

- policies and procedures;
- governance and leadership;
- systems and processes; and;
- people and skills.

This plan has clear ownership for each action, a timeline for achievement and a RAG rating to confirm progress. This is considered by the DQOG on a regular basis with updates provided to the Risk and Audit Committees. One area of future focus within this plan is potential Kitemarks for the SOF and other information reported to the Board **(see Recommendation 16 and Appendix 3).**

Information technology systems are used effectively to monitor and improve the quality of care.

The Trust is still part way through the delivery of the Data Quality Improvement Plan that seeks to improve the use of data across the Trust. As noted in the previous section specific plans are in place to address the use of paper systems alongside SystmOne in ED and to move towards real time reporting using the Medway system. Responses to our survey indicate that the Board are aware of the improvements required in this area.

Data or notifications are consistently submitted to external organisations as required.

As part of the Data Quality Strategy the Trust has identified all data submissions made under the requirements of the standard NHS contract. In the strategy these are split between national audits, clinical outcome reviews and regular submissions to other NHS bodies such as NHS Improvement, NHS Digital or Commissioners.

For each of these submissions a quality assurance and sign off process is set out. For each submission an assurance process is carried out (by the Divisional General Manager or Clinical Lead) and each submission is then signed off by an Executive Director.

Also within the Data Quality Strategy the Trust has a timetable of all submissions to highlight when each piece of information is required.

There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

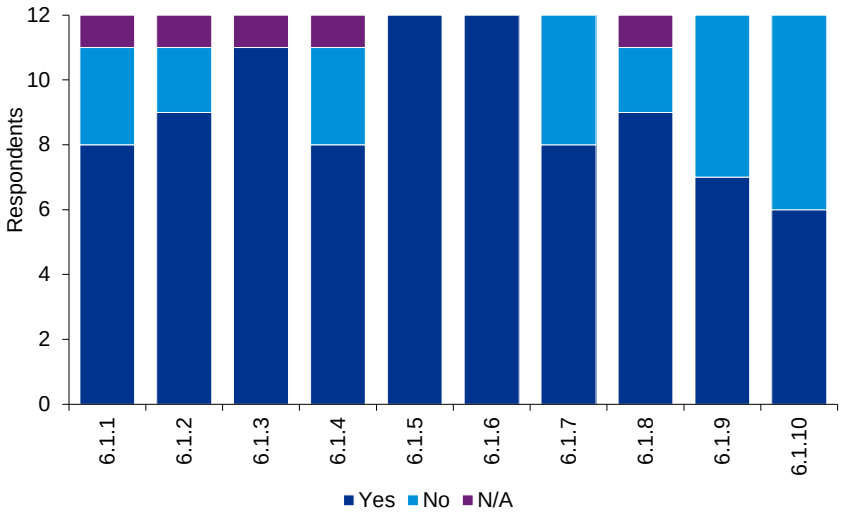
The Trust has an Information Governance Framework in place and has during the year updated its Cyber Security Plan as overseen by the Cyber Security Delivery Group.

The Trust has responded to the General Data Protection Regulation (GDPR) landscape with a GDPR group reporting into the Trust's governance structures. This is subject to Internal Audit with audits planned for the overall Data Quality Framework, DSP Toolkit and Cyber Security during the 2018/19 year.

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on? (cont.)

Board survey results

Overall respondents rated this domain as **GREEN**



What do you regard as the five most critical IT systems at the Trust?	
– Finance / GL	– Windscribe
– Medway	– ESR
– ICE	– Allocate
– Orion	– Nervecentre
– SystmOne	– Microsoft Outlook

#	Question
6.1.1	Has the Board approved a data quality strategy?
6.1.2	Is a Data/Information Assurance Framework in place for all primary indicators of performance reported to the Board?
6.1.3	Is independence assurance on the robustness of information periodically sought?
6.1.4	Is the Board sufficiently sighted on key estates metrics and progress against the estates strategy?
6.1.5	Does the board receive assurance that all regulatory requirements are met?
6.1.6	Is there a data/information security policy in place?
6.1.7	Do staff have a mechanism through which they can review and challenge at Board and divisional meetings?
6.1.8	Has the Trust reviewed and understood its portfolio of clinical systems and the quality of data generated by each one?
6.1.9	Does the Board receive routine reports assuring the underlying data used in Board reporting?
6.1.10	Does the Trust actively seek assurance over data quality and security of its third party service providers?

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Summary of our findings	KPMG rating	AMBER/GREEN

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

The Trust Board presents a patient story at each meeting and a brief discussion and questions follow. The sessions are powerful and set the focus for the subsequent agenda items. Some Board meetings we have attended reflect on the patient story at the end of the Board meeting, and this allows them to consider any of the Board agenda items that could further impact or relate to the patient experience.

Some Boards are also introducing short staff stories and this can add an interesting perspective and bring to life key experiences within the Trust's services.

The 2017 NHS National Staff Survey results were presented to the Trust in March 2018. The Trust had 2515 staff take part in this survey, a response rate of 57% which is in the highest 20% of acute trusts in England (44%), and compares with a response rate of 41% at the Trust in the 2016 survey.

The survey highlighted many areas that had shown a significant change since the previous year. The top five ranking scores were all in the best 20% of acute Trusts in England.

Staff experience had improved in the following areas:

- % of staff experiencing physical violence from staff in the last 12 months;
- Support from immediate managers; and
- % of staff reporting good communication between senior management and staff.

Staff experience deteriorated in the following areas:

- % of staff witnessing potentially harmful errors, near misses or incidents in the last month.

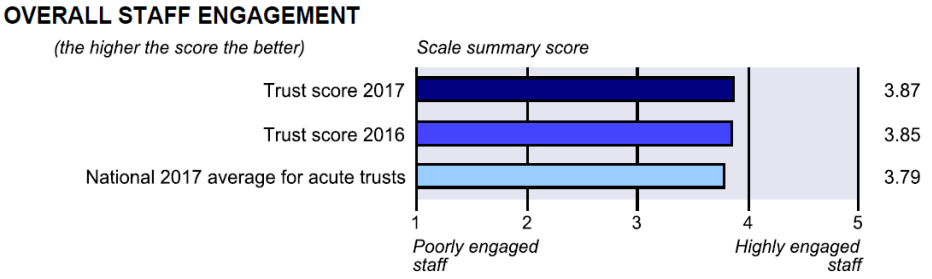
The Trust has developed an action plan to address emerging issues. In addition the Trust undertakes local staff surveys to gauge progress with actions being taken.

Recommendation as a place to work or receive treatment - national staff survey data compared with local trusts.

Trust	Response rate	Engagement score	Recommendation as a place to work or receive treatment
Chesterfield Royal Hospitals	63	3.71	3.71
Sherwood Forest Hospitals	57	3.87	3.92
United Lincolnshire Hospitals	45	3.63	3.43
Derby Hospitals	42	3.90	4.02
Doncaster & Bassetlaw	50	3.66	3.58
Nottingham University Hospitals	37	3.80	3.84
Sheffield Teaching Hospitals	44	3.83	3.92
University Hospitals of Leicester	34	3.76	3.68

Extract from Board papers

The Trust compared favourable nationally with regard to overall staff engagement. The score had increased since last year and is above the national average. This places SFH in the top 20 acute Trusts in England for this measure and it is ranked second in the East Midlands.



