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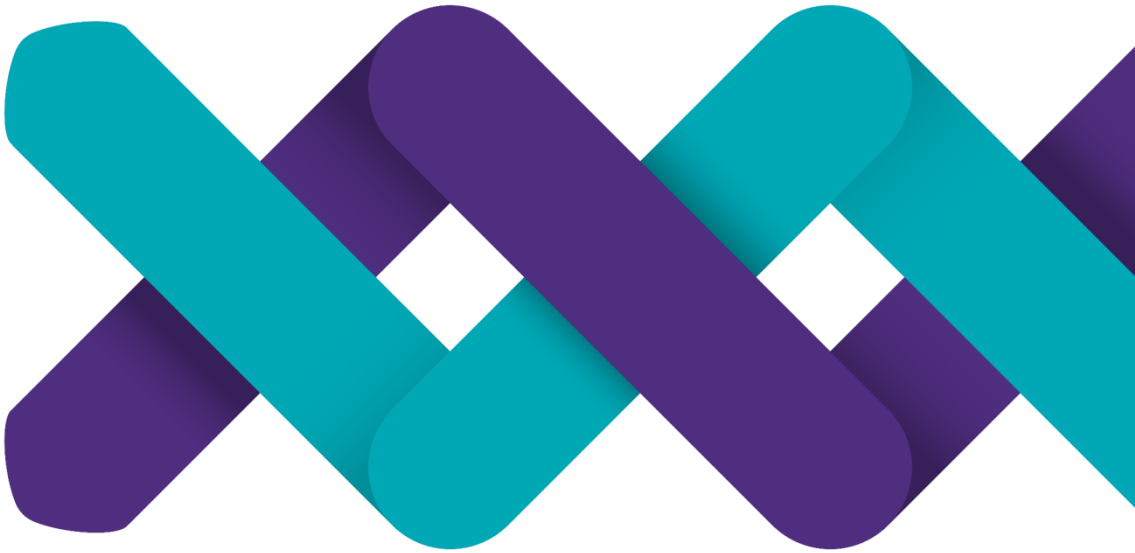
Sherwood Forest Hospitals NHS Foundation Trust

Well-Led review

FINAL REPORT

March 2022



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This report is confidential and is intended for use by the management and directors of Sherwood Forest Hospitals NHS Foundation Trust. It forms part of our continuing dialogue with you. It should not be made available, in whole or in part, to any third party without our prior written consent. We do not accept responsibility for any reliance that third parties may place upon this report. Any third party relying on this report does so entirely at its own risk. We accept no liability to any third party for any loss or damage suffered or costs incurred, arising out of or in connection with the use of this report, however such loss or damage is caused.

It is the responsibility solely of the Trust's management and directors to ensure there are adequate arrangements in place in relation to risk management, governance, control and value for money.

Introduction

Introduction

Sherwood Forest Hospitals was formed in 2001 and gained Foundation Trust status in 2007.The Trust provides healthcare across the community to 500,000 people in Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. The Trust has over 5,300 colleagues across three hospitals – King's Mill, Newark and Mansfield Community and is a partner in the Mid-Nottinghamshire Integrated Care Partnership (ICP) that provides health and social care throughout its locality.

In May 2020, the Trust was rated as Good overall following its Care Quality Commission (CQC) inspection. King's Mill Hospital, where 90% of services are based, was rated Outstanding by the Care Quality Commission. Newark Hospital and Mansfield Community Hospital were both rated Good.

This review was commissioned in line with NHSE/I's guidance that all NHS Trusts should undertake a review of its governance arrangements every 3-5 years. The Trust's previous Well-Led review was undertaken in 2018.

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 Foundation Trusts, 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 8 key lines of enquiry (KLOEs):

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 risk, 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?

The Well-Led review is an important assessment for the Trust, not only because trusts are expected to advise NHSE/I of any material governance concerns that have arisen from the review and the action plan in response to those concerns, but more importantly because it provides the opportunity for 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.

This Well-Led review was undertaken during the Covid-19 pandemic. All interviews and meeting observations were undertaken virtually using MS Teams. We were unable to visit staff in clinical areas due to the infection control guidance in play at this time that was aligned with national guidance.

Introduction

For each of the 8 KLOEs 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 shortfalls within 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 short falls are in an early stage of development with limited evidence of track record of delivery.
Red	Does not meet expectations.	Major omissions 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 at a time of high operational activity.

Executive summary

Executive summary

Conclusion

Overall we have raised 15 recommendations consisting of no high level recommendation; three medium level recommendations; and 12 low level recommendations.

The 3 medium level recommendations relate to:

- Maintaining visibility on the balance of internal and externally facing work to ensure portfolios of work are manageable as the establishment of the ICS progresses.
- The refresh of the out of date Data Quality Strategy, ensuring that it adequately documents roles and responsibilities and the governance structure where data quality issues will receive oversight and management.
- Documenting the vision and strategy for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use.

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

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

Executive summary

Below we provide a summary of our key findings for each of the 8 KLOE

GT rating	NHSI well led framework
Amber/Green	**KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?** There are two interim arrangements in Executive portfolios, one of which is the Chief Executive post. However interim arrangements are working well and we observed cohesive and collaborative working arrangements amongst Board members. Executives had the capacity, experience and capability to provide a strong focus on the delivery of high quality, safe patient care in line with the Trust's strategy. Executive portfolios are established and Board members and senior leaders were consistent in their understanding of the priorities for the Trust, and the areas where challenges are prominent. The Trust had undertaken a formal succession planning exercise for its Executive roles in 2019 however this requires a refresh and could be extended to include Non-Executive Director roles to identify any skills gaps for future appointments, and Divisional Triumvirate Leadership teams. Whilst Divisional Triumvirate Teams have deputies in place they have not formalised any succession plans or detailed any development requirements for aspirant leaders and this should be considered. This could be incorporated into the executive succession planning exercise. We found a strong and positive focus on leadership development at different levels in the organisation, and this was evident in the Divisional triumvirate teams. All five Divisional triumvirate teams appeared cohesive and supportive of each others roles.
Amber/Green	**KLOE 2. Is there a clear vision incredible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?** The Trust launched its 'Healthier Communities, Outstanding Care' 5 year strategy in 2019 and this was formed following extensive consultation with staff colleagues and partners. The Trusts strategic objectives have clear measures and are monitored regularly by embedded processes including Board Committees. The CARE values are aligned to the strategic objectives and these are well understood throughout the Trust's services. The Trust's strategy is outward facing and Executive Director involvement in the ICS is significant, and the CCG were positive regarding the Trust's leadership within the wider system. The Trust does need to ensure a balance of workload as its Executives participate in many meetings, and lead some portfolios and agendas in the creation of the Integrated Care System (ICS). The Trust has many examples of how it works with its local partners to achieve the aims and objectives of the system and is providing mutual aid and support to other Trusts. The Trust has joint working arrangements in place with Nottinghamshire Healthcare Trust and Nottingham University Hospital. In particular the Director of Human Resources is a shared post with NHT and this is reported to work well, supported by strong Deputy Director arrangements.

Executive summary

GT rating	NHSI well led framework
Amber/Green	**KLOE 3. Is there a culture of high quality sustainable care?** The Trust has a Culture and Improvement Directorate that aims to support the growth and sustainability of a culture underpinned by the Trust's CARE values. We observed many examples of how the Trust's values are at the centre of behaviours and expectations. Staff could cite examples where poor behaviours had been called out and managed appropriately. The Trust has recently increased its resource to the Freedom to Speak Up agenda. A full time Guardian has now been appointed and a recent recruitment drive has resulted in a significant uplift of Champions posts. Speaking up is actively encouraged within the Trust and this is reinforced by Board members, for example via the CEO blogs and updates. A NED is aligned to the FTSU agenda, and this is reported to work well. The Trust performs well in the National FTSU index score (2021) that measures what the speaking up culture is like for staff. The Trust scored high in the upper quartile and were ranked as the top acute Trust in Midlands. There are examples of lessons learnt from concerns that have been raised, however it needs to formalise its arrangements to ensure that staff do not experience detriment following raising a concern. The Trust is working on its Leadership Strategy and is proposing a new approach to leadership development with an overarching leadership management development offer. Bespoke development offers will run beneath this framework for leaders and services. The Proud2bAdmin Network was recently launched with its purpose to develop, connect and recognise administration professionals across the Trust. This has been a key area of focus during the Covid-19 pandemic as staff have had to work differently to deliver new working arrangements. During our review we observed that support for staff was a key priority for the Trust's leadership teams and staff are supported by an expanded health and well-being offer that encompasses Occupational Health, employee assistance programme, clinical psychology, chaplaincy and HR support. The Trust has a full time Equality, Diversity and Inclusion (EDI) Lead. A new workforce EDI Strategy has been developed and a People, Diversity and Inclusion sub-cabinet work stream is in place to progress the Strategy objectives and actions. The Divisions have strong leadership teams and work well together. We observed a culture of collective responsibility and staff appeared supportive of each other and work together on relative priorities.

Executive summary

GT rating	NHSI well led framework
Green	**KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?** We observed a good understanding of the delineation between Executive and Non-Executive Director roles. The Trust has an established governance framework in place and the Board and its Committees we attended were effective and in line with the terms of reference. The quality and presentation of papers was consistently high, and agendas although busy allowed for an appropriate level of debate and challenge. Highlight reports to the Board from its Committees could be updated to further strengthen the impact. There is a good flow of information throughout the Trust, and governance issues are escalated from the services to the Board using established escalation routes. Divisional teams we interviewed were clear on these. Roles and responsibilities in the Divisions were clear. The Divisions were structured in terms of roles and meetings that offered clear lines of accountability. Routes of escalation are well understood and we saw a good flow of information from services to their Divisional Leadership Teams, and from there through to the relevant Directors or Committees. Line management arrangements of the Divisional Leadership Teams are clear and reported to work well. Access to Executives is good and the relationships between the Chief Operating Officer, Medical Director and Chief Nurse are strong with meetings or conversations generally occurring on a daily basis to support clinical activity and quality.
Green	**KLOE 5. Are they clear and effective processes for managing risks, issues and performance?** The Trust has good effective processes in place to identify, monitor and manage its risks. The BAF is well documented and there is an embedded structured approach to the review of the Principal Risks. The Risk Committee further supports the Board Committees by maintaining oversight of the organisation's Divisional and Corporate risk registers and escalating risks that may be pertinent to the Board Committee's consideration of the BAF. The Trust has a current Risk Management and Assurance Policy. This is a comprehensive document that supports staff at all levels in the organisation to understand and manage risk. The policy aims to establish a culture of effective risk management throughout the organisation. Monthly Divisional Performance Reviews are in place and these are well established. The reviews provide a forum for Divisions to discuss issues and the challenges facing their services with Executive Directors and agree solutions in partnership. Divisional Leadership Teams were positive regarding these reviews stating they felt supported through the process. The Internal Audit plan is agreed in collaboration with the Executive Team and NEDs also have the opportunity to impact on the programme. The programme includes areas where the Executives are seeking additional assurance in areas where issues have emerged or to test recently improved or new processes. Internal Audit reports are responded to appropriately and have significant airtime at the appropriate Committees.

Executive summary

GT rating	NHSI well led framework
Amber/Green	**KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?** The Trust is currently recruiting a Chief Digital Information Officer who will lead the digital agenda and manage the Data Quality Team, and this post will report to the Medical Director. Performance reporting at the Trust encompassed many areas of best practice. The Trust's Single Oversight Framework (SOF) 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. The report is comprehensive, covering all portfolios in one report, and highlights areas for exception at the beginning with good narrative to support and explain the metrics. The narrative contains root causes, actions and impact/timescale as well as national/local benchmarking where available. The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group that was disbanded in November 2020. Currently the Trust does not have a stand-alone formal forum through which data quality issues are monitored and addressed and this should be reviewed. Information used in reporting, performance management and delivering care was reported as being accurate, valid, reliable, timely and relevant. This is tested by Internal Audit. At present, the Trust does not have a data quality kitemark system in place although we note this was recommended in its previous Well-Led review. Internal Audit has also made a recent recommendation in this area. The Trust should consider the use of such a system to inform users of any data quality risks that might impact decision making. However the national Data Quality Maturity Index that measures aspects of data quality across a range of national data sets scored the Trust an overall value of 88.9% (September 2021 data) and this is above the current average of 82.1%. The Trust reviews its performance against a significant number of data sets and scored above average in all of its submissions.
Green	**KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?** The Trust works hard to seek the views and address issues raised by colleagues. The NHS staff survey 2020 results were positive for the Trust. 61% of staff responded to the survey, significantly above the average response rate of 45%. The Trust increased its scores in 7 of the 10 theme areas from the previous year, with the remaining 3 themes scoring the same. A targeted area for improvement was to address the occurrence of violence from patients and the Trust is actively undertaking work to address this with a programme of work on incivility. The Trust has established 4 staff networks and these are all active and supported by an Executive Director sponsor. The Governors are passionate about their roles and are keen to engage with the Trust. Relationships are good and the Board of Directors and Council of Governors interact in a constructive partnership, seeking to work effectively together.

