NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	External Well-Led Review – Recommendations, Progress Report			**Date:** 3rd August 2023	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs				
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs				
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs				
Purpose					
The purpose of this paper is for the Board to receive assurance about progress towards meeting the recommendations identified in the final report from the Grant Thornton Well Led Review conducted in March 2022				**Approval**	
				Assurance	X
				Update	
				Consider	
Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X		X	X		
Principal Risk					
PR1	Significant deterioration in standards of safety and care				X
PR2	Demand that overwhelms capacity				X
PR3	Critical shortage of workforce capacity and capability				X
PR4	Failure to achieve the Trust's financial strategy				X
PR5	Inability to initiate and implement evidence-based Improvement and innovation				X
PR6	Working more closely with local health and care partners does not fully deliver the required benefits				X
PR7	Major disruptive incident				X
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change				x
Committees/groups where this item has been presented before					
Executive Team					
Acronyms					

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 of any material governance concerns that have arisen from the review and the action plan in response to those concerns, but more importantly because it provides the opportunity for the Trust to fully understand the strengths and weaknesses of its current governance arrangements and implement actions at an appropriate pace.

The initial report detailing the 15 recommendations was presented to Board in April 2022 with further updates in August 2022 and February 2023.

This report provides progress against those recommendations, noting 13 are complete (an increase of two since the last report) and two remain outstanding (Actions 13 and 15). A progress report on each is provided below with both, requiring discussion and agreement by the Board.

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public

Subject: External Well-led Review – Recommendations, Progress Report
Date: 27th July 2023
Author: Sally Brook Shanahan, Director of Corporate Affairs

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

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

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

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

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

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

This report provides progress against those recommendations, noting 13 are complete and two remain outstanding. Progress reports are provided for the two which remain outstanding (Recommendations 13 and 15):

Recommendation 13: **Data Quality Strategy**

The recommendation noted 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.

The Review recommended that 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.

Progress update July 2023:

The Patient Information and Data Assurance Group (PIDAG) is in place. The Chief Digital Information Officer is chairing. That enables the detailed work that is necessary in the field of data quality. Bringing the various teams together under the digital structure is also enabling closer working and a focus on data standards, quality, and completeness. All developments or configuration changes will be reviewed by PIDAG. The appointment of a Head of Information Services will provide professional oversight to this area going forward.

Recommendation 15: **Continuous Improvement**

The recommendation noted 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.

The Review recommended 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.

Progress update July 2023:

The Q1 (2023/24) ambition was to deliver a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and/or transformation. The Improvement Faculty launched as planned on 4th May 2023 and has brought together a number of existing teams, including the Improvement Team, Transformation Team and PMO to create a centre of excellence.
The Faculty's work plan is based on the following four pillars:
a. Pillar 1 - Improving Capability, Engagement and Culture – Building 'The Sherwood Way'
b. Pillar 2 - Evaluating New Ideas and Providing Solutions
c. Pillar 3 - Programme and Project Delivery
d. Pillar 4 - Programme Monitoring, Evaluation and Assurance
There are several large-scale transformation programmes for which the Faculty are providing coordinated support (Pillar 3). These include the Optimising Patient Journey (OPJ) Programme, Planned Care Programme (including Theatres, Outpatients and Diagnostics), a series of Workforce Programmes, several Capital Programmes and a number of Financial Improvement Programmes.

All large-scale transformation programmes have robust governance arrangements in place, have completed PIDs and identified senior leadership in place.

The remaining pillars are under development and will continue to be shaped and delivered during Q2 including strengthening the organisation's vision for improvement and developing in line with NHS Impact (national improvement direction) across ICS partners.

Development of the Improvement and Innovation strategy, as an enabler to the Trust strategy, will fully implement and embed the recommendation.

Recommendation

The Board is asked to note the progress updates about Recommendations 13 and 15 and that further assurance is required before their closure.   This will be provided in the next update due in February 2024.

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

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

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

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

		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 have suffered detriment as a result of speaking up	A formal process to contact staff who have raised concerns to ascertain if they have suffered detriment has been developed and implemented **Complete**	Director of Corporate Affairs	**Complete**	June 2022

8.	**Low**	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation:** The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.	**Progress update July 2023**: At its meeting on 2nd February 2023 the Board of Directors agreed this recommendation could be closed, and requested a review take place in 6 months' time to ensure the data is monitored. A report will be brought to the October 2023 Board.	Director of Corporate Affairs and Executive Medical Director	**Complete**	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	A quadrant template has been developed and has been implemented from April Committees. **Complete**	Director of Corporate Affairs	**Complete**	June 2022

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

		be beneficial to allow for regular discussion of progress, current issues and the identification of areas where further work my b indicated **Recommendation:** The Chair of the People, Culture and Improvement Committee should set up regular meetings with the lead Executive Directors				
	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 future Divisional Performance Reviews will include the presentation of their HR Performance report. All divisions now have an HR report which they present monthly within their DPRs **Complete**	Chief Operating Officer	**Complete**	June 2022

		All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.				
	KLOE 6 – Is appropriate and accurate information being effectively processed, challenged and acted on					
13.	**Medium**	**Data Quality Strategy** The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However, the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore, the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. The Trust is currently in the process of moving to a more integrated approach, where data quality is 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	**Progress update July 2023:** The Patient Information and Data Assurance Group (PIDAG) is in place. The Chief Digital Information Officer is chairing. That enables the detailed work that is necessary in the field of data quality. Bringing the various teams together under the digital structure is also enabling closer working and a focus on data standards, quality, and completeness. All developments or configuration changes will be reviewed by PIDAG. The appointment of a Head of Information Services will provide professional oversight to this area going forward.	Executive Medical Director		December 2022

		responsibilities need to be clarified. It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed. **Recommendation :** Once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.				
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:**	**Progress update July 2023:** We recognise the importance of providing assurance on the quality of data and highlighting potential risks. Identifying appropriate kite marks would involve a full review of each key performance indicator with engagement from operational and clinical colleagues, focusing on the four domains:	Director of Corporate Affairs	**On-Going**	On-Going

		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.	timeliness, completeness, validity, process. Once set up there would be an ongoing requirement to review regularly to ensure any changes in data quality and risks are reflected.			
	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	**Progress update July 2023** The Q1 (2023/24) ambition was to deliver a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and/or transformation. The Improvement Faculty launched as planned on 4th May 2023 and has brought together a number of existing teams, including the Improvement Team, Transformation Team and PMO to create a centre of excellence.	Director of Strategy and Partnerships	**On-Going**	September 2022

		not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation:** Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.	The Faculty's work plan is based on the following four pillars: a. Pillar 1 - Improving Capability, Engagement and Culture – Building 'The Sherwood Way' b. Pillar 2 - Evaluating New Ideas and Providing Solutions c. Pillar 3 - Programme and Project Delivery d. Pillar 4 - Programme Monitoring, Evaluation and Assurance There are several large-scale transformation programmes for which the Faculty are providing coordinated support (Pillar 3). These include the Optimising Patient Journey (OPJ) Programme, Planned Care Programme (including Theatres, Outpatients and Diagnostics), a series of Workforce Programmes, several Capital Programmes and a number of Financial Improvement Programmes. All large-scale transformation			

			programmes have robust governance arrangements in place, have completed PIDs and identified senior leadership in place. The remaining pillars are under development and will continue to be shaped and delivered during Q2 including strengthening the organisation's vision for improvement and developing in line with NHS Impact (national improvement direction) across ICS partners. Development of the Improvement and Innovation strategy, as an enabler to the Trust strategy, will fully implement and embed the recommendation.			