Extract from 2017 NHS Staff Survey results

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? (cont.)

The Trust can demonstrate multiple activities and events to engage and support staff including:

— Staff awards, including awards to staff in non-clinical services;

— Chief Nurse awards;

— Annual awards ceremony;

— Leadership and development programmes to support staff across the various grades and disciplines.

The CQC in the most recent inspection found multiple examples of senior staff engaging staff and patients in order to obtain their views on improving the service.

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape service and culture.

There is significant evidence of ways where service user engagement has impacted on the service design or delivery of care and examples of 'you said ..we did' are documented in the Quality Account.

The Trust considers its Workforce Race Equality Standard data at its Organisational Development and Workforce Committee. The Board is aware that further work is required on its position in relation to its number of staff from a BME background. Currently less than 9% of staff are from a BME background and are underrepresented in senior AfC pay bands. A new NED has been recruited with a wealth of experience in leading organisational strategy, partnership working and engagement. This person will broaden the Board's experience, additionally as a person from a BME background, will also extend the diversity of the Board.

The Trust undertakes exit interviews for those staff who chose to leave the organisation. In our Board level survey some members stated they were unaware of any themed analysis in this area, and it may be beneficial to report this information more widely. As previously stated in this report the Trust does not currently have a Workforce sub committee of the Board. If this is established then items such as thematic analysis of exit interviews and progress with plans to address any outcomes could be considered at that Committee. **(Recommendation 17)**

The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

The Trust contracts with two Clinical Commissioning Groups (CCGs) - Mansfield and Ashfield CCG and Newark and Sherwood CCG. These CCGs now work as one with joint management arrangements in place. Mansfield and Ashfield CCG are the lead commissioner and key contract holder for the Trust.

Executive to Executive meeting of Sherwood Forest Hospitals NHS FT and Newark and Sherwood CCG and Mansfield and Ashfield CCG occurs regularly, usually weekly. Meetings alternate by site and chairing responsibilities. Commissioner relationships are reported to be good. Our interview with Commissioners confirmed a positive culture within the Trust and a willingness to learn and escalate issues as appropriate. The CCG views the governance structure within the Trust as rigorous.

The relationship is described as appropriately challenging but one of mutual respect. There are some issues that the CCG and Trust are working together to improve and this includes the reporting styles of performance information. The Trust is required to report in a certain style to NHSI and the CCG would like to see more granular information. This is an issue that both parties are working to resolve and therefore we have not made a recommendation in this area.

The Trust is heavily involved in partnership working. As one of the national NHS Vanguard sites the Mid Nottinghamshire Better Together Board is chaired by the Trust's Chairman, and the Trust continues to work with partners in the NHS and local councils to deliver more coordinated care for people with long term conditions, whilst reducing reliance on hospital and residential care.

The Trust is an active member of the STP, with Executive Directors undertaking lead roles for many of the work streams. This work is progressing well and a Strategic Partnership Forum is also in place. The Trust serves as an active member of the ICS and is contributing to a full system plan to ensure future financial sustainability of the healthcare system. Minutes of this are reported at the private session of the Trust's Board meeting.

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KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? (cont.)

The Nottinghamshire Integrated Care System (ICS) requires the whole health system to work together more formally to deliver financial sustainability for the population of Nottinghamshire. This will require further integration between healthcare providers and commissioners in order to forge a common approach to sustainability for the County.

The Trust works well on engagement with its Council of Governors (CoG), and has introduced initiatives that are considered best practice. For example, the Board has invited two members from the CoG to observe the Board sub-committees. This adds to their experience and assists in their role of holding the Non-Executive Directors individually and collectively accountable for the performance of the Board of Directors. However, this is a relatively new process and the Board needs to ensure a more a rigorous and consistent approach is taken in order for it to maximise benefits.

The role of the Governor requires further clarification, and training should be undertaken to define the role and set expectations. We have recently worked with a Trust that has adopted similar Governor activities and are willing to share their training materials. There is a significant opportunity for the Trust to refocus and strengthen the Governor role through training and the subsequent adoption of a more systematic approach. There are a number of Governor positions that are due for election in April 2019, and the training should be implemented at that time. **(Recommendation 18)**

The Board had previously introduced a NED/Governor 'buddy' scheme, however this was not sustained. The Trust should consider relaunching the 'buddy' scheme as this may assist with consistency of approach in the Governor role and assist in embedding and reinforcing the key messages and learning from the proposed training. **(Recommendation 19)**

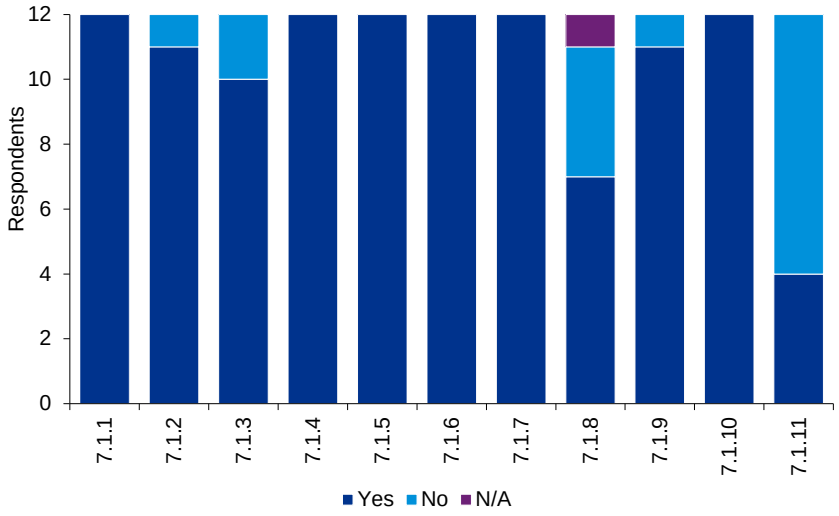
We held a focus group with a group of Governors and also interviewed two others, one of whom was the lead Governor. Although the CQC found the Governors of the Trust had an "improved awareness and understanding of their role in holding to account the Executive and Non-Executive Directors" we found variance in the level of understanding of the role and the way the CoG can contribute as the 'voice' of local people to help set the direction for the future of the hospital based on Members' views. This is an area for improvement.

Governors regularly hold 'Meet Your Governor' sessions across all three hospital sites, and feedback from these sessions is incredibly important to the Trust and helps inform strategic and operational plans. These sessions allow Governors to engage with the public and members, and this assists them in their representation of members and the public. Using these forums the Trust has invited its Governors to gain patients views in areas where they are considering changes, for example choice of meals; disability access and signage etc. Some of the Governors are happy to undertake this, however others felt this should not be part of the role. **(see Recommendation 18)**

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? (cont.)

Board survey results

Overall respondents rated this domain as **AMBER-GREEN**



Which is the most critical issues the Board needs to address to achieve the objectives of its workforce strategy?