Executive summary

GT rating	NHSI well led framework
Amber/Red	**KLOE 8. Are there robust systems and processes for learning continuous improvement and innovation?** The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality Programme and Clinical Audit are linked. Although staff refer to a Continuous Improvement Strategy this is not articulated in a document and this would help in aligning the various strands of improvement and how they link together. During our interviews, including some Board level interviews this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. The Trust is implementing the Quality Service Improvement Redesign (QSIR) methodology although training plans have been interrupted due to the Covid-19 pandemic. In some areas such as mortality data and review the Trust could demonstrate significant work to further understand the data and how it performs against the national picture. The continuous work on mortality review is well documented and it is clear that lessons learnt from these reviews are impacting future practice. The Trust uses benchmarking data where possible to review its services, and we saw good use of this in Single Oversight Framework performance report presented at Board. Internal and external reviews are initiated as required and the Trust has good examples of where reviews have changed practice. The Trust also offers peer support to other Trusts to work through areas of challenge, which it describes to be mutually beneficial. The Trust celebrates success with its staff. Staff Excellence Awards is an annual ceremony and celebrates outstanding performance from colleagues and teams across the Trust. It is an opportunity to publicly recognise, reward and thank staff (clinical and non-clinical) who go above and beyond the call of duty. 'CARE' awards are presented monthly and this is inclusive to all colleagues, clinical and non-clinical. Colleagues are nominated by other colleagues for going above and beyond their role and displaying the Trust's values.

Section 2
Detailed findings

Detailed findings

Detailed findings

This section sets out our detailed findings in relation to our work. We have reported our findings for each of the 8 key questions in accordance with NHSI's Well-Led framework for governance reviews.

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

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

KLOE	GT rating 2022
1	Amber/ Green

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

The Trust Board has had some recent change in membership during the last year. The former Chair left the Trust in April 2021 and the Deputy Chair provided interim arrangements with the substantive appointment being made in September 2021. The new Chair had been a NED at the Trust since 2013 and the transition of personnel has been stated by many Board members as seamless.

The Trust's former Chief Executive Officer (CEO) left the Trust in October 2021. The substantive Director of Finance/Deputy CEO is currently the interim CEO and interviews for the CEO post are scheduled for February 2022. The Deputy Director of Finance is currently the interim Director of Finance. These arrangements are working well and Board members we interviewed were complimentary of how settled and established the Board feels.

Relationships at Board are strong and all Executives are experienced and were observed to be operating well in their roles.

We saw cohesive and collaborative working arrangements amongst Board members. Executives had the capacity, experience and capability to provide a strong focus on the delivery of high quality, safe patient care in line with the Trust's strategy. Executives demonstrated a good understanding of adjacent portfolios and in particular the Board triumvirate of Chief Operating Officer, Chief Nurse and Medical Director was particularly strong.

The Chief Nurse is dual qualified as a nurse and midwife. This is of particular benefit with the current significant national focus on maternity and the requirements of the national Ockenden report. Board members noted this as strength in the make-up of the Board.

The Director of Human Resources is a joint post with Nottinghamshire Healthcare NHS Foundation Trust. However, due to the way the portfolio of work is arranged and the existence of a strong deputy this appears to, and is reported to work well.

The Director of HR is also prominent in the Integrated Care System (ICS) leading the people agenda, and this workload needs to be regularly reviewed for all Executive Directors to ensure it remains manageable. **(Recommendation 1)**

In October 2020 the Trust's substantive Director of Corporate Affairs commenced joint working arrangements with Nottinghamshire Healthcare NHS Foundation Trust (NHT). This was initiated by NHT to assist in taking forward the recommendations made in their Well-Led review and has worked well. The arrangement ends in March 2022 and NHT are currently recruiting for a full time Director of Corporate Affairs.

The skills and experience of the Non Executive Directors (NEDs) is evident, and the level of challenge and debate at Board and in Board Committees was robust. Two new NEDS have been recently appointed and are due to start in post. The new NED appointments came from a strong pool of applicants and the Governors were engaged in the shortlisting, interview and appointment panels.

In terms of its skills and experience we observed the current Board to be strong and it functions well as a team. CQC in its latest inspection report (April 2020) stated that leaders had the skills and abilities to run the service. They stated leaders understood and managed the long-term priorities and issues the service faced.

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?

During our interviews and observations and Board and Divisional level we found a demonstrable culture of high quality, sustainable care which was delivered across the Divisions and their services.

Staff were knowledgeable and consistent in their understanding of key risks and priorities. Timescales to address priorities and future plans were well articulated.

Executive portfolios are established and line management arrangements of the Divisional triumvirate teams are reported to work well. From our observation and discussions with the Divisional teams this in part can be attributed to the working relationships of the Chief Operating Officer, Chief Nurse and Medical Director.

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

Board members and senior leaders were consistent in their understanding of the priorities for the Trust, and the areas where challenges are prominent. This review was undertaken during the Covid-19 pandemic with the additional challenges to trusts nationally that the pandemic has imposed. However the Trust remained significantly prominent in the wider system working, including offering mutual support to other Trusts, some of which are outside of the locality.

The Trust recognises the importance of its digital agenda and a Chief Digital Information Officer is currently being recruited and this post will report to the Medical Director. Board members were positive about this appointment and the assurances it will bring.

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 Trust had undertaken a formal succession planning exercise for its Executive roles in 2019, and this is best practice. It is important to refresh this periodically and this should be completed following the appointment of the CEO. Some Trusts include the NED skills in this exercise as this can help to identify any gaps and target skill sets of future appointments. **(Recommendation 2)**

Whilst Divisional Triumvirate Teams have deputies in place they have not formalised any succession plans or detailed any development requirements for aspirant leaders and this should be considered. This could be incorporated into the executive succession planning exercise. **(see Recommendation 2)**

The Board has a development programme in place and this is well established. A range of topics are covered including sessions on the Estates Strategy; Newark Hospital Strategy; Digital Inclusion and some sessions were more outward facing addressing issues in the wider health and social care system such as such as Health Inequalities and the Clinical Services Strategy. These have been well evaluated by Board members. Sessions during the last 18 months have been run virtually via MS Teams.

We found a strong and positive focus on leadership development at different levels in the organisation, and this was evident in the Divisional triumvirate teams. All five Divisional triumvirate teams appeared cohesive and supportive of each others' roles. Their performance as a team at events such as Divisional Performance Reviews was strong.

Are leaders at every level are visible and approachable.

There is good visibility and access to the Trust's leaders, including those at Board level. Many of the Executives work on site for the majority of their working week and this visibility was positively evaluated by the Divisional triumvirate teams we spoke to.

Staff reported good support from Executive colleagues and in particular the COO was noted to be extremely visible attending daily capacity meetings etc. Deputy Director arrangements to support the CCO are being expanded, with a new Deputy post being currently recruited that covers the entire portfolio of work – cancer, elective and emergency care.

Our interviews with the Divisions discussed the level of support they receive from the Trust's Executive. Divisions generally felt very well supported stating they were consulted regarding decisions that impact on their sphere of control and had the opportunity to impact on key decisions that were made. The Trust Management Team meeting was observed to be a key forum for interactive decision making. There are good effective relationships in place and we observed many supportive interactions at Divisional level. Accessibility of Board members was described as 'excellent'

The structured quality visits programme where NEDs and Executive Directors undertake more formal visits to the services has been suspended and is planned to be reinstated when the Covid-19 restrictions on access to clinical areas allow. This will be particularly helpful to the new NEDs as they familiarise themselves with the Trust's services. **(Recommendation 3)**

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

In the absence of the structured quality visits programme the Chief Nurse has arranged ‘twilight’ visits that are usually scheduled following the Trust Board meeting. These have involved manly Executive colleagues, but some NEDs have also participated, to visit clinical areas to observe activity and to talk to and support staff. These have been well evaluated both by the clinical services and by Board members.

The Trust is using MS Teams extensively and this has enabled meetings to remain functional and interactive, and this has worked well. Face to face meetings will resume as Covid-19 restrictions allow. The NEDs are keen to return to face to face activities in the Trust once the restrictions are eased.

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

KLOE	GT rating 2022
2	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 launched its 'Healthier Communities, Outstanding Care' 5 year strategy in 2019. The strategy was formed from the outcomes of multiple conversations and listening events that took place in 2018/19 and the Trust's personal and collective learning over the last five years. Over 750 conversations took place with the public, colleagues and partner organisations in one of the Trust's largest engagement exercises.

The Trust's vision 'Healthier communities and outstanding care for all' is underpinned by 5 strategic objectives:

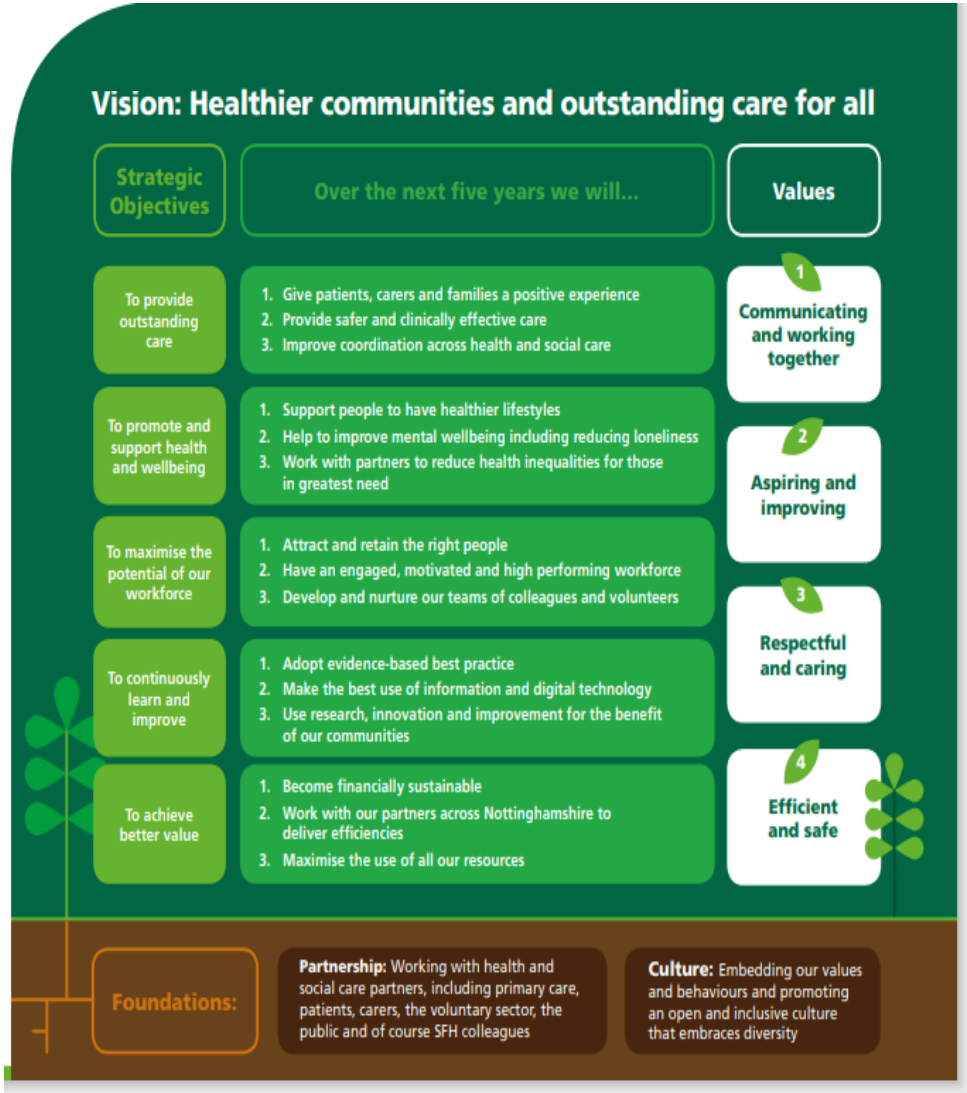
- To provide outstanding care;
- To promote and support health and well being;
- To maximise the potential of our workforce;
- To continuously learn and improve; and
- To achieve better value.

