Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Well – Led Review, Progress Report	**Date:** 4th July 2019	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	John MacDonald, Chair , Richard Mitchell, CEO		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
The purpose this paper is for the Board to receive assurance from the progress made with regard to the recommendations identified in the final report from the KPMG 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	
Indicate the risks or issues created or mitigated through the report	
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

N/A

Executive Summary

KPMG undertook an external well-led review of the organisation, as required by NHSI, these should be undertaken every 3 years, the final report including recommendations was presented to Board in December 2018.

The following report details the progress against the twenty recommendations: 10 rated as Medium priority and 10 rated as Low priority.

The attached report details the actions taken against each recommendation, 15 are now completed, 3 are in progress and 2 are an on-going process.

Board are asked to consider and be assured by the progress identified

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

No.	Priority	Recommendation	Actions taken	Status
KLOE 1:Isthere the leadership capacity and capability to deliver high quality, sustainable care?				
1	❷	**Board skills assessment** Although the Board has time-out away days and development sessions a formal skills assessment has not been undertaken since 2014. As all Board positions are recruited to and substantive it would be a good time to undertake this. The findings of the assessment should be used to inform any subsequent Board development sessions.	The skills of board members are reviewed whenever there is a vacancy both for Non-Executive and Executive members. Evidence of this is provided through the recruitment of a NED with a clinical background and a NED with specific OD and change management background. All members of the board receive an annual appraisal which considers any development, career progression requirements. All members of the Executive have recently undertaken a Myers Briggs personality type assessment to review how the team can work together more effectively by considering individual strengths and weaknesses	**On-going process**
2	❷	**Allocation of management time to Clinical Directors** Each Clinical Chair has four programmed activity (PAs) sessions allocated to them in order to undertake the role. Some Clinical Chairs have maintained their on-call rota responsibilities and this has impacted on their capacity to undertake all aspects of the roles in the time allocated. Clinical Chairs do not have an appointed deputy, usually the Divisional General Manager and Head of Nursing/Midwifery deputise in their absence. The Trust should undertake a post implementation review of the Clinical Chair role to establish the capacity of the post holders.	Job plans have been reviewed for the Clinical Chairs to ensure they have enough time and support to carry out the role. They have all had a management appraisal in recent months being clear on the objectives for the coming year in the Clinical Chair role, including what development is required, along with what managerial support is required to enable them to achieve. A formal review hasn't taken place of capacity at this stage.	**On-going process**
3	❸	**Divisional Triumvirate team development** A number of leadership development programmes are in	All Divisional triumvirates have been through the Trusts senior leadership programme. Individual Divisional General Managers have all been appraised	**Completed**

		place. However, some staff we interviewed stated the Divisional Triumvirate teams would benefit from a targeted team development programme and this should be considered.	and have individual Personal Development Plans to support their leadership development where required. Many of them are on, or have completed recently NHS leadership academy programme such as EGA and Nye Bevan. Heads of the Nursing who do not have a Masters are currently undertaking an MSC programme on leadership at Derby University.	
4	❸	**Succession planning** The Chief Executive has undertaken work regarding succession planning, focussed on post holders that may retire within the next two years. Some Trusts we have worked with have addressed succession plans in a detailed way, assessing each Executive Director with contingency plans in the event of an immediate absence, plans if given 3-6 months notice and plans for scheduled retirement	Non-Executive Directors are appointed and re-appointed in line with the Constitution. The CEO has undertaken the work regarding succession planning for the Executives	**Completed**
5	❸	**Trust's strategy** In our Board survey only 50% of respondents agreed that the strategy included a clear vision for the Trust, and underpinning values and priorities. This may be because the strategy is currently being consulted upon and therefore not finalised. However this should be discussed to ensure the strategy is explicit and easily understood.	The Trusts strategy was launched in April, supported by a 1 page brief document highlighting the strategic objectives and how these would be implemented at a high level. An easy read version was also developed and published	**Completed**
KLOE 3: Is there a culture of high quality sustainable care?				
6	❷	**Freedom to Speak Up Guardian** The Trust recognises that it needs to reassess its arrangements for its Freedom to Speak Up Guardian. It currently has four Guardians and one supporting 'champion' and reporting lines are formally through Human Resources. We have discussed the appropriateness of this with the Trust and a change has recently been made and the role now reports to the Director of Corporate Affairs. Common practice would be to have one FTSU Guardian supported throughout the Trust's services by a number of 'champions' or 'listeners'. These should be of varying levels and disciplines to ensure staff feel they are accessible by locality and grade.	A dedicated Speaking up Guardian is now in post, 2 days per week. The role of the champions is in development, a number of staff have already expressed an interest, and this will be implemented from September, supported by training to ensure the champions are clear on the responsibilities of their role. Effectiveness of the role and the process will be reviewed after 12 months	**Completed**
7	❸	**Audit of the quality of appraisals** A new appraisal system was launched in April 2017and this includes talent conversations. Appraisal rates are high with compliance meeting the Trust's target. The Trust provides training for appraisers and appraisees but a trust-wide process in is not in place to review or audit the quality of completed appraisals, and this should be undertaken on a regular basis.	The Trust is developing a new Toolbox Talk for all staff to prepare them to get the best out of their own appraisals to ensure it is a meaningful experience. The 19/20 Maximising our Potential action plan contains a specific action to undertake an audit of appraisals to ensure t they are a quality experience for staff and this is due to be completed by the end of Q3. As part of the 2019/20 annual audit cycle 360* will conduct a formal audit of appraisals.	**In Progress**