- Recruitment and retention
- Underlying consistent themes of favouritism
- Age profile of staff
- Reduce reliance on agency staff

#	Question
7.1.1	Does the Board periodically meet with the governors both formally and informally?
7.1.2	Are the results of patient surveys know to the Board?
7.1.3	Is a patient participation strategy in place?
7.1.4	Do individual Board members interact with patients on a routine basis?
7.1.5	Are the results of the staff survey presented to the Board?
7.1.6	Do individual Board members interact with staff on a routine basis?
7.1.7	Do Board members ensure that their interactions with staff are varied by staff group, location and time of day?
7.1.8	Does the Trust have clearly set out responsibilities for engaging and managing interactions with all key partners (e.g. commissioners, local authority, education provider and the voluntary sector)?
7.1.9	Where issues are identified from stakeholders is progress against actions identified reported on consistently?
7.1.10	Are the Board routinely aware of areas where staff shortages are impacting service delivery?
7.1.11	Are the Board aware of the themes emerging from exit interviews with staff?

KLOE 8. Are there robust systems and processes for learning continuous improvement and innovation?

Summary of our findings	KPMG rating	AMBER/GREEN

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

The Trust's 'Journey to Outstanding' is a compelling story and resonates throughout its various financial, improvement, quality and safety plans.

There are many examples of continuous learning with tangible outcomes.

The Trust's mortality review process is embedded across the services and the Trust has appointed the role of Medical Examiner to its Consultant End of Life Lead. The Medical Examiner role has a wide and significant remit, including:

- Scrutiny following deaths, ensuring all appropriate cases are subject to the correct depth of review;
- Correct certification and supporting junior doctors on concluding and reporting the cause of death;
- Liaising with relatives regarding any concerns around cause of death;
- Working across Nottinghamshire on the development of a panel of Medical Examiners to provide independent views from across the organisations.

The Medical Examiner has developed professional working relationships with the Coroner and also is a valuable resource in terms of training and support within the Trust's Divisions. Proactive support is in place to enable the Divisions to undertake mortality reviews and a Mortality Surveillance Group is in place and this is Chaired by the Trust's Medical Director. The Trust previously had significant mortality issues, highlighted in 2012 in a report by Sir Bruce Keogh, however mortality rates are now average and as expected throughout the services.

The Trust has undertaken significant developments and can demonstrate positive outcomes with work on sepsis. The Medical Director has shared this work nationally. The management of deteriorating patients is an area linked to this and the implementation of Nerve Centre will support and strengthen work in this area.

There are a number of leadership and development programmes that are grade related to support staff in their roles. The Trust has also secured places on national leadership programmes.

To coincide with World Menopause Day in October 2018, the Trust launched an innovative new campaign to break the menopause taboo in the workplace and support female staff who are experiencing menopausal symptoms. Four out of ten women who work at King's Mill Hospital, Mansfield Community Hospital and Newark Hospital are over the age of 50, and with women living and working longer than before, it's likely that they will experience menopausal symptoms whilst still working. The Trust worked with the Government Equalities Office Menopause Report Team and Henpicked: Menopause in the Workplace to put best practice in place. The campaign includes line manager training and support for women who are experiencing symptoms of the menopause.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

The Trust is working towards developing and training staff in a single Quality Improvement (QI) methodology, and for this to be rolled out across the organisation. The QI programme will require implementation and embedding across the Trust's services. **(Recommendation 20)**

There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

The Trust holds an annual Staff Excellence Awards event to celebrate individual members of staff, teams, and volunteers who go above and beyond the call of duty and who have had a positive impact on the Trust's services, patients, visitors and colleagues. Eighteen of the Trust's individual members of staff, volunteers and teams were recognised for the outstanding care and service that they deliver at the annual Staff Excellence Awards in November 2018.

KLOE 8. Are there robust systems and processes for learning continuous improvement and innovation? (cont.)

The Trust has some good examples of innovative service delivery and have been awarded national recognition in several areas, including:

- The Learning Difficulties team won in the HSJ 2018 Enhancing Care by Sharing Data and Information category for their work improving how the Trust cares for some of its most vulnerable patients - those with learning disabilities and autism. The team has worked with partner organisations to identify people with these needs before they come into contact with the hospital, allowing the Trust to make sure they are communicated with appropriately, and to implement any plans to make sure their care journey is as easy as possible.
- The Trust has been commended for the way it manages its waste after winning a Sustainable Health and Care Award for Waste and Resource Management. The Trust was recognised for its ground breaking work in waste management, which began in 2014 when the Trust, working alongside partners Skanska, began analysing and improving the Trust's waste management, which involved auditing more than 127,000 waste bins, looking at their location, how they were being used and how staff could be better trained in waste management. Since the programme began the Trust has shown vast improvements in its waste management, with more than 3600 staff being trained in waste management, resulting in zero amount of domestic waste going to landfill. Domestic waste is now split into refuse derived fuel (RDF) and dry mixed recycling (DMR).
- The Trust also engaged its partners, Nottinghamshire Healthcare's Clinical Psychology Cancer Service, and won a Macmillan Professionals Excellence Award for their joint working. The team won the Integration Excellence Award which commended them for their excellent psychological support service to Sherwood Forest Hospital's patients, their families and all cancer staff teams at King's Mill Hospital. The team have worked hard to develop the service over the past four years, to provide much needed psychological support and intervention for cancer patients in the area. They have also extended their psychological provision to all people living with cancer through a public self-help website.

The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

The Trust was able to share examples where it has used peers to review areas such as Ophthalmology.

Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

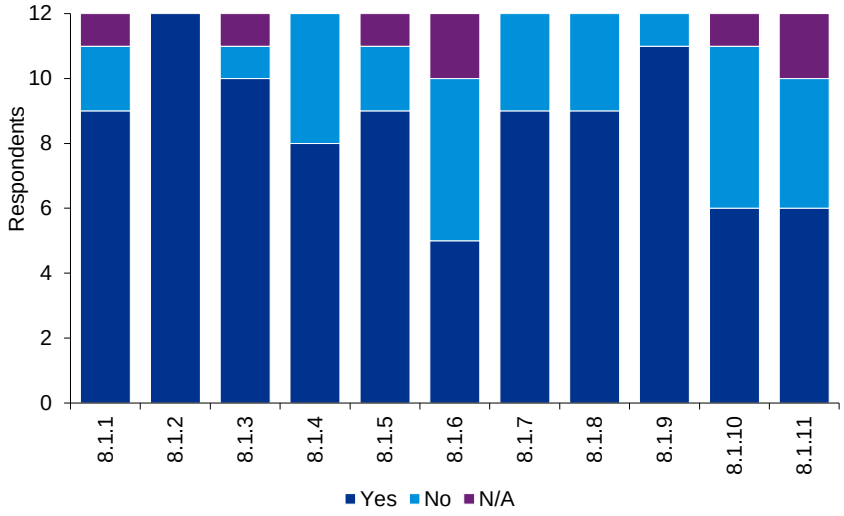
The Trust had good examples of where benchmarking information from similar Trusts has been used to drive improvement.