Each strategic objective has a description of its aims and indicators of how success will be measured. Specific deliverables are monitored in Board committees and public Board meetings.

The Trust's 4 CARE values are aligned to these strategic objectives:

- **C**ommunicating and working together;
- **A**spiring and improving;
- **R**espectful and caring; and
- **E**fficient and safe.

The CARE values have existed in the Trust for several years and were reviewed as part of the 2019 strategy development. Feedback from staff was that the values remained relevant and staff requested to keep them. The Trust did however update the descriptors of each value to ensure they reflected and aligned to the themes of the new Strategy.



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

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

The Strategy has been developed in line with the NHS Long Term Plan, in the context of the wider NHS and Social Care and local factors. The Trust has many examples of how it works in partnership to achieve financial sustainability as well as improving quality. The Trust has invested time to build on relationships with primary care, commissioning partners, patient groups and other organisations in the ICP and ICS. The CCG were positive regarding the Trust's contribution in the wider system.

There are a number of enabling strategies that contribute to the Strategy including a Quality Strategy and the Engagement and Involvement Strategy.

The current Quality Strategy came to the end of its term in 2021, and the Executives considered a more holistic approach was required to reflect the increased expectation of individual organisations working together in the ICS to deliver safe and effective care against a backdrop of rising demand, constrained funding growth and increasing patient expectations.

A new Quality Strategy is in development. A working draft version was presented at the November 2021 Quality Committee. The new strategy will run from 2022-2025 and has four campaigns on delivering quality care:

1. Create a positive practice environment to support the delivery of safest and most effective care;
2. Excellent patient experience for users and the wider community;
3. Strengthen and sustain a culture of continuous quality improvement and learning; and
4. Deliver high quality care through kindness and supporting each other.

Each campaign has key areas of focus and measurables as appropriate. Links are made to the enabling strategies and national initiatives. The Trust's Quality Committee members had the opportunity to comment on the formation of the Quality Strategy and will receive the final version for ratification.

It is not clear however how the third campaign links to the improvement techniques that are currently been rolled out in the Trust and this should be made more explicit in the Quality Strategy. **(Recommendation 4)**

The Trust is participating in the Advancing Quality Programme to measure, embed and drive quality improvement within its services. As part of the programme it intends to measure the success of the Quality Strategy by reviewing the progress of each focus listed in the campaigns. The programme will review and where necessary refresh the focus for each of the campaigns on an annual basis, aiming to successfully deliver this Quality Strategy.

The Trust's Engagement and Involvement Strategy was developed to achieve the Trust's vision of "dedicated people delivering outstanding healthcare for our patients and communities". It aims to focus on delivering the following Trust's strategic priorities:

- Strategic Priority 1: To provide outstanding care to our patients.
- Strategic Priority 4: To get the most from our resources.
- Strategic Priority 5: To play a leading role in transforming local health and care services.

The links to the Quality Strategy are clear and the forums for monitoring progress are clearly stated.

Do staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them? Have the vision, values and strategy been developed through a structured planning process in collaboration with people who use the service, staff and external partners?

Staff were involved in the development and refresh of the Trust's goals and values and it was clear that staff felt they were relevant and did not see a need to change the values. Staff could give examples of where behaviours had been called out if they were not in line with the Trust's values.

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

In our interviews and in the meetings we observed it is clear that the CARE values are front and centre to the organisation. Staff we spoke to could give good examples of how the values are used in everyday behaviours and were described by many as being 'business as usual'.

Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence of this. Do quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation?

The Trust has identified specific deliverables for each of the strategic objectives and these are aligned to the Board Assurance Framework (BAF). The progress of these deliverables are monitored via the Board Committees and public Board meetings. The oversight and monitoring of Strategic Objectives is allocated appropriately to the relevant Board Committee. We observed all Board Committee meetings and saw robust reviews of the relevant BAF items.

The BAF lists its sources of assurances and these include various tiers of the organisation, e.g. Divisional performance/risk reports; Infection Prevention and Control Committee and Board Committees.

Are the challenges to achieving the strategy, including relevant local health economy factors, understood and is an action plan in place?

The Trust's strategy is outward facing and Executive Director involvement in the ICS is significant. The Chief Executive has discussed some initiatives that are being considered to assist in the management of the enlarged health system agendas. These include the potential of a Strategy post and the option of expanding the communications role into a wider strategic partnership agenda.

The Trust has many examples of how it works with its local partners to achieve the aims and objectives of the system. Working in mutual support of others is evident and the Trust is providing support to other Trusts (both locally and further afield) with regard to maternity services, Nottingham University Hospital; Shrewsbury and Telford Hospitals; working together across the system with managing the flow of patients who arrive via ambulance; and also with Queen Elizabeth Hospital King's Lynn regarding service improvements.

The Trust works jointly with Nottinghamshire Healthcare Trust with shared posts for the Human Resources function in particular, and this is reported to work well with strong deputy appointment in place to support the portfolio.

In KLOE 1 we refer to the balance of time spent by Executives in internally facing and outwardly facing activities. The Trust is considered a strong leader in the wider system and need to ensure that priorities are continually reviewed. **(see Recommendation 1)**

Throughout the Committees we attended we saw a focus on the wider system in many areas, particularly in strategy development e.g Quality Strategy and People, Culture and Improvement Committee agenda items.

The Trust has a set of Culture and Improvement priorities for 2021/22 and these detail a 'quadruple aim' of:

- Patient Outcomes;
- Population Health;
- Use of Resources; and
- Colleague Experience.

It is clear that the Trust's overarching strategy is underpinned by a number of enabling strategies that also link to the NHS wider agenda such as NHS Long Term Plan and the NHS People Plan.

The CCG commented positively regarding the Trust's system wide working, contribution and leadership in ICS activities.

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

KLOE	GT rating 2022
3	Amber/ Green

Do leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. Do they encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services?

The Trust has a Culture and Improvement Directorate that aims to support the growth and sustainability of a culture underpinned by the Trust's CARE values.

Throughout our interviews within the Divisions, and with Board members and from our observations of the meetings and Committees we attended there are many examples of how the Trust's values are at the centre of behaviours and expectations. Staff could give examples of times when poor behaviours had been called out and dealt with. There are examples where staff have been supported with the implementation of behavioural contracts, and this helps to set and monitor expectations.

Staff we spoke to were proud to work for the Trust, felt well supported and valued. Whilst working throughout the Covid-19 pandemic has been challenging staff stated they felt involved in key decision making, were listened to and valued. In one area of high acuity and activity the Board Executives meet with staff on a planned and regular basis with to ensure they are supported through difficulties.

The Trust has developed and introduced a new 'Welcome Day', replacing the induction day for new colleagues joining the Trust. The day is more interactive and focussed on the Trust's culture and values.

Are candour, openness, honesty, transparency and challenges to poor practice the norm? Does the leadership actively promote staff empowerment to drive improvement, and is raising concerns encouraged and valued? Do staff actively raise concerns and are those who do supported? Are concerns investigated sensitively and confidentially, and are lessons shared and acted on?

The Trust has recently increased its resource to the Freedom to Speak Up (FTSU) agenda. A full time Guardian has now been appointed and a recent recruitment drive has resulted in a significant uplift of Champions posts appointed. The Trust previously had 4 FTSU Champions, however this has increased to 22.

The recruitment campaign has resulted in a diverse group of Champions covering many professional backgrounds, including medical and administration staff.

These FTSU Champions have received some local training and are in place to signpost staff and support the Guardian. Information on the number and type of contacts with Champions is now collated, and this includes contacts that are closed at that stage and do not progress further. This is useful for the Guardian to have oversight of areas of low level concerns, to triangulate data and information, to have early sight of issues and to understand what the Trust needs to improve upon.

The FTSU Guardian experienced a good response when presenting the bi-annual reports to Board and quarterly updates to the People, Culture and Improvement Committee. Speaking up is actively encouraged and this is reinforced by Board members, for example via the CEO blogs and updates.

The FTSU Guardian is line managed by the Director of Corporate Affairs and this is reported to work well with regular meetings and support. A Non Executive Director is aligned to the FTSU agenda and, although new to the role, has undertaken two of the training modules on-line with plans to access the 'follow up' module for senior leaders when it becomes available on the national Guardian's office web-site. This training is encouraged nationally to ensure staff aligned to this agenda have a full understanding of the speaking up process.

The Guardian has regular meetings within one Division as these were established by her predecessor, however does not meet regularly with all of the Divisional triumvirates, generally only meeting with them to discuss specific cases. It may be beneficial to establish regular meetings to develop relationships and a more proactive approach and this should be considered. **(Recommendation 5)**

Nationally the data suggests medical staff tend not to use FTSU mechanisms to raise concerns and in some trusts we see the Guardian of Safe Working Hours used to raise a broad range of issues. We note the Trust has successfully recruited a doctor to a FTSU Champion role and this may encourage medical staff to speak up if they have concerns.

FTSU Guardian should also arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles. **(Recommendation 6)**

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

It is important to ensure that people do not suffer detriment as a result of speaking up. Currently, following the closure of a case, the FTSU Guardian sends out a short four question email to staff who have raised concern. However the response rate is low and the questions do not adequately assess if there has been any detriment. The FTSU Guardian should formalise a process to contact staff who have raised concerns three to six months following closure of the case to discuss how they are and if they have suffered detriment as a result of speaking up. **(Recommendation 7)**

The FTSU index is an indicator that can help build a picture of what the speaking up culture feels like for staff. It is a metric drawn from four questions in the NHS annual staff survey asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree that they would be treated fairly if involved in an error near miss or incident.

The National FTSU index score (2021) for Sherwood Forest Hospitals NHS FT was 82.2 and was ranked 27/219 Trusts. This is a good result with performance high in the upper quartile. The Trust's result ranked them as the top acute Trust in Midlands.

The FTSU Guardian submits data as required to the National Guardian's Office and reports to the Board twice a year. The FTSU Guardian does not report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **(Recommendation 8)**

The Trust has a Guardian of Safe Working Hours. This role is currently undertaken by a Consultant Physician. The Guardian of Safe Working Hours is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service for doctors in training. The role is to identify and either resolve or escalate problems, and act as a champion of safe working hours for junior doctors.

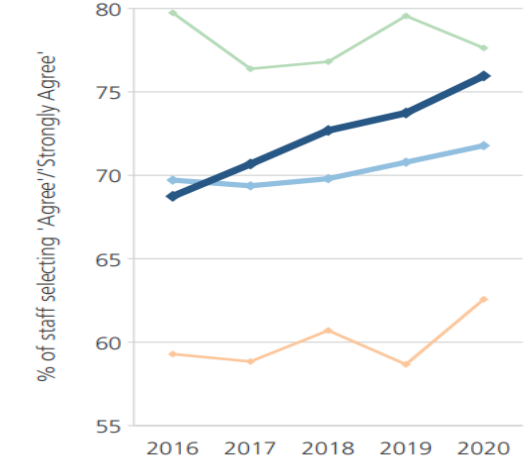
The Guardian of Safe Working Hours reports to the Local Negotiating Committee and also attends Educational Supervisor's meeting where he has recently raised awareness of the role. He also attends the junior doctor's meetings. The Guardian provides assurance to the Trust issues of compliance with safe working hours will be addressed, as they arise.

The Guardian of Safe Working Hours is accountable to the Board and reports on key issues as required and presents an annual report. The Guardian does not report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **(see Recommendation 8)**

In the 2020 National staff survey staff were asked if they felt secure raising concerns about unsafe clinical practice. The result shows an increase each year in performance when the Trust was compared to other acute and community trusts. This is indicative of the work the Trust has progressed in improving its culture and encouraging staff to feel safe in raising concerns.

Question 17b

I would feel secure raising concerns about unsafe clinical practise



	2016	2017	2018	2019	2020
Best	79.7%	76.4%	76.8%	79.6%	77.6%
Your org	68.7%	70.7%	72.7%	73.7%	76.0%
Average	69.7%	69.4%	69.8%	70.8%	71.8%
Worst	59.3%	58.8%	60.7%	58.7%	62.6%

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

Are there processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations?

