Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	External Well-led Review - Recommendations	**Date: 7th April 2022**	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Claire Ward, Chair		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
The purpose of this paper is for the Board to receive assurance regarding the recommendations identified in the final report from the Grant Thornton Well Led Review		**Approval**	
		Assurance	**x**
		Update	
		Consider	

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

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	A Well-led organisation helps mitigate the risk of financial loss
Patient Impact	A Well-led organisation supports high quality patient care
Staff Impact	A Well-led organisation encourages a motivated workforce
Services	A Well led organisation works effectively with stakeholders to deliver optimal services
Reputational	A Well-led organisation enhances the reputation of the Trust

Committees/groups where this item has been presented before

Executive Team meeting 30th March 2022

Executive Summary

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

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

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

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

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

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

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

The attached report details each of the recommendations, the actions being taken, the executive lead and the timeline for completion.

Risk rating for recommendations raised		
HIGH 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.	**MEDIUM** 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.	**LOW** 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.

No.	Risk	Recommendation	Action	Lead	Timeline
KLOE 1. – Is there the leadership capacity and capability to deliver high quality, sustainable care?					
1	**Medium**	**Internal v external priorities** The Director of Human Resources is a joint post with Nottinghamshire Healthcare NHS Foundation Trust. However, due to the way the portfolio of work is arranged and the existence of a strong deputy this appears to and is reported to work well. The Director of HR is also prominent in the Integrated Care System (ICS) leading the people agenda and this workload needs to be regularly reviewed to ensure it remains manageable. **Recommendation:**	All joint posts with Nottinghamshire Healthcare will cease in Quarter 1 of 2022/23.	Chief Executive Officer	June 2022

		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	A report will be presented to the Nomination and Remuneration Committee	Chief Executive Officer	September 2022
3	**Low**	**Structured visits programme** The structured quality visit programme where NEDs and Executive Directors undertake more formal visits to the services has been suspended and is planned to be reinstated when the Covid -19 restrictions on access to clinical areas allow. This will be particularly	Visits will commence in line with Government guidance	Chief Nurse	TBC

		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			
KLOE 2 – is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?					
4	**Low**	**Quality Strategy** A new Quality Strategy is in development. A working draft version was presented at the November 2021 Quality Committee. The new strategy will run from 2022-2025 and has four campaigns on delivery quality care: 1. Create a positive practice environment to support the delivery of safest and most effective care 2. Excellent patient experience for users and the wider community 3. Strengthen and sustain a culture of continuous quality improvement and learning 4. Deliver high quality care through kindness and supporting each other It is not clear however how the third campaign links to the improvement techniques and	The Quality Strategy will detail the quality improvement methodology embedded throughout the Trust	Chief Nurse	September 2022

		training that are currently being 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.			
KLOE 3 – Is there a culture of high quality sustainable care?					
5.	**Low**	**Freedom to Speak up Guardian meetings with Divisions** The Guardian has regular meetings within one Division as these were established by her predecessor however does not regularly meet with all of the Divisional triumvirates, generally only meeting with them to discuss specific cases. **Recommendation:** The FTSU Guardian should schedule regular meetings with the Divisional triumvirate teams to develop relationships and establish a more proactive approach	Regular meetings with all triumvirates will be scheduled	Director of Corporate Affairs	June 2022
6.	**Low**	**Freedom to Speak U Guardian meetings with the Guardian of Safe Working Hours** Nationally the data suggests medical staff	Regular meetings with the Guardian of Safe Working Hours will be scheduled	Director of Corporate Affairs	June 2022

		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 FTSU Guardian does not meet with the Guardian of Safe Working Hours and this would be a useful link. **Recommendation:** The FTSU Guarding should arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles.			
7.	**Low**	**Awareness of detriment** It is important to ensure that people do not suffer detriment as a result of speaking up. Currently, following the closure of a case, the FTSU Guardian sends out a short four question email to staff who have raised concerns, however the response rate is low and the questions do not adequately assess if there has been any detriment. **Recommendation:** The FTSU Guardian should formalise a process to contact staff who have raised concerns three to six months following closure of the case to discuss how they are and if they	A formal process to contact staff who have raised concerns to ascertain if they have suffered detriment will be developed and implemented	Director of Corporate Affairs	June 2022

		have suffered detriment as a result of speaking up			
8.	**Low**	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and the 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.	Future reports to Board from the FTSU guardian and Guardian of Safe Working Hours will include data by gender and ethnicity	Director of Corporate Affairs and Executive Medical Director	September 2022
KLOE 4 – Are there clear responsibilities, roles and systems of accountability to support good governance and management?					
9.	**Low**	**Highlight report to the Board of Directors** There is variance in the quality of reporting the work of the Committees to the Board. A more common approach using a quadrant style 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	A quadrant template has been developed and will be implemented from April Committees	Director of Corporate Affairs	June 2022

		meeting. Headings of the 4 quadrants are commonly: • Matters of concern or key risks to escalate • Major actions commissioned / work underway • Positive assurances to provide • Decisions made			
10.	**Low**	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation:** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.	A schedule to ensure all chairs of committees observe the key meetings which feed into their committees will be developed and implemented	Director of Corporate Affairs	September 2022
11.	**Low**	**People, Culture and Improvement Committee** The Chair of the Committee does not routinely meet with the Lead Executive for this Committee, more ad-hoc arrangements occur. Setting up a scheduled arrangement would be beneficial to allow for regular discussion of progress, current issues and the identification of areas where further work my b indicated	A schedule of regular meetings prior to committee meeting will be developed and implemented	Director of People and Director of Culture and Improvement	June 2022

		Recommendation: The Chair of the People, Culture and Improvement Committee should set up regular meetings with the lead Executive Directors			
KLOE 5. – Are there clear and effective processes for managing risks, issues and performance?					
12.	**Low**	**Divisional Performance Reviews** We attended the November 2021 round of Performance Reviews for all five clinical Divisions. The Performance Review meetings are well organised and mutually supportive. We note that Urgent and Emergency Care Division presented an informative HR performance report and whilst other Divisions talk about their HR issues, they did not include a presentation of metrics. HR performance reports are routinely created and supplied to Divisions via the HR Business Partner, and these should be presented at each Division Performance Review. **Recommendation:** All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.	All future Divisional Performance Reviews will include the presentation of their HR Performance report	Chief Operating Officer	June 2022
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. 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 :**	The Chief Digital Information Officer will refresh the Data Quality Strategy, once in post.	Executive Medical Director	December 2022

		Once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.			
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.	The Trust has previously considered the use of Data Quality Assurance Indicators and agreed not to utilise. However, this recommendation will be further considered and an update provided to the Board of Directors	Director of Corporate Affairs	September 2022
KLOE 7. – Are people who use services, the public, staff and external partner engaged and involved to support high quality sustainable services?					
We have not made any recommendations in this area as the Trust is already working on issues identified.					
KLOE 8. – Are there robust systems and processes for learning, continuous improvement and innovation?					
15.	**Medium**	**Continuous Improvement**			

		The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation:** Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth	The QI Maturity Matrix survey results will be shared with SLT in June, this will provide a new focus for QI. Regular QI development sessions with all Senior Leaders are scheduled over 2022/2023 The Quality Strategy will be aligned with the quality improvement methodology embedded throughout the Trust	Director of Culture and Improvement	September 2022

		of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.			