The Trust has been externally commended for its use of technology to improve clinical and performance targets by ensuring safe staffing levels. The award for 'Impacting clinical and performance targets' was given as part of the annual Allocate Awards. The awards recognise excellence delivered across the healthcare sector, to make a difference for patients and staff. The Trust used Allocate to implement a system that ensures safe and efficient staffing across all three hospital sites. The system is reported to have helped to improve accuracy and quality of care for patients by aligning patient administration systems, paper rotas, job plans and specialist knowledge across departments to ensure that staffing levels were met in the most appropriate way.

KLOE 8. Are there robust systems and processes for learning continuous improvement and innovation? (cont.)

Board survey results

Overall respondents rated this domain as **AMBER-GREEN**



Which service do you think has been most innovative in its service delivery of the past 12 months?	
– HR	– A&E
– Occupational Health	– 'Sepsis
– Procurement	– CAU

#	Question
8.1.1	Does the Trust regularly review and update its learning and training offering?
8.1.2	Is compliance and performance against statutory and mandatory training reviewed and actions taken to address?
8.1.3	Does the Trust apply consistent criteria of performance to all staff during performance reviews?
8.1.4	Does the Trust review and analyse overall performance of staff at the Trust and any themes or trends in performance?
8.1.5	Are actions identified and monitored to address area specific requirements for performance improvement?
8.1.6	Has the Trust undertaken an exercise to review the effectiveness of training and development?
8.1.7	Do staff receive time for performance management on an ongoing basis?
8.1.8	Do you know how staff suggest changes to clinical or working practice they might identify?
8.1.9	Does the Board have a clear set of benchmark organisations it uses to measure service quality or performance?
8.1.10	Does the Board have a method for understanding the consistent application of standardised clinical practice across its services?
8.1.11	Are all clinical and non-clinical systems on a routine cycle for review of their continued efficiency and effectiveness?

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Recommendations

Recommendations

This section summarises the recommendations that we have identified as a result of this review. We have allocated a risk rating to each of these recommendations as per the following table:

Risk rating for recommendations raised		
❶ **High priority (one):** A significant weakness in the system or process which is putting you at serious risk of not achieving your strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of the Trust's strategic risks will occur. Any recommendations in this category would require immediate attention.	❷ **Medium priority (two):** A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving your strategic aims and objectives. In particular, having the potential for adverse impact on the Trust's reputation or for raising the likelihood of the Trust's strategic risks occurring.	❸ **Low priority (three):** Recommendations which could improve the efficiency and/or effectiveness of the system or process but which are not vital to achieving the Trust's strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

No.	Priority	Recommendation
KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?		
1	❷	**Board skills assessment** Although the Board has time-out away days and development sessions a formal skills assessment has not been undertaken since 2014. As all Board positions are recruited to and substantive it would be a good time to undertake this. The findings of the assessment should be used to inform any subsequent Board development sessions.
2	❷	**Allocation of management time to Clinical Directors** Each Clinical Chair has four programmed activity (PAs) sessions allocated to them in order to undertake the role. Some Clinical Chairs have maintained their on-call rota responsibilities and this has impacted on their capacity to undertake all aspects of the roles in the time allocated. Clinical Chairs do not have an appointed deputy, usually the Divisional General Manager and Head of Nursing/Midwifery deputise in their absence. The Trust should undertake a post implementation review of the Clinical Chair role to establish the capacity of the post holders.
3	❸	**Divisional Triumvirate team development** A number of leadership development programmes are in place. However, some staff we interviewed stated the Divisional Triumvirate teams would benefit from a targeted team development programme and this should be considered.
4	❸	**Succession planning** The Chief Executive has undertaken work regarding succession planning, focussed on post holders that may retire within the next two years. Some Trusts we have worked with have addressed succession plans in a detailed way, assessing each Executive Director with contingency plans in the event of an immediate absence, plans if given 3-6 months notice and plans for scheduled retirement.

Recommendations (cont.)

No.	Priority	Recommendation
KLOE 2: Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
5	3	**Trust's strategy** In our Board survey only 50% of respondents agreed that the strategy included a clear vision for the Trust, and underpinning values and priorities. This may be because the strategy is currently being consulted upon and therefore not finalised. However this should be discussed to ensure the strategy is explicit and easily understood.
KLOE 3: Is there a culture of high quality sustainable care?		
6	2	**Freedom to Speak Up Guardian** The Trust recognises that it needs to reassess its arrangements for its Freedom to Speak Up Guardian. It currently has four Guardians and one supporting 'champion' and reporting lines are formally through Human Resources. We have discussed the appropriateness of this with the Trust and a change has recently been made and the role now reports to the Director of Corporate Affairs. Common practice would be to have one FTSU Guardian supported throughout the Trust's services by a number of 'champions' or 'listeners'. These should be of varying levels and disciplines to ensure staff feel they are accessible by locality and grade.
7	3	**Audit of the quality of appraisals** A new appraisal system was launched in April 2017 and this includes talent conversations. Appraisal rates are high with compliance meeting the Trust's target. The Trust provides training for appraisers and appraisees but a trust-wide process in is not in place to review or audit the quality of completed appraisals, and this should be undertaken on a regular basis.
8	3	**Workforce Race Equality Standard data** The Trust considers its Workforce Race Equality Standard data at its Organisational Development and Workforce Committee. This is not however a sub-committee of the Board. The Board is aware that further work is required on its position in relation to its number of staff from a BME background. Currently less than 9% of staff are from a BME background and are underrepresented in senior AfC pay bands. The Trust is progressing further work with regard to this and progress should be reported through a sub-committee of the Board or to Board.

Recommendations (cont.)

No.	Risk	Recommendation
KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
9	2	**Workforce Committee** The Trust does not have a workforce sub-committee of the Board, and there was considerable debate at the Board meeting with regard to workforce issues. This, is part, was due to a number of papers that were scheduled to report at Board for that meeting. However the challenge and questions from the NEDs was significant and this is perhaps due to the fact that none of the NEDs had been in forums to debate the detail of these reports. At a time where the workforce agenda is significant in terms of recruitment and organisation development, the Trust's Chairman and Chief Executive should consider reinstating the Workforce Committee as a sub committee of the Board.
10	3	**Timetabling of Committees** Whilst the timetabling of Committees was well organised, there may be scope to ensure timetabling allows all Board sub-committees time to input their 'highlight' report to Board. For example the Finance Committee had to report verbally to the October 2018 Board meeting due to the Committee being held earlier that week.
11	2	**Frequency of the Quality Committee** The Quality Committee meets bi-monthly. This is a well chaired and important Committee for the Trust to gain assurance over its patient safety and quality agenda. We were informed that there is some discussion with regard to changing the frequency of this Committee to quarterly. The Trust has undertaken considerable improvement work across its services from being placed in special measures in 2013, and has recently improved its CQC rating from 'Inadequate' in 2015 to 'Good' in 2018. We would recommend that the Trust maintains the bi-monthly frequency of its Quality Committee with a view to reviewing this once the new Committee Chair has been in post 12 months.
12	2	**Attendance at Divisional Performance Review meetings** The Trust holds monthly Divisional Performance Review meetings and these forums drill down on key performance issues. Meetings are chaired by the Chief Operating Officer and attended by many of the Executives. The Director of Nursing, Medical Director, Director of Human Resources and Finance Director are all invited, although on occasions they are unable to attend or send representation and this is an area for improvement.