Whilst there are general leadership and management offers available to staff in line with what we would see at other NHS trusts, the Trust has reflected on its offer to staff and is developing a more strategic approach with targeted leadership development. The Leadership Strategy is due for review in 2022 and proposes a new approach to leadership development with an overarching leadership management development offer. Bespoke development offers will run beneath this framework for leaders and services.

The Trust is currently working on several areas to improve staff development. It aims to grow its Apprenticeship scheme and has had a good response from applicants for its first Degree Apprenticeship Nurse programme. The reverse mentoring programme has also been expanded and work continues to improve the quality of appraisals to support staff experience.

There are a number of new developments planned including Women in Leadership Programme; Medical Leadership Programme; People and Improvement Coaches (of which 20 are now trained); and The Experience Programme in support of the SFH Talent Management approach.

Staff we spoke to at Divisional level felt there were good opportunities for learning and development within the Trust and were aware of the planned developments.

The Trust has adapted its mandatory and statutory training (MAST) to e-learning where possible to allow for the social distancing requirements of the Covid-19 pandemic. Training rates have remained high at 86% overall but below the Trust's target of 90%. A recent review has been undertaken of the Trust information and reporting on MAST compliance. Reporting has been enhanced to provide managers and leaders with greater insight of compliance, with the intent to strengthen support and compliance across professional staff groups and course. A task and finish group is planned to be established to work across professional groups and with system partners to review MAST requirements, improve compliance and support colleagues. Due to the recent focus and monitoring of MAST compliance and the improvement work that is planned we have not made a recommendation in this area.

Appraisal rates are currently 87% overall and this is an increase from September 2021 when rates were 85%. The Trust's target is 95%. The key cause of below trajectory performance on appraisal compliance is related to the delivery and capacity issues associated with the pandemic and winter pressures. The Human Resources Business Partners are supporting discussions with line managers at confirm and challenge sessions to identify appraisals which are outstanding and seeking assurance regarding timescales for completion.

The Trust reports its position relative to the national and local situation and indicated in its latest Board report that it benchmarks favourably nationally and local intelligence suggested the Trust's appraisal rates are amongst the highest in the region. and

In November 2021 the Trust ran a Proud2bAdmin virtual event – 'Recognising, Developing & Investing in our Admin Professionals'. There are a variety of development opportunities available for admin staff and the two day workshop event covered topics ranging from career development, incivility, service improvement and staff empowerment.

The event was supported by external leaders, national partners and Trust colleagues. The event marked the launch of the Proud2bAdmin Network, its purpose to develop, connect recognise administration professionals across the Trust. This is an area of key focus for the Trust in 2022/23.

Do leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported? Are there processes to support staff and promote their positive wellbeing.

Following the 2020 staff survey results the Trust worked with its staff to develop areas of improvement – 'You Said, Together We Did'. One area staff requested was ongoing well-being and psychological support. The Trust has built on its SFH Welfare and Wellbeing offer and the on-site well-being service, including bespoke decompression and engagement support. The health and well-being offer in place encompasses Occupational Health, employee assistance programme, clinical psychology, chaplaincy and HR resources and input.

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

The welfare of the Trust's staff is prominent in the Trust and we heard reference to this at many of the meetings we observed.

The Trust's colleague welfare and wellbeing offer was shortlisted in the 2021 HSJ Patient Safety awards in the category 'best mental health initiative' and although it did not win, it recognised the support to colleagues.

Some staff have experienced violence and aggression from patients or visitors and the Trust engaged external support to undertake a risk assessment and produce recommendations for action. Training for staff in managing challenging behaviours is available and being rolled out. Staff are being encouraged to report occurrences of poor behaviours so the Trust can take action to reduce occurrences and the subsequent impact on staff. This remains a current area of focus for the Trust.

The Trust can demonstrate its proactivity in addressing issues that are raised by staff. For example the 2020 national Staff Survey evidenced concerns in relation to staff experiencing bullying and harassment from patients, carers and staff. A Bullying and Harassment Task and Finish group was established in 2020 to take forward actions to reduce bulling and harassment experienced by staff. This group is being reframed with the title of Civility and Respect at Sherwood, aligning itself to the work on civility that is being undertaken centrally by the Trust, focusing on the positive behaviours expected from colleagues and devising a positive programme of work that focuses on learning and change.

Is equality and diversity actively promoted and the causes of any workforce inequality identified and action taken to address these? Are staff including those with protected characteristics under the Equality Act feel they are treated equitably?

The Trust has a full time Equality, Diversity and Inclusion (EDI) Lead. This post was established in March 2021, prior to that Human Resources Business Partners were undertaking aspects of the EDI portfolio of work.

A new workforce EDI Strategy has been developed and published on the Trust's intranet and a People, Diversity and Inclusion sub-cabinet work stream is in place to progress actions as detailed in the Strategy.

During the last 18 months the Trust's focus for Equality, Diversity and Inclusion has been on the support of those colleagues most at risk from COVID-19, in particular, BAME colleagues, those with underlying health conditions; staff who initially were required to shield; and pregnant colleagues.

A summary of the Workforce Race Equality Standard (WRES) was reported to the Board in September 2021. The Trust has measured its performance against the nine indicators, and whilst its position has improved there is recognition that there is still work to undertake. Staff we interviewed were clear on the priority areas for improvement and an action plan is in place and is monitored via the People, Culture and Improvement Committee. The groups that actively work on the improvement actions include:

- People and Inclusion Cabinet
- Ethnic Minority staff network
- People, Diversity and Inclusion Sub-Cabinet

Work has also been undertaken on Workforce Disability Equality Standards (WDES) and a new Disability Staff network has been established. All of the staff networks have an Executive Director as sponsor, and the Chief Executive's communications are frequently used to celebrate and promote the EDI work taking place within the Trust.

The Trust can demonstrate its participation in events to promote the EDI agenda, Black History Month was celebrated with events and work has been undertaken on addressing racism. There is significant work being undertaken on WRES with six high impact actions The Trust also celebrated by taking part in the Pride march this year.

The EDI Lead's role was made permanent in September 2021 and the Lead has plans to ensure visibility and access to the role throughout the Trust, with posters, screen saver banners and an EDI pack. The EDI Lead meets regularly with the Freedom to Speak Up Guardian recognising the interdependencies of the adjacent portfolios, and this is best practice.

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

Is there a culture of collective responsibility between teams and services? Is there positive relationships between staff and teams where conflicts are resolved quickly and constructively and responsibility is shared?

We interviewed all five Clinical Divisional triumvirate teams and observed the Divisional Performance Reviews. Despite activity and acuity of patients being high and the added pressure of the Covid 19 pandemic staff remained professional and positive and Divisional leadership was observed to be strong in all Divisions. It is clear that the triumvirate teams have good working relationships and the meetings structures and lines of accountability are clear.

The Divisions work well together and there are multiple interdependencies, some of which are more evident due to the pandemic. However we saw the Divisions working well together and observed this in meetings such as Trust Management Team and the Risk Committee.

Staff appear supportive of each other and work together on relative priorities. A good example of this is the clear collective responsibilities around patient flow and how this is managed on a daily basis. There are cross Divisional meetings with the Clinical Chairs meeting collectively, the General Managers meet together with the Chief Operating Officer and the Heads of Nursing also met as a group and with the wider senior nursing teams.

Staff we interviewed at Divisional level stated they had really come together over the management of the Covid-19 pandemic and relationships had been further strengthened during this challenging time.

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

KLOE	GT rating 2022
4	Green

Are structures processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, clearly set out, understood and effective?

The Trust has an established governance framework in place and the Board and Committees we attended were effective and in line with the terms of reference.

We observed the following Committee meetings:

- Audit and Assurance Committee;
- Finance Committee;
- Quality Committee;
- People, Culture and Improvement Committee; and
- Risk Committee.

Common observations at all Committees

- Action trackers are in place and managed well at all Committees.
- All Committees are allocated the appropriate items of the Board Assurance Framework to review, and this is undertaken at each meeting.
- An annual work plan/cycle of business is in place for each Committee and agendas were consistent with the annual work plan.
- The majority of items were supported by papers and verbal updates were kept to a minimum. Papers had a cover sheet detailing purpose and linkage to the Trust's strategic aims.
- Most Committee Chairs evaluated the performance of each meeting, and this is best practice.
- Committees provide a highlight report to the Board although these vary in terms of presentation and content. Using a simple quadrant style grid to identify matters of concern or key risks to escalate to the Board; detail of major actions commissioned or work underway; provide information on positive assurances; and to record decisions made could offer a more concise report that identifies the relative priorities. **(Recommendation 9)**
- A comprehensive annual assessment of each Committee's effectiveness is undertaken.
- All Committees have a current Terms of Reference.
- All Committees were quorate. (People, Culture and Improvement Committee was not initially quorate).

Audit and Assurance Committee

We observed the Committee on 23 November 2021. Relationships are good with the Trust's Internal and External Audit Teams, and the Counter Fraud Specialists.

- The Committee was well run and ran to time.
- Counter Fraud provided a clear and useful report.
- Internal Audit provided an update report and presentation of latest reports which were well received. Executives were in attendance to discuss the required actions for any limited assurance audit reports and these reports generated some good challenge and responses. Appropriate time was given to these discussions.
- A process for providing updates on outstanding audit actions was discussed and agreed and this will provide further assurances on the completeness of actions and the process taken to close actions.
- Decisions were taken regarding presenting Internal Audit reports at other Committees, e.g. Consultant Job Planning will be presented at People, Culture and Improvement Committee.
- External Audit presented a progress report and provided a useful benchmarking report that generated debate.
- Committee updates were available from the other Board level Committees and these are helpful in the identification of issues that cross over agendas and impact the Audit Committee on discharging its duties.
- The Chair gave a good summary of items that had been presented and any issues that were to be escalated to the Board.

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

Finance Committee

We observed this Committee on 21 December 2021

- The Committee was well run and ran to time.
- Papers were well presented and clear with good summaries.
- Presenters were good, explained the details and issues well, and focussed on risks.
- Good probing around financial implications, both short and long term.
- The Committee offered a rounded of finance – not limited to income and expenditure – but picked up value for money, efficiency, operational delivery, clinical quality etc.
- Items were frequently discussed in the context of the wider system's perspective (ICS).
- Good challenge from the Chair and NEDs who could demonstrate a strong grasp of the detail.
- Inclusive/transparent arrangements with the governor observer.
- Items were not rushed and the Committee was inclusive of all attenders.
- The Chair gave a good summary of items that had been presented and any issues that were to be escalated to the Board.

Quality Committee

We observed this Committee on 8 November 2021.

- The Committee was well run and ran to time.
- The Chair does not periodically observe the key meetings that feed into Quality Committee for assurance e.g. the Quality Assurance and Safety Cabinet, and this should be considered for on an annual basis to confirm confidence in the governance and reporting framework. **(Recommendation 10)**
- Mortality data was well presented and there was time taken to allow a thorough discussion for members to understand the complexities of this data.
- A paper was presented on an updated process for undertaking quality impact assessments for Financial Improvement Programmes (FIPs). This was well received and demonstrated lessons learnt from the previous process.
- The Committee had the opportunity to comment and input to the draft version of the Quality Strategy. A good discussion occurred about health inequalities and how this will feed into the system wide work.
- The Chair gave a good summary of items that had been presented and any issues that were to be escalated to the Board.

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

People, Culture and Improvement Committee

We observed this Committee on 25 November 2021 (workshop Committee) and 31 January 2022 (full Committee)

November 2021 Committee

- The meeting was not quorate at the start due to the late apologies of a NED member. However no decisions were made prior to another NED,(who had been delayed at another meeting) arriving one hour into the meeting.
- The Committee was a 'workshop' event that allowed time for specific agenda items as opposed to usual Committee business, although some routine items were covered e.g. review of the BAF.
- The two main areas for discussion were well presented and did generate some good debate and demonstrated the wide ICS view of direction of travel for the people agenda.
- The Committee did not have the same feel of flow and organisation as the other Committees we observed. However, this may have been due to the fact that it was a 'workshop' Committee. We therefore attended a further Committee in January 2022 to assess the full session.