Recommendations (cont.)

No.	Risk	Recommendation
KLOE 5: Are there clear and effective processes for managing risks, issues and performance?		
13	2	**Board level discussion on performance** In our discussions with the Executive team and from our observation of the Board we have noted that a significant portion of Board time is spent discussing performance issues. Elsewhere Trusts consider performance issues within a Finance and Performance Committee to allow Non-Executive Directors to challenge issues in that forum rather than the Board. We recommend that the Trust move to this structure to allow regular performance scrutiny to take place at the Committee level rather than at full Trust Board.
14	3	**Chairing responsibilities of Divisional Performance Review meetings** The Trust's Divisional Performance Review meetings are currently chaired by the Chief Operating Officer. Whilst the current process works well our experience elsewhere tells us that similar meetings at other Trusts are frequently not chaired by the COO in order to enable the meetings to be led outside of the operational team. We recommend that the Trust reviews who chairs these meetings to see if another approach may maintain the effectiveness of the process.
15	3	**Outcomes of Clinical Audit** The Trust develops an annual Clinical Audit Programme, which takes into account key national priorities; Trust priorities for quality improvement; and service priorities. Progress against the annual plan is monitored by the Clinical Audit and Effectiveness Group, with regular updates reported to the Patient Safety and Quality Group with relevant updates then provided to the Trust Board. As at October 2018 93% of audits were reported as on track, discontinued or complete however the report does not consider the tangible benefits and outcomes accruing to the Trust from the clinical audits undertaken.
KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?		
16	3	**Data Quality Kitemark** The Trust has prepared a Data Quality Improvement Plan which seeks to improve overall data quality at the Trust by considering the following areas: • policies and procedures; • governance and leadership; • systems and processes; and; • people and skills This plan has clear ownership for each action, a timeline for achievement and a RAG rating to confirm progress. This is considered by the DQOG on a regular basis with updates provided to the Risk and Audit Committees. One area of future focus within this plan is potential Kitemarks for the SOF and other information reported to the Board we recommend that the Trust introduce these and have included examples of those used at other Trusts in Appendix 3 on page 63.

Recommendations (cont.)

No.	Risk	Recommendation
KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
17	3	**Exit interviews for leavers** The Trust undertakes exit interviews for those staff who chose to leave the organisation. In our Board level survey some members stated they were unaware of any themed analysis in this area, and it may be beneficial to report this information more widely. As previously stated in this report the Trust does not currently have a Workforce sub-committee of the Board. If this is established then items such as thematic analysis of exit interviews and progress with plans to address any outcomes could be considered at that Committee.
18	2	**Council of Governors – training and development** The Trust has introduced initiatives that are considered best practice. For example, the Board has invited two members from the CoG to observe the Board sub-committees. This adds to their experience and assists in their role of holding the Non-Executive Directors individually and collectively accountable for the performance of the Board of Directors. However, this is a relatively new process and requires further work to define and embed the approach in order for it to maximise benefits. The role of the Governor requires further clarification, and training should be undertaken to define the role and set expectations. There is a significant opportunity for the Trust to refocus and strengthen the Governor role as there are a number of Governor positions that are due for election in April 2019, and the role should be redefined at that time.
19	2	**Council of Governors – NED 'buddy' scheme** The Board had previously introduced a NED/Governor 'buddy' scheme, however this was not sustained. The Trust should consider relaunching the 'buddy' scheme as this may assist with consistency of approach in the Governor role and assist in embedding and reinforce the learning from the proposed training. (Recommendation 18)
KLOE 8: Are there robust systems and processes for learning continuous improvement and innovation?		
20	2	**Quality Improvement methodology** The Trust is working towards developing and training staff in a single Quality Improvement (QI) methodology, and for this to be rolled out across the organisation. The QI programme will require implementation and embedding across the Trust's services.

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Appendices

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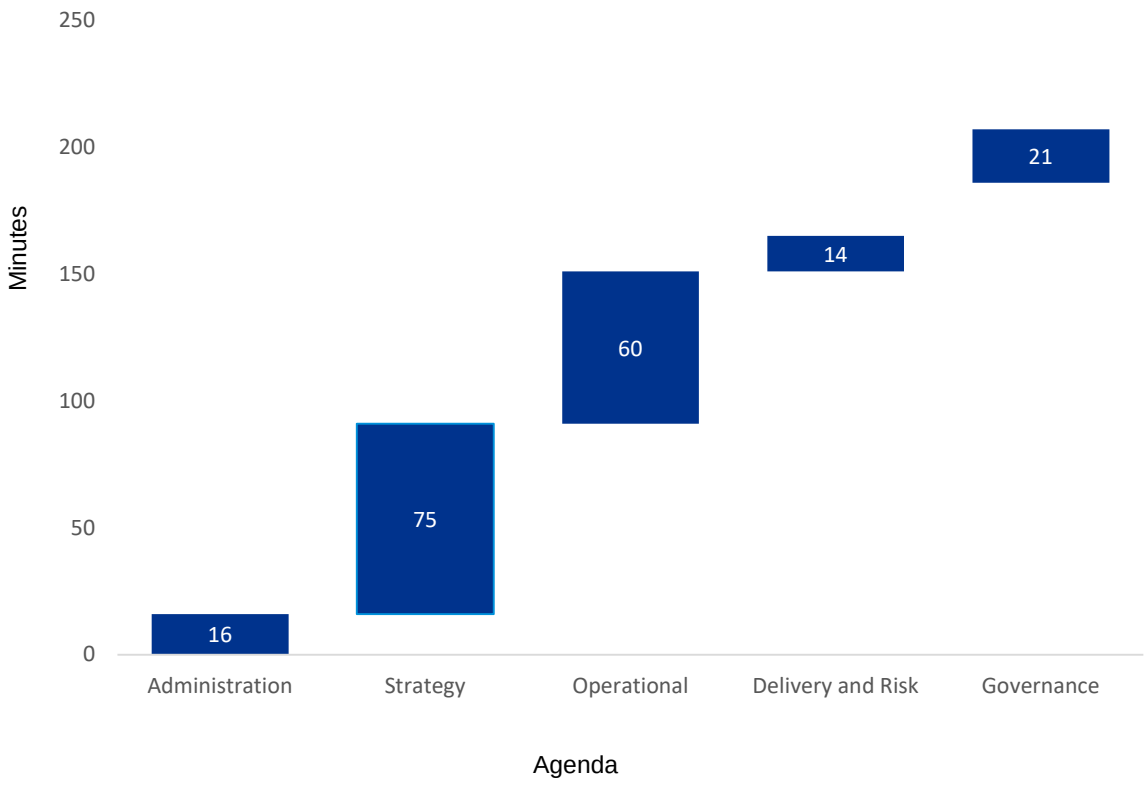
Appendix 1