January 2022 Committee

- This meeting was quorate. The agenda was full and items were rearranged to allow full participation of members who had to leave early.
- The agenda was full and there was significant time spent on some items, however this resulted in some items being rushed.
- One paper was not presented as the presenter was not in attendance.
- The Chair does not periodically observe the key meetings that feed into People, Culture and Improvement Committee for assurance. This should be considered on an annual basis to confirm confidence in the governance and reporting framework. **(see Recommendation 10)**
- The Chair of the Committee does not routinely meet with the Lead Executives for this Committee, more ad-hoc arrangements occur. **(Recommendation 11)**

Risk Committee

We observed this Committee on 7 December 2021.

- The Committee is Chaired by the CEO and was well organised.
- Divisions present their risks on a rolling programme and at this meeting Diagnostics and OPD Division gave a presentation of their risks. This was clear and well presented.
- Corporate Risk Reports were discussed and changes noted. The discussion on the Corporate Risk Report for Estates and Facilities noted a change to the membership of the Estates and Facilities Governance meeting to include the Deputy Chief Nurse to allow for clinical representation and views on key decisions to recognise the interdependencies of these portfolios, for example infection prevention and control risks.
- BAF risks owned by this Committee were reviewed and there was a good rounded discussion regarding a new climate change risk that has been added to the BAF and the Trust is in discussions with NHT to align this agenda.
- Items from this Committee are escalated to Executive Team for appropriate action/information and the Audit and Assurance Committee receives an update report.
- There was a useful paper presented to update the Committee around medical attendance at Trust Committees and groups as this has been identified as an issue. A paper had previously been presented to this Committee in October 2021. Further work is ongoing to review SPA allocations as there is considerable variation and what is included in that activity allocation, and a risk around medical attendance has been recorded on the risk register.
- The Committee agenda allows for good coverage of risks and discussions on mitigating actions. Divisions contributed well to the discussions.

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

Board meeting – public and private sessions

We attended the public and private Board meetings on 4 November 2021.

- The Board meetings were well chaired. The agendas of both the public meeting and the private meeting were appropriate. The private Board session only contained items that were appropriate to that session and focussed on items that were clinically or commercially sensitive.
- Board agenda is organised into three main sections - strategy, operational items and governance.
- A patient story featured in the Strategy section of the proceedings. This was thought provoking and staff who presented it spoke about the impact and change this story had brought about to improve the experience of other stroke patients and the rehabilitation services they receive.
- The Chair and Chief Executive updates were comprehensive and provided evidence of an open and inclusive culture.
- A particularly comprehensive report on activity and planning for the second half of the financial year was presented by the COO, and this generated significant debate and response on issues such as patient safety and staff well being.
- There was some good challenge from the NEDS on the Safer Staffing report and whether medical staffing data could add to the overall staffing picture.
- A good discussion occurred on patient falls and subsequent learning from these events. A falls group has been initiated.
- An area for the Quality Committee to undertake deep dives was identified. (Cardiac arrest)
- The Strategic Oversight Framework quarterly performance report was well presented and contained good narrative to describe issues off target or new initiatives etc.
- Committee Chairs presented highlight reports for assurance and the impact and style of these varied. **(see Recommendation 10)**
- Questions were invited from members of the public and Governors.

Council of Governor meeting

We attended the Council of Governor's meeting on 9 November 2021.

- The meeting was well attended by Governors; Executives and Non-Executives.
- The Trust's Chair shared an update report – we observed the style to be inclusive and open.
- There was an informative discussion regarding interim arrangements for the CEO role and DoF role.
- The COO presented a report to update on activity and planning for the second part of the year.
- The Lead Governor spoke about the recent successful recruitment for 2 new NEDs and was positive regarding the process.
- During this meeting due process was followed in the approval of a 1 year extension to the post of an existing NED.
- Clinical staff attended and presented a patient story and this was well received.
- Councillors who are observers of the Board Committees commented on the management and work of the Committee meetings they had attended.

Does the Board and other levels of governance in the organization function effectively and interact with each other appropriately?

Governance arrangements at the Trust are strong. The Trust has developed its governance framework and supporting structures and this is well documented.

There is a good flow of information throughout the Trust, and governance issues are escalated from the services to the Board using established escalation routes. Divisional teams we interviewed were clear on these.

The Trust has five clinical Divisions: Diagnostics and Outpatients; Surgery; Urgent and Emergency Care; Women's and Children's; and Medicine.

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

The Divisions were structured in terms of roles and meetings that offered clear lines of accountability. Routes of escalation are well understood and we saw a good flow of information from services to their Divisional Leadership Teams, and from there through to the relevant Directors or Committees.

Are staff clear on their roles and accountabilities?

Our findings concluded that staff we interviewed were clear on their roles and accountabilities. We observed a good understanding of the delineation between Executive and Non-Executive Director roles.

The Board and its Committees have up-to-date and appropriate terms of reference.

Each Division has a triumvirate leadership team comprising of a Clinical Chair; Divisional General Manager; and a Divisional Head of Nursing/Midwifery or Clinical Lead. Reporting lines are clear. The Clinical Chairs report operationally to the Chief Operating Officer and are clinically accountable to the Medical Director. Divisional General Managers report to the Chief Operating Officer and Heads of Nursing/Midwifery and Clinical Lead posts report to the Chief Nurse. Frequent formal and ad-hoc meetings occur with Divisional staff and the Chief Operating Officer who is very visible throughout the services. The Medical Director attends the Clinical Chair's meetings alongside the Chief Operating Officer. Divisional staff state that leadership is clear and unified. Relationships between the Chief Operating Officer, Medical Director and Chief Nurse are strong with meetings or conversations generally occurring on a daily basis.

The Board Committee membership is designed to allow cross membership of Executive Directors and NEDs and this assists with the consideration of the impact of decisions on adjacent portfolios. The Committee structure information we were provided with requires updating to reflect recent changes in personnel/ new appointments etc.

Escalation routes from Committees and groups that feed into Committees is clear, and highlight reports we reviewed were generally of good quality although we have suggested an alternative reporting grid to enhance the impact and readability. **(see Recommendation 9)**

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

KLOE	GT rating 2022
5	Green

Is there an effective and comprehensive process to identify, understand, monitor and address current and future risks?

The Trust has good effective processes in place to identify, monitor and manage its risks.

The Trust has a Board Assurance Framework that is well managed and maintained.

The BAF has seven principal risks and each of these are assigned to a Lead Director and to a Board Committee, and this allows the Board to maintain effective oversight of strategic risks through a regular process of formal review.

In our attendance at Board and Board Committees we saw the treatment the BAF was afforded, and this was well executed at all meetings where the Committees reviewed their allocated individual principal risks. Appropriate time was given in meetings to allow for meaningful debate and challenge.

The Risk Committee further supports the Board Committees in their role by maintaining oversight of the organisation's Divisional and Corporate risk registers and escalating risks that may be pertinent to the Board Committee's consideration of the BAF.

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

The Board receives the BAF quarterly and the Risk Committee undertakes a full review each quarter. These processes are well established. The Risk and Assurance Manager has a structured and consistent approach to risk and is considered a valuable asset to the Trust. The Director of Corporate Affairs manages this portfolio, and this works well.

The Trust has a current Risk Management and Assurance Policy. This is a comprehensive document that supports staff at all levels in the organisation to understand and manage risk. It contains many elements of best practice.

The main objective of the policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

A matrix has been developed for monitoring compliance and effectiveness of risks and this details responsibilities, frequency of monitoring and the governance route (Committee) for oversight.

A risk scoring matrix and risk assessment form are appended to the policy to support staff in their assessment of risks.

The Trust has an established Risk Committee, chaired by the CEO. We observed the December 2021 meeting and this performs well. The agenda was well supported by relevant papers that prompted some good challenge and discussions.

A rolling deep dive into Division's risks allows the Committee to systematically review, scrutinise and challenge risk profiles across all Divisions and Corporate functions.

The Trust's Risk Register is maintained on the Datix Risk Management System and every clinical specialty, corporate service, division and directorate within the Trust is expected to make active use of the Datix risk register to support their management of risks. In our discussions with the five clinical Division's triumvirate teams they demonstrated a good understanding of their risks and the way issues are raised, documented and escalated as appropriate.

Risk escalation and reporting arrangements are embedded and we saw good oversight of this through our review of Divisional meeting papers, Divisional Performance Reviews and Risk Committee.

The Risk and Assurance Manager meets regularly with the Divisions to discuss and modify risk ratings and actions. This process was reported to work well and was reflected in reports we have reviewed where risks are well documented and had been updated in a timely way.

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

Are financial pressures managed so that they do not compromise the quality of care?

The Trust set an annual plan to break even in 2021/22, which was based on the national finance regime operating under the Covid-19 Pandemic where Trust expenditure would be covered by block payments and top-up income. This was updated in-year due to first half performance to a planned deficit of £1.5m at year end. At month 8 (November 2021) the Trust reported a year to date deficit of £3.4m, which was £1.9m adverse to plan. This was due to underachievement, and changes in the recognition criteria, of the Elective Recovery Fund (ERF) in the first half of the year. The Trust is forecasting a breakeven position for 2021/22, although there are known risks to the delivery of the plan.

Prior to Covid-19, the Trust calculated that it had an underlying deficit of £51.6m (17% of turnover) and that if no action was taken, this could grow to £83.5m by 2023/24. To support its understanding, the Trust commissioned external reviews into the drivers of the deficit and developed a 5 year financial strategy “Achieving Better Value 2019/20 to 2023/24” which was approved by the Board in September 2019. Given the change to the financial framework as a result of the pandemic, many of the assumptions and aspirations set out in the original financial strategy are no longer relevant or valid. However, the need to address the underlying deficit, and many of the drivers of that deficit, such as the Trust’s PFI scheme and the need to drive operational productivity, remain. As the Trust moves into 2022/23, and there is more certainty around national allocations and operational and planning guidance, in-line with expectations from NHSE/I the Trust will need to develop new financial plans, including aligning these with the Integrated Care System (ICS).

The Trust has been working collaboratively with the ICS to manage the financial performance across the whole system, and at month 8 are expecting to achieve the annual plan of a break-even position across the ICS, although a number of risks have been identified within the forecast such as a shortfall in ERF funding. A break-even position is a best-case outcome and scenario planning indicates a probable deficit position for the ICS of £3.2m and a worst case position up to £8.8m.

Are service developments and efficiency changes developed and assessed with input from clinicians so that their impact on the quality of care is understood?

A Project Management Office coordinates the Transformation and Efficiency Programmes and we were told that this runs well.

A new Quality Impact Assessment (QIA) process was implemented in August 2021 and this was the result of learning from a review of delays to previous QIAs. The new process aims to improve the timeliness of Divisional approvals and strengthen the review process. Monitoring of Financial Improvement Programmes (FIPs) is in place and this includes the status of QIA completion.

Divisional triumvirate teams stated that the QIA process was embedded and worked well. Post implementation reviews of higher risk schemes occur as required to assess for any ongoing impact. During the last 18 months due to the Covid-19 pandemic there had been less schemes in place, however staff stated they had performed in line with the plans.

The Director of Nursing and Medical Director undertake the final approval and sign-off of quality impacts for the schemes. The Chief Operating Officer would be included in discussions as appropriate. The relationship between these three post holders is good, there is mutual respect and appreciation of each others portfolios and a good understanding of the impact of the adjacent portfolios.

Does the organisation have the processes to manage current and future performance?

The Trust has a Divisional Performance Review process in place and this is well established. Reviews are monthly and are chaired by the Chief Operating Officer although it is clear that the Chief Operating Officer does not dominate the discussion or agenda, and the majority of Executives attend or have appropriate deputies in attendance. Where deputies were present we observed they contributed fully and added value to the meeting.

The reviews provide a forum for Divisions to discuss issues and the challenges facing their services with Executive Directors and agree solutions in partnership.

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

We attended the November 2021 round of performance reviews for all five clinical Divisions. The Performance Review meetings are well organised and mutually supportive.

Divisional Performance Reviews have a standard agenda.

- Action Tracker;
- Divisional Highlight Report – key successes and key risks and issues;
- Finance report;
- Any other business.

We note that Urgent and Emergency Care Division presented an informative HR performance report, and whilst other Divisions talked about their HR issues they did not include a presentation of metrics, and this should form part of the agenda and a report should be included in the meeting pack. These reports are routinely available for Divisions via the HR Business Partners. **(Recommendation 12)**

The Divisions are clear regarding expectations. Attendance includes the Business Partners for support functions such as Finance and HR and the Divisions are well supported by the input from these functions.

Our observations were that the Divisions were very well prepared for these meetings, Executives were aware of key issues facing the various Divisions and these were clearly presented with some good discussion.