Board and Committee observations

Appendix 1

Board Observation - Public Session

Summary of the Meeting of the Board of Directors in Public Meeting 25 October 2018



Breakdown of Topics discussed

1. Administration
   - 0902 Welcome
   - 0903 Declarations of Interest
   - 0903 Apologies for Absence
   - 0903 Minutes of the meeting held on 27th September 2018
   - 0904 Matters Arising/Action Log
   - 0905 Chair's Report
   - 0909 Chief Executive's Report
2. Strategy
   - 0918 Strategic Priority 2
   - 0940 Strategic Priority 3
   - 1002 Patient Story
   - 1032 Strategic Priority 5 Operational
3. Operational
   - 1045 Single Oversight Framework Performance – Quarterly Report
4. Delivery And Risk
   - 1145 Board Assurance Framework
   - 1152 Learning from Deaths Quarterly Report
   - 1155 Progress Against CQC Planning
5. Governance
   - 1159 Use of Trust Seal
   - 1200 Assurance from Sub Committees – Finance Committee
   - 1208 Assurance from Sub Committees – Charitable Funds Committee
   - 1212 Joint Planning Process 2019/20
   - 1216 Communications to Wider Organisation
   - 1217 Any Other Business
   - 1218 Date of Next Meeting
   - 1220 Chair Declares the Meeting Closed

Board observation - public Board meeting

Key observations

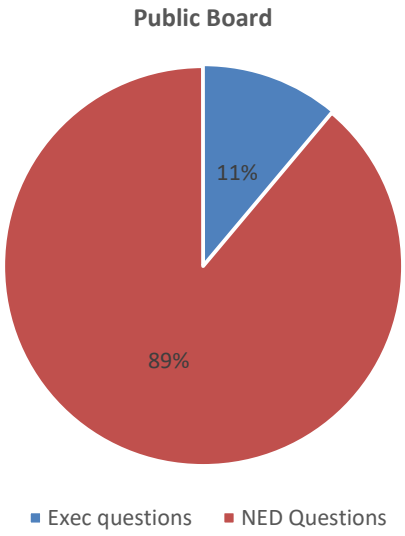
There was good engagement from all Board members throughout the session. The attention to comfort needs such as a break assisted with this.

Complex issues were discussed fully. The items in the public Board meeting were commensurate with those that could be disclosed, and no items were unnecessarily held back.

The questions and actions demonstrated a good balance of support versus challenge between Board members, and evidence of a system-wide view of healthcare, was shown in the discussions.

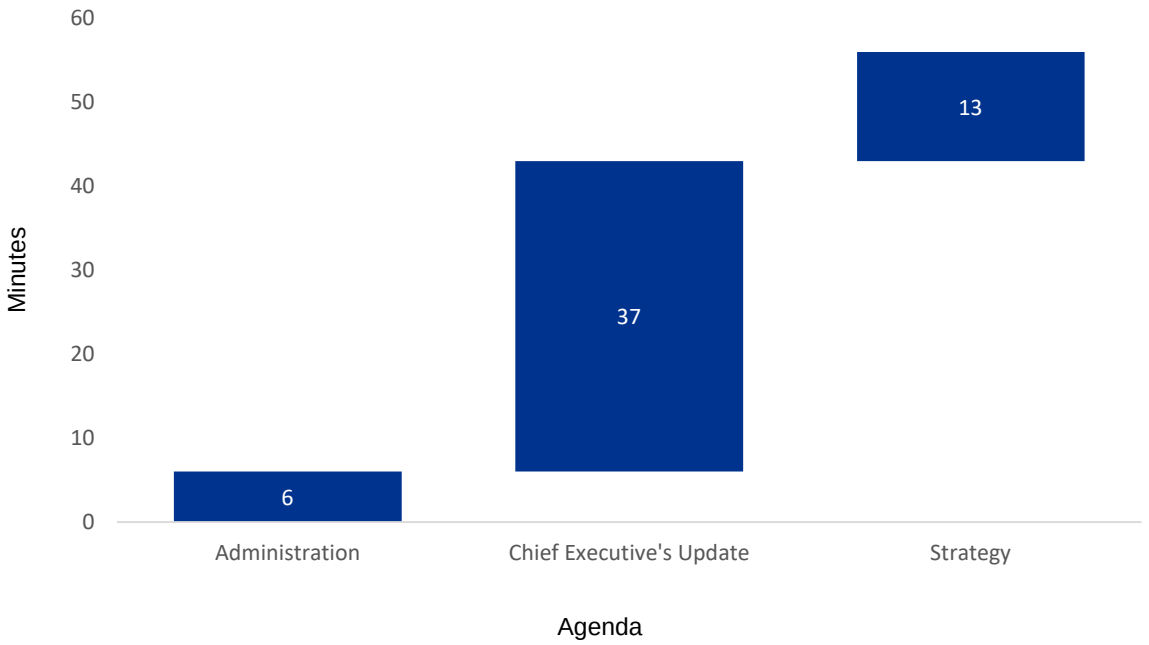
There is no dedicated workforce Board sub-committee – the challenges on workforce got into a lot of detail. This discussion would have been better served in a sub-committee to the Board.

Questions asked in public Board meeting



Board Observation - Private Session

Summary of the Board of Directors in Private Meeting 25 October 2018



Breakdown of Topics discussed

1. Administration
   - 1257 Apologies for Absence
   - 1258 Declarations of Interest
   - 1258 Minutes of the Private Meeting Held on 27th September 2018
   - 1259 Matters Arising/Action Log
2. Chief Executive's Update
   - 1303 Chief Executive's Update
3. Strategy
   - 1340 Strategic Priority 2
   - 1345 Strategic Priority 5
   - 1352 Any Other Business
   - 1352 Date of Next Meeting
   - 1353 Meeting Close

Board observation - private Board meeting

Key observations

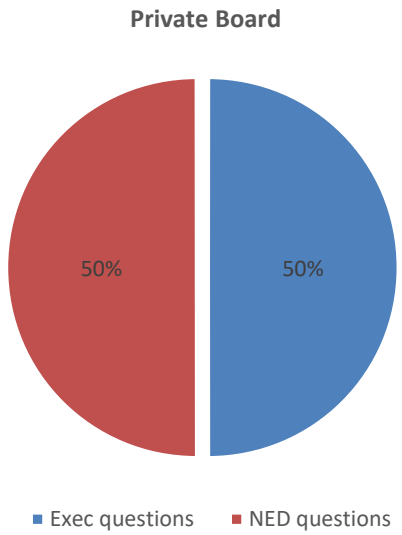
The private board focused on those items of a strategic nature that could not be shared more widely.

Again, there was good engagement, and the Board members were listening and attentive for the discussion.

The balance of questioning and discussion between Execs and NEDS was about equal, which felt appropriate for the discussion.