Divisional Teams reported that these meetings were supportive and that they were appropriately held to account in these meetings when required.

Are performance issues escalated to the appropriate Committees or the Board through clear structures and processes?

Escalation routes are clear and the Trust has worked to standardise the reporting and escalation of issues from meetings and groups into the Board level Committees.

Staff we spoke to in the Divisions were clear on escalation routes. All Divisions have a governance framework for the management of risk and performance, and these arrangements are largely consistent.

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

The Internal Audit plan is agreed in collaboration with the Executive Team and NEDs also have the opportunity to impact on the programme. The programme includes areas where the Executives are seeking additional assurance in areas where issues have emerged or to test recently improved or new processes. Internal Audit reports are responded to appropriately and have significant airtime at the appropriate Committees.

All Internal Audit reports feature at the Audit and Assurance Committee as intended, however they also are presented at other relevant Committee e.g. Quality Committee as appropriate. This allows for a more in-depth discussion, particularly around the areas identified for improvement.

Internal Audit recommendations are tracked at the Audit Committee and this process has recently been strengthened to allow for greater assurance on actions that have been marked as complete.

The Internal Auditors are complimentary about the working relationship with the Trust and state their recommendations are well understood and acted upon. Access to Executive colleagues and nominated leads for the reviews is good.

The Trust has a Clinical Audit Plan and uses Audit Management and Tracking (AMaT) software to manage and monitor audits and other quality improvement projects. The progress of the Clinical Audit Plan is monitored and progress reported via an annual report to the Quality Committee. During part of the previous year a temporary suspension to clinical audit activity was in place due to the Covid-19 pandemic and progress with the Clinical Audit Plan was clearly affected. Clinical audit activity has been slow to re-start as colleagues and services enter the Covid recovery phase, and In line with the national situation the Trust reviewed its participation in national audits. In 2021/2022 the Trust is participating in 56 National audits across all five Divisions.

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

The Director of Culture and Improvement leads this portfolio of work and the vision is to strengthen the alignment of clinical audits to improvement work; increase the visibility of audit activities via the Trust's QI Hub; increase local ownership at a local level; and step up the progress with the clinical audit plan as activity levels and clinical prioritisation allows.

Using clinical audit the Trust aims to provide further tangible measures of improved patient outcomes. Staff were however able to talk through examples of where clinical audit findings have led to the introduction of new protocols to enhance the care given to patients, for example oxygen prescribing.

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

KLOE	GT rating 2022
6	Amber/ Green

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

The Trust is focussed on quality and sustainability and this was evident in the meetings we attended, from information we have reviewed and interviews we have undertaken throughout the levels of the organisation.

In line with the national situation the Trust is undertaking considerable work on waiting list backlogs, prioritisation of patients and harm reviews of patients as required. Divisional staff were aware of the current position and the mitigations in place and ongoing management of these issues. The position is well documented in the SOF report.

For cancer patients there is good reporting on waiting times and some metrics are performing better than expected re-forecasts. The Faster Diagnostic Standard currently exceeds the 75% standard, and demonstrates a good position nationally. Exception reports detailing the root causes and actions are presented with the SOF.

Elective care performance has exceed the targets set in many areas.

Diagnostics continue to perform well despite increased pressure particularly for CT from both emergency and cancer pathways. Mutual aid is in place across the Nottinghamshire system for MRI and CT capacity with SFH and NUH supporting each other where there is inequity of waiting times.

Staff feel well supported in terms of the information they receive. Information we reviewed was of high quality, up to date and presented in a way that was easy to read with good narrative to support any anomalies or areas off target.

Divisions are able to self serve some reports, however they stated the information teams are responsive to any requirements they have and data is accessible.

We saw Divisions reported their activity and performance in common reports during our attendance at their Performance Reviews and reporting styles appear to be well established.

Do integrated reporting support effective decision-making? Is there a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information?

Board members were positive about the presentation of data at Board and Board Committees. Information is well presented and complete.

The Trust's Single Oversight Framework (SOF) 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.

The SOF report is comprehensive, covering all portfolios in one report, and highlights areas for exception at the beginning with good narrative to support and explain the metrics.

Narrative contains root causes, actions and impact/timescale as well as national/local benchmarking where available.

Is performance information used to hold management and staff to account?

In our observation of the Board meetings, Committees and Performance Reviews we noted a good level of assurance and also some challenge arising from the discussions on the Performance Reports.

Divisional General Managers reported the performance information available was effectively used to hold staff to account in Divisional and service meetings. Divisional Leadership Teams were aware of where their challenges were and had plans in place to mitigate risks and improve performance. Service Line Reporting is available for key services.

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

Is the information used in reporting, performance management and delivering quality care usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses?

All staff we interviewed stated they were confident in the data they receive. Work has been undertaken to promote a common approach to reporting information and progress and the Divisional managers were positive regarding the format of reporting for instance at Performance Review meetings and the Risk Committee.

A Data Quality Framework review was undertaken in 2021 by the Trust's Internal Auditors. A significant assurance rating was awarded to the Trust. Internal Audit concluded that the risk management activities and controls are suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed.

The Trust is currently recruiting a Chief Digital Information Officer who will lead the digital agenda andmanage the Data Quality Team, and this post will report to the Medical Director.

The Trust hosts Nottinghamshire Informatics Service, which is a shared service hosted by the Trust.

The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed. **(Recommendation 13)**

The Trust is currently in the process of moving to a more integrated approach, where data quality is owned and monitored across the wider governance structure. It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework. However this process is not yet fully documented and roles and responsibilities need to be clarified. Internal Audit have also recommended this in their recent report**. (see Recommendation 12)**

It is good practice for Trusts to implement a performance indicator assessment process. A number of Trusts prepare Data Quality Assurance Indicators or Kite Marks to support members' review and assessment of performance indicator information reported in integrated performance reports.

A data quality traffic light or kite mark appears next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based.

At present, the Trust does not have a data quality kitemark system in place although we note this was recommended in its last Well led review. Internal Audit has also made a recent recommendation in this area. The Trust should consider the use of such a system to inform users of any data quality risks attached to the data that might impact decision making. In Appendix 1 we have detailed a simple Data Quality Assurance Indicator system that may be helpful to the Trust. **(Recommendation 14)**

Are information technology systems used effectively to monitor and improve the quality of care?

Since the Covid-19 pandemic began the Trust has significantly transformed its delivery of outpatient care with digital platforms in use to hold virtual appointments with patients where appropriate. Training and enhanced kit has enabled staff to work most effectively in the most appropriate location to continue to deliver services where possible.

Staff told us that systems are in place to allow for clinical validation of patients and that data is monitored appropriately by the Trust. A dashboard is in place to monitor the elective waiting lists and record the dates and outcomes of clinical reviews and risk assessments of patients.

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

Considerable work is being undertaken for priority groups of patients to ensure potential harm is reviewed whilst they await admission or treatment due to the delays resulting from the Covid-19 pandemic. Processes are in place to communicate with patients on the waiting list to inform them of the next steps in their treatment and identify if reprioritisation of patients is required. This is a challenging area nationally, however board members and Divisional Leaders could articulate the processes in place to manage and monitor the patients and the associated risks.

Is data or notifications consistently submitted to external organisations as required?

Internal Audit has undertaken work relating to data systems and some of this has included validation of data for external submission.

The Data Quality Strategy identifies all data submissions made under the requirements of the standard NHS contract. The Trust monitors its schedule for national data submissions and can demonstrate good compliance. We were told there had been no recent omissions. The relevant departments have embedded processes in place to report data externally. Appropriate and effective mechanisms for collection, preparation and sign off of necessary information is in place to support timely delivery to external organisations.

NHS Digital publishes a monthly Data Quality Maturity Index (DQMI), measuring aspects of data quality across a range of national data sets that trusts submit. For the most recently published month, September 2021, the Trust scored an overall value of 88.9% and this is above the current average of 82.1%. The Trust reviews its performance against a significant number of data sets and scored above average in all of its submissions.

Patient information/data protection incidents and breaches are reported to the Information Governance Team. Any breaches rated as serious are subject to a full investigation and the findings are reported to the Information Governance Committee and action is taken. Any breaches are externally reported to the regulatory bodies in line with stated requirements.

Are there robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems?

Internal Audit reviews the Trust's data quality arrangements as part of the Annual Audit Plan. In May 2021 Internal Audit reported on the Trust's data Security and Protection Toolkit self assessment. The auditors reported a high level of confidence in the veracity of the self-assessment. The report contained some low level recommendations for improvement.
The Trust has an Information Governance Policy and this was refreshed in September 2021. The policy is well written, contains good information for staff to understand their responsibilities, from the Chief executives' role, Senior Information Risk owner, Information Asset owners to Line Mangers and all staff. Signposting for internal advice or how to report any Information Governance breaches is also documented as well as links to other related Trust policies e.g. Information Security and national guidance and policy.
The policy was approved at the Information Governance Committee.
The Trust maintains the confidentiality and security of the personal confidential data it processes and integrity and confidentiality is maintained through system access controls.
Annual data security awareness level 1 (formally known as Information Governance) training is mandatory for all new starters as part of the induction process. In addition all existing staff must undertake data security awareness level 1 training on an annual basis.

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

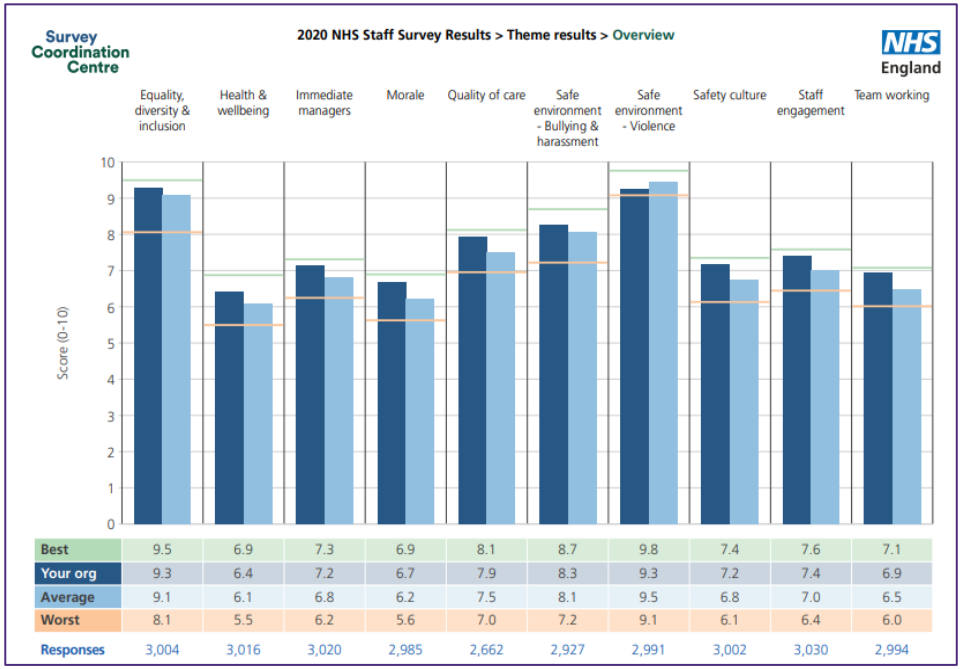
KLOE	GT rating 2022
7	Green

Is a full and diverse range of people's views and concerns encouraged, heard and acted on to shape services and culture?

The National Staff Survey closed at the end of November 2021, with its highest ever response rate to date (66.4%). The results of the survey will be made available in early February and nationally published in March 2022. Learning from the survey will be taken into actions at a Trust, Division and Service Line level.

The NHS staff survey 2020 results were positive for the Trust. 61% of staff responded to the survey and although this was a decrease from the previous year it was significantly above the average response rate of 45%.

The Trust had increased its scores in 7 of the 10 theme areas from the previous year, with the remaining 3 themes scoring the same.

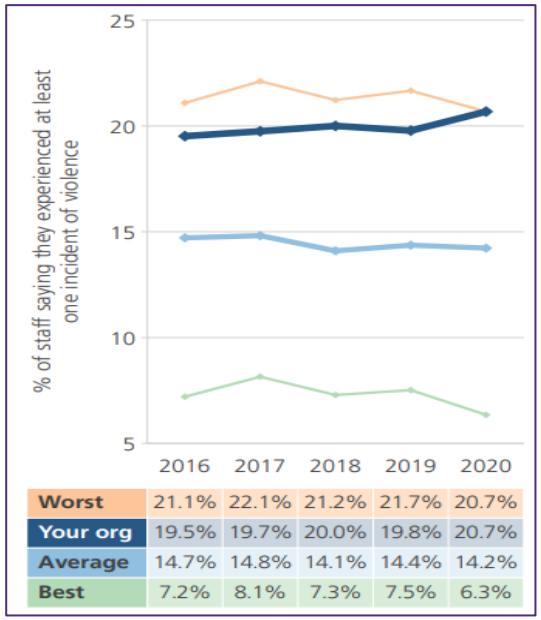


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.3	6.4	7.2	6.7	7.9	8.3	9.3	7.2	7.4	6.9
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	3,004	3,016	3,020	2,985	2,662	2,927	2,991	3,002	3,030	2,994

There is one area where the Trust performs lower than the average and that is in relation to safe environment – violence.

Question 12a

In the last 12 months how many times have you personally experienced physical violence at work from patients/service users their relatives or other members of the public?



	2016	2017	2018	2019	2020
Worst	21.1%	22.1%	21.2%	21.7%	20.7%
Your org	19.5%	19.7%	20.0%	19.8%	20.7%
Average	14.7%	14.8%	14.1%	14.4%	14.2%
Best	7.2%	8.1%	7.3%	7.5%	6.3%

The survey results report that the Trust has the highest occurrence of violence from patients when compared to its peer Trusts.

Results also indicate that where staff had experienced episodes of violence or aggression from patients there is a culture of under reporting. Only 62% of staff stated they had reported the episode against an average of 67.5%. The Trust is actively undertaking work to address this and a programme of work on incivility has commenced and posters are displayed that inform staff about expectations and to obtain support and raise any concerns.

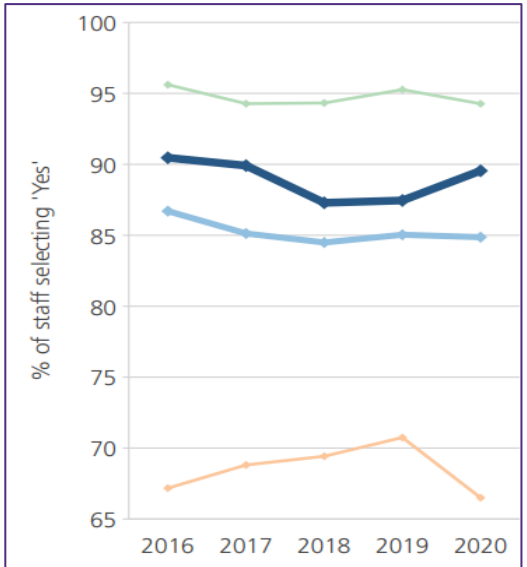
KLOE 7 - Are people who use services, the public staff and external partners engaged and involved to support high quality sustainable services?

Does the service proactively engage and involve all staff (including those with protected equality characteristics) and ensure that the voices of all staff are heard and acted on to shape services and culture.

In order to gain feedback on the direction of travel with the work undertaken to address the results of the staff survey the Trust undertakes Staff Pulse surveys. This allows the Trust to benchmark itself with other local and national trusts. The Staff survey results were positive when staff were asked if all groups were treated fairly with regard to progression in their careers.

Question 14

Does your organisation at fairly with regard to career progression/ promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2016	2017	2018	2019	2020
Best	95.6%	94.3%	94.3%	95.3%	94.3%
Your org	90.5%	89.9%	87.3%	87.5%	89.5%
Average	86.7%	85.1%	84.5%	85.0%	84.9%
Worst	67.2%	68.8%	69.4%	70.7%	66.5%

The Trust has an Equality, Diversity and Inclusion lead. This was a new post that was established in March 2021. Prior to this the HR Business Partner Team managed the agenda.

The EDI reports progress to the People, Culture and Improvement Committee and the Board receive an Annual Report.

The Trust has four staff networks. Each has an Executive Director sponsor and active membership.

The networks that are established are:

- Disability (WAND)
- LGBTQ+
- Ethnic Minority
- Carers network (recently established)

Is the service 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 Board works well with its governors. The Council of Governors consists of elected representatives from three areas, service users/patients, public; staff; and appointed representatives of key local stakeholder organisations. We held a focus group with a group of Governors to gather views on their role. We also attended a Council of Governors' meeting in November 2021.

The Governors have a good understanding of their roles and responsibilities and gave some good examples of their involvement with statutory duties such as appointing the Trust's auditors.

Nominated Governors attend the Board level Committees, and this is working well. It allows the Governors to observe the NEDs in their roles and this contributes to the Council's role in holding the NEDs, individually and collectively, to account for the performance of the Board of Directors.

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

The Trust's Governors are offered regular opportunities to participate in training events. NHS Providers offer places to the Trust for the 'GovernWell' training, which is the national training programme for Foundation Trust Governors to help equip them with the knowledge and skills they need to perform their role effectively. Records of Governor training are maintained.

The Trust's Governors have also attended NHS Providers Governor Focus conferences and this offers the opportunity to explore developments in the health and social care sector, examining issues more directly relevant to the Governor role.

The Governors are clearly passionate about their roles and are keen to engage with the Trust. Relationships are good and this was clearly portrayed at the Council of Governor's meeting we attended where the Board of Directors and Council of Governors interacted in a constructive partnership, seeking to work effectively together.

Governor activities are in place and during the course of this review we observed that Governors were active in seeking feedback from its members and patients/visitors to the Trust, for example undertaking questionnaires in outpatient areas, regular 'Meet your Governor' sessions across all 3 hospital sites and participating in '15 steps' visits to wards and departments. This work has been limited due to the Covid-19 pandemic, however Governors were keen to further increase their involvement once restrictions are lifted. Governors are also active on the Forum for Patient Involvement

Governors represent the interests and views of local people and members, and the Governors stated they have been involved in activities with their constituents to help raise the profile of the Trust and assist with recruitment, retention and engagement of members, of which the Trust has 15,000.

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

KLOE	GT rating 2022
8	Amber/ Red

Is there 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 has a vision for 'Continuous Improvement at SFH' and this is reported at Board with progress on improvement training featuring in the Single Oversight Framework report.

Whilst it is clear that there is considerable improvement activity at the Trust (although some plans have been understandably stalled due to the Covid-19 pandemic), it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked, and this is important for staff to be able to articulate.

Although staff refer to a Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how the continuous improvement work aligns to other strategies e.g. Quality Strategy, and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **(Recommendation 15)**

In some areas such as mortality data and review the Trust could demonstrate significant work to further understand the data and how it performs against the national picture. The continuous work on mortality review is well documented and it is clear that lessons learnt from these reviews are impacting future practice.

The Trust is currently developing a spreadsheet to list the number **and** type of external review/inspections it participates in. This work is almost complete. The Trust has a External Accreditation, Regulation and Quality Assurance Management Policy and this details the process for coordination a, management and learning from the visits.

The policy sets out the process to ensure that all recommendations made following visits are implemented within a specified timescale; that they are monitored following their implementation; and that there is a formal reporting and review process. Reporting routes for assurances are also identified and this is best practice.

The Trust has a Research and Innovation Department and staff support studies that are occurring throughout the Trust's services. Research Champions are in place throughout services and although some non-essential research activities were temporarily paused during 2020/21 due to the Covid-19 pandemic, 13 Covid related research studies commenced.

The Board meeting was recently presented with a summary of research undertaken in critical care.

The Trust communicates its research activities to staff with Research Snapshot, a quarterly research newsletter that updates staff on research activities.

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

Is there knowledge of improvement methods and the skills to use them at all levels of the organisation?

SFH recognise the need to adopt a robust, well-embedded and systematic continuous quality improvement approach to service delivery at all levels of the organisation. The Trust aims to create an embedded culture of continuous improvement underpinned by a safety and just culture model. However this work requires a more coordinated approach and an output to describe the approach taken that can then be described to Trust colleagues. **(see Recommendation 15)**

The Trust is currently ratifying its new Quality Strategy 2022-2025. This has four campaigns on delivering quality care:

1. Create a positive practice environment to support the delivery of safest and most effective care;
2. Excellent patient experience for users and the wider community;
3. Strengthen and sustain a culture of continuous quality improvement and learning; and
4. Deliver high quality care through kindness and supporting each other.

The Advancing Quality Programme has been established to measure, embed and drive quality improvement within the Trust. As part of the programme it will measure the success of the Quality Strategy by reviewing the progress of the actions detailed in the four campaigns.

The Trust is implementing the Quality Service Improvement Redesign (QSIR) training, supported by partners including NHS England and Improvement. Training trajectories were on schedule, however the Covid-19 pandemic had paused training. This recommenced in July 2021 and over 70 colleagues are trained to QI bronze level, and 26 colleagues have undertaken silver level training.

The Nottinghamshire system is adopting the same Quality Improvement approach and system level collaboration is being advanced via an Organisational Development and Quality Improvement Community of Practice. This Community is being sponsored and led by the Trust's Director of Culture and Improvement.

Significant support has been provided at ward level to advance the Pathway to Excellence work as part of the Nursing, Midwifery and AHP agenda.

Does the service makes effective use of internal and external reviews, and is learning shared effectively and used to make improvements?

During the Trust's improvement journey over the last few years it has invited peers and external agencies in to support and review its services. The Trust is keen to learn from others and this has been evident in many aspects of this review. More recently the Trust is engaged with providing peer review and support to other Trusts, for example Nottingham University Hospitals NHS Trust and Shrewsbury and Telford NHS Trust.

The Trust accesses external support as required and had a good example of this during this year where it requested an independent review of a concern that a member of staff had raised. This was a thorough review and there have been elements of learning that have resulted from this process.

The Trust can demonstrate where it has taken action to address and learn from untoward incidents. During Q2 2021/22 the Trust declared a Never Event under the Wrong Site Surgery category. This brings the total number of Never Events under this category to 6 in the last 21 months. It is noted that 2 of these incidents relate to the removal of the wrong tooth. NHSE/I has since removed wrong tooth removal from the Never Event list as currently there are no nationally identified protective barriers to prevent this type of incident from occurring.

The Trust has identified recurring themes and a number of actions are underway as a result from the previous Never Events, e.g. learning events to reinforce positive patient identification processes and formal WHO safer surgery checklist audits for all departments where surgical techniques are undertaken. The Medical Director has also commissioned a piece of work to review the learning from Wrong Site Surgery for dissemination across the Trust's services.

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

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 uses benchmarking data where possible to review its services, and we saw good use of this in performance reports. The Trust works jointly with a number of other providers in some specialties and this is mutually beneficial to take stock of systems and processes used to deliver care.

Due to the Covid-19 pandemic nationally we have observed that teams have not been able to participate in 'time out' and team events in their specialities. However the Divisions reported that the Covid-19 pandemic has increased team working and the way the Divisions interact. There has been significant support amongst colleagues and Divisions stated that everyone had 'pulled together' through these challenging times.

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

As part of the Continuous Improvement Strategy, funding for a 12 month Chief Nurse Fellow post was secured with SFH Charities to advance a standardised approach to providing psychological support for colleagues involved in human-centred critical incidents. Interviews will take place in December.

The Trust holds annual Staff Excellence Awards and this has been held virtually for the past 2 events. The awards celebrates outstanding performance from colleagues and teams across the Trust. It is an opportunity to publicly recognise, reward and thank staff (clinical and non-clinical) who go above and beyond the call of duty.

A significant communication campaign is held to advertise the event and to ensure staff are aware of how to nominate colleagues. Staff in the Divisions we spoke to felt the awards were motivating for staff and teams and helped staff feel valued particularly in the challenging times of the Covid-19 pandemic.

The Trust has been running 'Star of the Month' awards for over five years. This is open to all colleagues and consists of two categories, clinical and non-clinical. Colleagues are nominated by other colleagues for going above and beyond their role and the nomination form asks them to demonstrate which CARE value the individual has demonstrated.

In June 2021 the Trust relaunched this initiative as 'CARE' awards and this now aligns with the Trust's branding. Central communications regarding this went to all staff. CARE awards are judged monthly with a clinical and non-clinical winner chosen by a panel of judges made up of Board Executives; colleague representatives; Staff Side representatives; governors; and the previous month's winners.

Recommendations

Recommendations

This section summarises the 15 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		
HIGH	**MEDIUM**	**LOW**
Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management.	Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management.	Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.