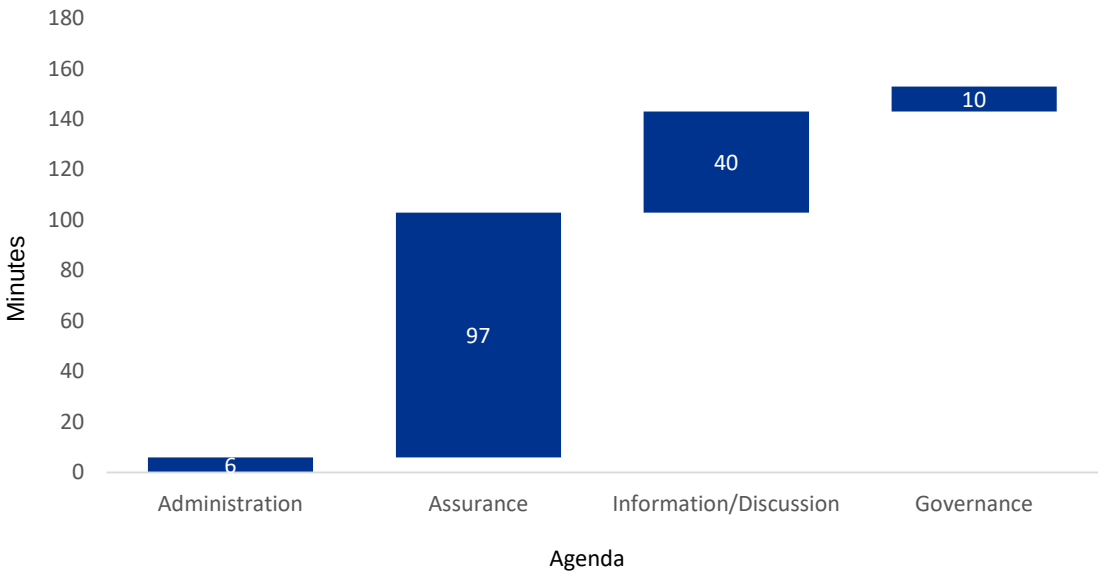
As the Board appears to be mature and fully functioning, it would be worth considering using a process other than a formal agenda to create new insight and knowledge. For example: a working session for 75 minutes could be introduced, perhaps every other month to solution some of the challenging issues that face the organisation and local system.

Questions asked in private Board meeting



Finance Committee Observation

Summary of the Finance Committee Meeting 23 October 2018



Key observations

- Appropriate balance of discussion – administration and meeting governance dealt with appropriately and quickly to allow the main focus of the meeting to be on the issues requiring a decision or providing assurance.
- Every agenda item had a supporting paper, which was presented by a suitable member of Trust staff
- There was a good balance of questions from the Non-Executives and Executives in attendance
- All Non-Executives were well briefed on the key issues and were challenging whilst supportive to the staff presenting papers

Breakdown of Topics discussed

1. Administration
   - 0902 Chair's Welcome and Apologies for Absence
   - 0903 Declarations of Interest
   - 0904 Action Tracker
2. Finance - Assurance
   - 0908 Surgery Division Financial Performance
   - 0943 NHIS Financial Performance
   - 0955 PFI Governance Report
   - 1006 Alliance Progress Report
   - 1014 2018/19 Financial Reports
   - 1027 2018/19 Financial Recovery Plan & CIP Performance Summary
   - 1125 Financial Planning & Budgeting
   - 1131 Reference Costs & PLICS
   - 1133 Capital Planning Group Summary
   - 1136 NHSI Update
   - 1139 Escalations to the Board
3. Information/Discussion
   - 1045 Financial Strategy
   - 1118 Any Other Business
4. Governance
   - 0937 Authorisation Limit Requests – Newark Breast Business Case
   - 1134 Board Assurance Framework
   - 1141 Any Other Business 2
   - 1142 Next Meeting
   - 1143 Meeting Close

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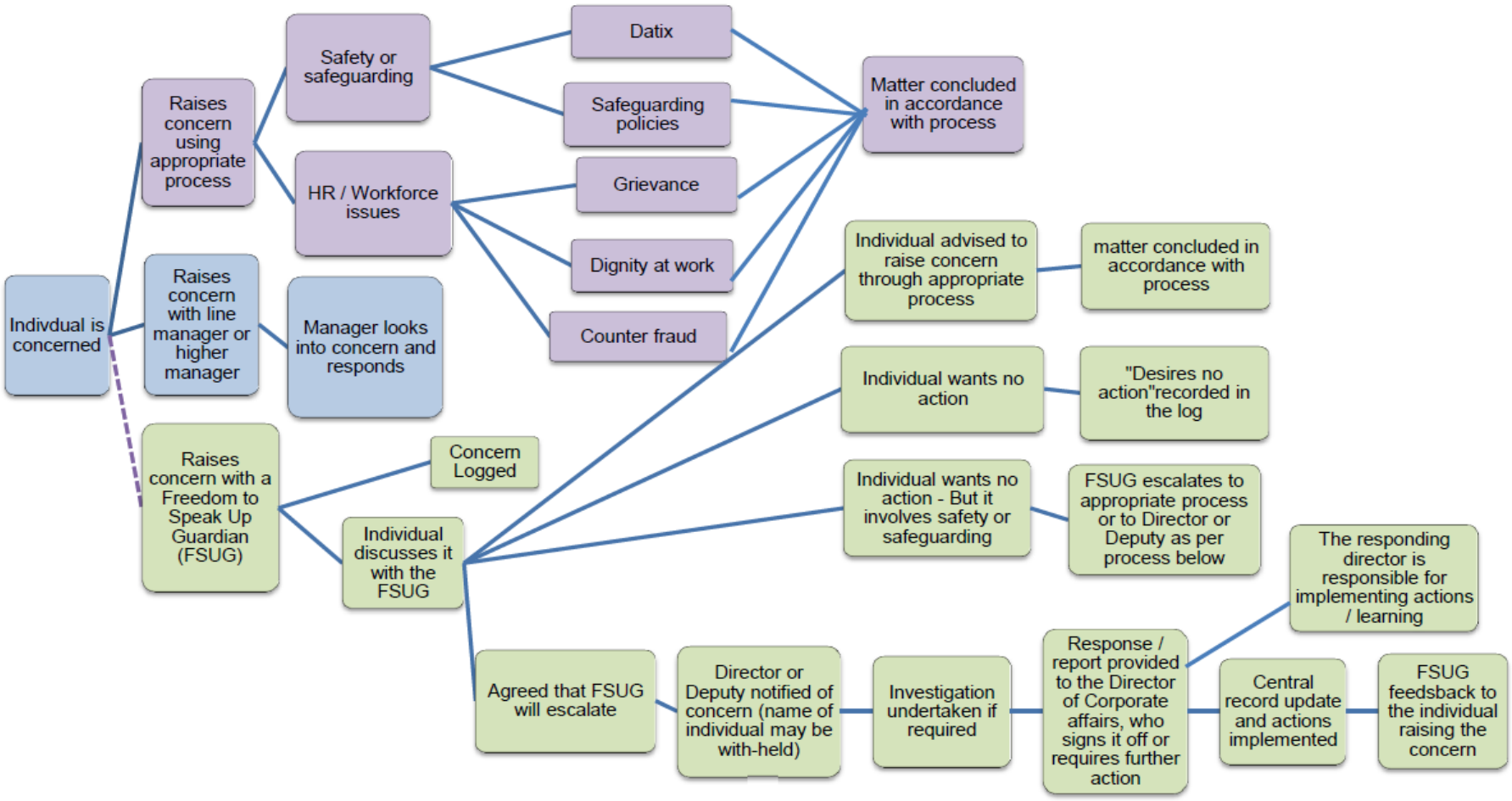
Appendix 2