Recommendations - KLOE 1

No.	Risk	Recommendation
KLOE 1 - Is there the leadership capacity and capability to deliver high quality, sustainable care?		
1	Medium	**Internal v external priorities** The Director of Human Resources is a joint post with Nottinghamshire Healthcare NHS Foundation Trust. However, due to the way the portfolio of work is arranged and the existence of a strong deputy this appears to, and is reported to, work well. The Director of HR is also prominent in the Integrated Care System (ICS) leading the people agenda, and this workload needs to be regularly reviewed to ensure it remains manageable. **Recommendation** As external priorities become more apparent in the establishment of the ICS a watching brief should be reviewed to ensure executives continue to have sufficient bandwidth to undertake their portfolio of work.
2	Low	**Succession planning** The Trust had undertaken a formal succession planning exercise for its Executive roles in 2019, and this is best practice. It is important to refresh this periodically and this should be completed following the appointment of the CEO. Some Trusts include the NED skills in this exercise as this can help to identify any gaps and target skill sets of future appointments. **Recommendation** Following the appointment of the Chief Executive post the Trust should refresh its succession planning and consider extending the exercise to include NEDs and Divisional triumvirate team members.
3	Low	**Structured visits programme** The structured quality visits programme where NEDs and Executive Directors undertake more formal visits to the services has been suspended and is planned to be reinstated when the Covid-19 restrictions on access to clinical areas allow. This will be particularly helpful to the new NEDs as they familiarise themselves with the Trust's services. **Recommendation** As soon as Covid 19 restrictions allow the Board should reinstate its structured visits programme to its services. This will be particularly beneficial to the new NEDs and existing NEDs who have missed the opportunities to undertake face to face activities.

Recommendations - KLOE 2

No.	Risk	Recommendation
KLOE 2 - Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
4	Low	**Quality Strategy** A new Quality Strategy is in development. A working draft version was presented at the November 2021 Quality Committee. The new strategy will run from 2022-2025 and has four campaigns on delivering quality care: 1. Create a positive practice environment to support the delivery of safest and most effective care; 2. Excellent patient experience for users and the wider community; 3. Strengthen and sustain a culture of continuous quality improvement and learning; and 4. Deliver high quality care through kindness and supporting each other. It is not clear however how the third campaign links to the improvement techniques and training that are currently been rolled out in the Trust and this should be made more explicit. **Recommendation** The Quality Strategy should more explicitly document the quality improvement methodology that is being rolled out within its campaign to strengthen and sustain a culture of continuous quality improvement and learning.

Recommendations - KLOE 3

No.	Risk	Recommendation
KLOE 3 - Is there a culture of high quality sustainable care?		
5	Low	**Freedom to Speak Up Guardian meetings with Divisions** The Guardian has regular meetings within one Division as these were established by her predecessor, however does not meet regularly with all of the Divisional triumvirates, generally only meeting with them to discuss specific cases. **Recommendation** The FTSU Guardian should schedule regular meetings with the Divisional triumvirate teams to develop relationships and establish a more proactive approach.
6	Low	**Freedom to Speak Up Guardian meetings with the Guardian of Safe Working Hours** Nationally the data suggests medical staff tend not to use FTSU mechanisms to raise concerns and in some trusts we see the Guardian of Safe Working Hours used to raise a broad range of issues. The Trust has successfully recruited a doctor to a FTSU Champion role and this may encourage medical staff to speak up if they have concerns. The Freedom to Speak Up Guardian does not meet with the Guardian of safe Working Hours and this would be a useful link. **Recommendation** The FTSU Guardian should arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles.
7	Low	**Awareness of detriment** It is important to ensure that people do not suffer detriment as a result of speaking up. Currently, following the closure of a case, the FTSU Guardian sends out a short four question email to staff who have raised concerns, however the response rate is low and the questions do not adequately assess if there has been any detriment. **Recommendation** The FTSU Guardian should formalise a process to contact staff who have raised concerns three to six months following closure of the case to discuss how they are and if they have suffered detriment as a result of speaking up.

Recommendations - KLOE 3

No.	Risk	Recommendation
KLOE 3 - Is there a culture of high quality sustainable care? (continued)		
8	Low	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation** The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.

Recommendations - KLOE 4

No.	Risk	Recommendation
KLOE 4 - Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
9	Low	**Highlight reports to the Board of Directors** There is variance in the quality of reporting the work of the Committees to the Board. A more common approach using quadrant style reporting could more effectively identify key issues and action taken. **Recommendation** Committee Chairs should consider the use of a quadrant style report to present at the Board meeting. Headings of the 4 quadrants are commonly: ▪ Matters of concern or key risks to escalate; ▪ Major actions commissioned / work underway; ▪ Positive assurances to provide; and ▪ Decisions made.
10	Low	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.
11	Low	**People, Culture and Improvement Committee** The Chair of the Committee does not routinely meet with the Lead Executive for this Committee, more ad-hoc arrangements occur. Setting up a scheduled arrangement would be beneficial to allow for regular discussion of progress, current issues and the identification of areas where further work may be indicated. **Recommendation** The Chair of the People, Culture and Improvement Development Committee should set up regular meetings with the lead Executive Director.

Recommendations - KLOE 5

No.	Risk	Recommendation
KLOE 5 - Are there clear and effective processes for managing risks, issues and performance?		
12	Low	**Divisional Performance Reviews** We attended the November 2021 round of Performance Reviews for all five clinical Divisions. The Performance Review meetings are well organised and mutually supportive. We note that Urgent and Emergency Care Division presented an informative HR performance report, and whilst other Divisions talked about their HR issues they did not include a presentation of metrics. HR performance reports are routinely created and supplied to Divisions via the HR Business Partners, and these should be presented at each Divisional Performance Review. **Recommendation** All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.

Recommendations - KLOE 6

No.	Risk	Recommendation
KLOE 6 - Is appropriate and accurate information being effectively processed, challenged and acted on?		
13	Medium	**Data Quality Strategy** The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. The Trust is currently in the process of moving to a more integrated approach, where data quality is owned and monitored across the wider governance structure. It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework, but this process is not yet fully documented and roles and responsibilities need to be clarified. Internal It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed. **Recommendation** Once in post the new Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.
14	Low	**Data Quality Assurance Indicators** The Trust does not at present utilise a Data Quality Assurance Indicator. A data quality traffic light or kite mark could be used to appear next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based. **Recommendation** The Trust should consider the use of Data Quality Assurance Indicators to inform users of any data quality risks attached to the data that might impact decision making.

Recommendations - KLOE 7

No.	Risk	Recommendation
KLOE 7 - Are people who use services, the public staff and external partners engaged and involved to support high quality sustainable services?		
We have not made recommendation in this area as the Trust is already working on issues identified.		

Recommendations - KLOE 8

No.	Risk	Recommendation
KLOE 8 - Are there robust systems and processes for learning continuous improvement and innovation?		
15	**Medium**	**Continuous Improvement** The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation 15** Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.

Appendices

Appendix 1
Data Quality Assurance Indicators

Data Quality Assurance Indicators

It is good practice for Trusts to implement a performance indicator assessment process. A number of Trusts prepare Data Quality Assurance Indicators or Kite Marks to support members' review and assessment of performance indicator information reported in integrated performance reports.

A data quality traffic light or kite mark appears next to key performance indicators in the dashboard to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based.

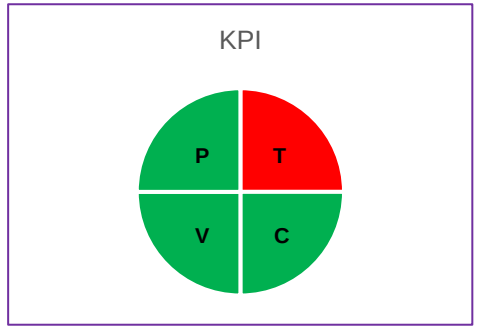
We have seen many different approaches to doing this but a simple and effective example is detailed below. Some Trusts use more complex measures with red/amber/green ratings and numerical scores and we have examples of these. However the example below is a method that works well for a number of good performing NHS Trusts we work with.

The kite-mark is presented as a coloured pie chart and sectors are:

- rated green for sufficient assurance; or
- red for insufficient assurance.

The assessment focuses on the following four domains;

- Timeliness (T);
- Completeness (C);
- Validity (V);
- Process (P).



Overleaf we detail the definition of the four **domains** and descriptors of the **red** and **green** ratings.

Data Quality Assurance Indicators

Domain	Definition	Sufficient for assurance	Insufficient for assurance
Timeliness (right upper quadrant)	This is the time taken between the end of the data and when the information can be produced and reviewed.	Where data is available daily for any an indicator, up to date data can be produced, reviewed and reported upon the next day. Where data is only available monthly, up to date data can be produced, reviewed and reported upon within one month. Where the data is any available quarterly, up to date data can be produced, reviewed and reported upon within three months.	Where data is available daily for an indicator, there is a data lag of more than one day. Where data is only available monthly, there is a data lack of more than one month. Where data is only available quarterly, there is a data lag of more than one quarter.
Completeness (right lower quadrant)	The extent to which all the expected attributes of the data are populated but also the extent to which all the records from the relevant population are provided.	Fewer than 3% blank or invalid fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements.	More than 3% blank or invalid fields in expected data set
Validation (left lower quadrant)	This is the extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements.	The Trust has agreed upon procedures in place for the validation of data for the KPI. A sufficient amount of the data, proportionate to the risk, has been validated to ensure data is: ▪ Accurate; and ▪ In compliance with relevant rules and definitions for the KPI.	Either: ▪ No validation has taken place; or ▪ An insufficient amount of data has been validated as determined by the KPI owner; or ▪ Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions.
Process (left upper quadrant)	This is the extent to which a process has been documented to support consistency and understanding of data capture requirements for all relevant staff	There is a documented process to detail the following core information: ▪ The numerator and denominator of the indicator. ▪ The process for data capture. ▪ The process for validation and data cleansing. ▪ Performance monitoring.	Either: ▪ There is no documented process; or ▪ The process is fragmented / inconsistent across the services

Appendix 2
Staff Interviewed

Staff Interviewed

- Claire Ward - Chair
- Paul Robinson - Chief Executive Officer
- David Selwyn - Medical Director
- Simon Barton - Chief Operating Officer
- Julie Hogg - Chief Nurse
- Richard Mills - Interim Chief Financial Officer
- Clare Teeney - Director of People (HR)
- Shirley Higginbotham - Director of Corporate Affairs
- Emma Challans – Director of Culture and Improvement
- Neal Gossage - Non-Executive Director Chair of Finance Committee
- Graham Ward - Non-Executive Director Chair of Audit and Assurance Committee
- Barbara Brady - Non-Executive Director Chair of Quality Committee
- Manjeet Gill - Non-Executive Director Chair of People, Culture and Improvement Committee
- Steve Banks - Non-Executive Director
- Ally Rashid - Non-Executive Director
- Andy Haynes - Specialist Non-Executive Advisor to the Board
- Marcus Duffield - Head of Communication
- Kerry Bosworth - Freedom to Speak Up Guardian
- Martin Cooper - Guardian of safe Working Hours
- Alison Pearson - Equality, Inclusion and Diversity Lead
- Medicine Division Triumvirate Management Team
- Urgent and Emergency Care Division Triumvirate Management Team
- Surgery Division Triumvirate Management Team
- Diagnostics and Outpatient Division Triumvirate Management Team
- Women’s and Children’s Division Triumvirate Management Team
- Governor’s focus group, including Lead Governor
- David Ainsworth - Locality Director – Nottinghamshire and Nottingham CCG
- Rosa Waddingham - Chief Nurse - Nottinghamshire and Nottingham CCG
- Richard Walton - External Auditor, KPMG
- Claire Page - Internal Auditor, 360 Assurance

Appendix 3
Meetings Observed

Meetings Observed

- Public Board meeting
- Private Board meeting
- Audit and Assurance Committee
- Finance Committee
- Quality Committee
- People, Culture and Improvement Committee
- Risk Committee
- Council of Governors meeting
- Executive Team meeting
- Trust Management Team Meeting
- Council of Governors
- Divisional Performance Review - Medicine Division
- Divisional Performance Reviews - Urgent and Emergency Care Division
- Divisional Performance Review - Surgery Division
- Divisional Performance Reviews - Diagnostics and Outpatient Division
- Divisional Performance Reviews - Women’s and Children’s Division

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