Process for raising concerns

Raising Concerns



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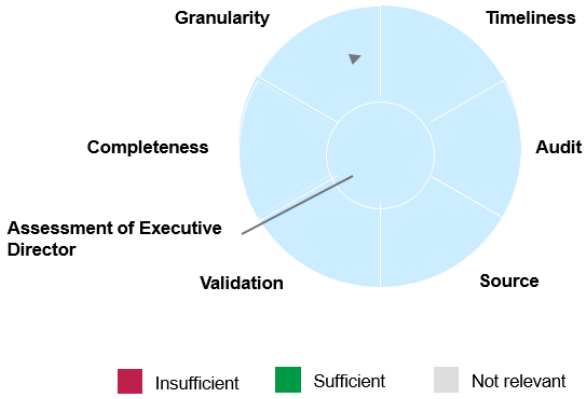
Appendix 3

Data quality kitemarks

Examples of data quality metrics and link to Integrated Performance Reports received by Trust Boards

It is good practice for trusts to implement a performance indicator assessment process. A number of trusts prepare data quality kitemarks to support members' review and assessment of performance indicator information reported in integrated performance reports (IPR). Alternative methods include a simpler data quality scoring in a range, such as 1-5 which are more reliant on judgement. The kitemark is used to assess the system against six domains: timeliness; audit; source; validation; completeness; and granularity to provide assurance on the underlying data quality. The relevant Executive Director's assessment of the sufficiency of the system is also included. More detail regarding each domain is included in the table overleaf.



Colours are used to document whether there is sufficient assurance over each of the individual criteria. The two important criteria are whether the indicator has received a satisfactory audit and whether the assessment of the responsible Executive Director is that there is assurance over the data quality.

We present below an example from an acute trust to demonstrate how data quality is linked to the indicators relied upon by Board members. Whilst the example relates to Referral to Treatment, the concept is consistent across all performance indicators.

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month
2			RTT - Admitted Care (18-weeks)	=> %	90.0	90.0
2			RTT - Non Admitted Care (18-weeks)	=> %	95.0	95.0
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0
	NEW		RTT - Backlog	No		
2			Patients Waiting >52 weeks	<= No	0	0
2	NEW		Patients Waiting >52 weeks (Incomplete)	<= No	0	0
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0
	NEW		Treatment Functions Underperforming (Incomplete)	<= No	0	0
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0
	NEW		Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No		

The IPR includes a data quality kitemark for each indicator reported.

For the Referral to Treatment (RTT) indicator, the Trust has assessed the system against each of the criteria included within the data quality kitemark.

Whilst the Trust in month performance is 90.04% against the nationally set performance target of 92%, the kitemark for the indicator acknowledges that four of the six kitemarks are insufficient in respect of completeness, validation, source and audit.

The indicator has received an audit via the Trust's Data Quality Assurance framework but this was not satisfactory, hence it is marked as red not white.

Appendix 3

Examples of data quality metrics and link to Integrated Performance Reports received by Trust Boards

Data Quality Indicator	Definition	Sufficient	Insufficient
Assessment of Executive Director	Does the responsible Director for the indicator believe the data used for this indicator to be a true reflection of actual performance.	The Executive Director can give significant assurance about the quality of the data.	The Executive Director cannot give assurance about the quality of the data.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self audit) in the last 12 months?	The system and processes involved in the collection, extraction and analysis of the data have been audited against the six dimensions of data quality: **Accuracy, Validity, Reliability, Timeliness, Relevance, Completeness** and presented to the Data Quality Group / Audit and Risk Committee/ other oversight committee.	No formal audit has taken place in the last 12 months (Time to be defined by Trust). Exceptions have been identified against one or more of the six dimensions of data quality.
Granularity	Can the data be disaggregated into smaller parts? E.g. evaluated at a division or ward level as well as a Trust level?	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.
Validation	Prior to publication, is the data subject to validation, e.g. spot checks, random sample checks, involvement of a clinician or approval by Executive Director?	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The information owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Timeliness	Is the data the most up to date and validated available from the system?	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract / prepare from the system.
Source	Is the source of the data fully documented and understood?	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.

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Appendix 4

Summary of work undertaken and stakeholders interviewed

Appendix 4

Summary of work undertaken

To inform our review we completed the following:

1. Review of Trust's self assessment

The Trust Board had not completed a self assessment of their performance against NHSI's eight Well-Led questions. However we used the CQC's well-led assessment to inform our work.

We requested and reviewed evidence the Trust presented against each of the eight Well-Led questions.

2. Determine the scope of review

We discussed the detailed scope of the review with the Trust on 10 October 2018 and how we planned to complete this.

We identified key areas of focus and investigation and ways to reduce disruption to the Trust.

We worked closely with the Trust to identify any further documentation we needed to review to address any gaps we had identified.

We planned meetings with key staff and stakeholders as requested by the Trust. This included key stakeholders.

3. Detailed Review

We completed our documentation review.

We held interviews with all Board members and Clinical Chairs and the Trust's Medical Examiner.

We observed the Board and Board-level Committees that fell within the assigned timeframe for the review.

We issued a 'Well Led' survey to all Board members.

4. Board report and action planning

We have provided our findings to the Trust in this report.

The Trust's Chair will be required to write to NHSI to advise that the review has taken place, setting out any material issues that have been identified and the proposed action plan to address these.

Appendix 4

Stakeholders interviewed

We held discussions with the following stakeholders:

Name	Job title
John MacDonald	Chair
Richard Mitchell	Chief Executive
Andy Haynes	Executive Medical Director
Simon Barton	Chief Operating Officer
Suzanne Banks	Chief Nurse
Paul Robinson	Chief Financial Officer
Julie Bacon	Executive Director of Human Resources and Organisational Development
Shirley Higginbotham	Director of Corporate Affairs
Peter Wozencroft	Director of Strategic Planning and Commercial Development
Neal Gossage	Non-Executive Director
Claire Ward	Non-Executive Director
Tim Reddish	Non-Executive Director
Graham Ward	Non-Executive Director

Name	Job title
Dr Achyuth Menon	Clinical Chair – Division of Suegery
Dr Anne-Louise Schokker	Clinical Chair – Division of Medicine
Dr Helena Clements	Clinical Chair – Division of Women and Children
Dr Gill	Clinical Chair – Division of Diagnostics and Outpatients
Dr Ben Lobo	Medical Examiner and Consultant End of Life Lead
Sue Holmes	Lead Governor
Keith Wallace	Governor
Amanda Sullivan	Accountable Officer - Mansfield and Ashfield CCG and Newark and Sherwood CCG