8	❸	**Workforce Race Equality Standard data** The Trust considers its Workforce Race Equality Standard data at its Organisational Development and Workforce Committee. This is not however a sub-committee of the Board. The Board is aware that further work is required on its position in relation to its number of staff from a BME background. Currently less than 9% of staff are from a BME background and are underrepresented in senior AfC pay bands. The Trust is progressing further work with regard to this and progress should be reported through a sub-committee of the Board or to Board	Since April 2019 the Trust has formally introduced a committee of the Board (People Culture and OD Committee) WRES details to be presented at July meeting. BAME board representation has improved and in line with local demographics. Overall The number of BAME staff has increased slightly including numbers in senior pay. A local leadership course for BAME staff is being developed with local Trusts to commence Autumn 2019. A WRES action plan for 2019/2020 has been developed and is being taken forward. The BAME staff support network continues to develop with members visiting local Trusts with well-established networks. The Trust now has a dedicated forum to focus on workforce diversity and inclusivity agenda including a revision of its Terms of Reference and extending the core membership.	**Completed**
KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?				
9	❷	**Workforce Committee** The Trust does not have a workforce sub-committee of the Board, and there was considerable debate at the Board meeting with regard to workforce issues. This, is part, was due to a number of papers that were scheduled to report at Board for that meeting. However the challenge and questions from the NEDs was significant and this is perhaps due to the fact that none of the NEDs had been in forums to debate the detail of these reports. At a time where the workforce agenda is significant in terms of recruitment and organisation development, the Trust's Chairman and Chief Executive should consider reinstating the Workforce Committee as a sub committee of the Board.	A People, OD and Culture Committee has been established, as a committee of the board, the committee is chaired by a Non-Executive Director.	**Completed**
10	❸	**Timetabling of Committees** Whilst the timetabling of Committees was well organised, there may be scope to ensure timetabling allows all Board sub-committees time to input their 'highlight' report to Board. For example the Finance Committee had to report verbally to the October 2018 Board meeting due to the Committee being held earlier that week.	The meetings of the Board have been re-scheduled to the first Thursday of each month to allow more time for reports from board committees	**Completed**
11	❷	**Frequency of the Quality Committee** The Quality Committee meets bi-monthly. This is a well chaired and important Committee for the Trust to gain assurance over its patient safety and quality agenda. We were informed that there is some discussion with regard to changing the frequency of this Committee to quarterly. The Trust has undertaken considerable improvement work across its services from being placed in special measures in 2013, and has recently improved its CQC rating from	The Quality committee is scheduled to meet a minimum of 6 times per year, this is reviewed during the year aligned with the workplan. If additional meetings are required, they are scheduled**.**	**Completed**

		'Inadequate' in 2015 to 'Good' in 2018. We would recommend that the Trust maintains the bi-monthly frequency of its Quality Committee with a view to reviewing this once the new Committee Chair has been in post 12 months.		
12	❷	**Attendance at Divisional Performance Review meetings** The Trust holds monthly Divisional Performance Review meetings and these forums drill down on key performance issues. Meetings are chaired by the Chief Operating Officer and attended by many of the Executives. The Director of Nursing, Medical Director, Director of Human Resources and Finance Director are all invited, although on occasions they are unable to attend or send representation and this is an area for improvement	All Executives have attended Divisional Performance Reviews in the past 6 months and where not able to attend, deputies have attended.	**Completed**
KLOE 5: Are there clear and effective processes for managing risks, issues and performance?				
13	❷	**Board level discussion on performance** In our discussions with the Executive team and from our observation of the Board we have noted that a significant portion of Board time is spent discussing performance issues. Elsewhere Trusts consider performance issues within a Finance and Performance Committee to allow Non-Executive Directors to challenge issues in that forum rather than the Board. We recommend that the Trust move to this structure to allow regular performance scrutiny to take place at the Committee level rather than at full Trust Board.	The Board have reviewed this recommendation and concluded the performance of the Trust is so significant it needs to be discussed and scrutinised in detail at Board and should not be delegated to a committee of the Board . The formatting of the SOF Integrated performance report has been redefined and the monthly and quarterly reports are to provide a different focus, the monthly report a brief overview of performance focusing on where the trust is off of trajectory. The Quarterly reports providing more insight and triangulation of the issues, causes and mitigations.	**Completed**
14	❸	**Chairing responsibilities of Divisional Performance Review meetings** The Trust's Divisional Performance Review meetings are currently chaired by the Chief Operating Officer. Whilst the current process works well our experience elsewhere tells us that similar meetings at other Trusts are frequently not chaired by the COO in order to enable the meetings to be led outside of the operational team. We recommend that the Trust reviews who chairs these meetings to see if another approach may maintain the effectiveness of the process.	After review, It is still felt that it most appropriate that the Divisional Performance Reviews are chaired by the Chief Operating Officer as the leader of the Divisions, but there is equal participation by all Executive in the conversation.	**Completed**
15	❸	**Outcomes of Clinical Audit** The Trust develops an annual Clinical Audit Programme, which takes into account key national priorities; Trust priorities for quality improvement; and service priorities.	The Clinical Audit and Effectiveness function of the Trust has developed over the past three years, reporting progress on compliance and implementation through the Trust Executive-led Patient Safety Quality Group. It has primarily focussed on ensuring robust systems and processes are in place at service	**In progress**

		Progress against the annual plan is monitored by the Clinical Audit and Effectiveness Group, with regular updates reported to the Patient Safety and Quality Group with relevant updates then provided to the Trust Board. As at October 2018 93% of audits were reported as on track, discontinued or complete however the report does not consider the tangible benefits and outcomes accruing to the Trust from the clinical audits undertaken.	and divisional level to identify and progress national, regional and local guidance and audits. A key focus for 2019/20 will be evaluating the consequent impact on patient care and outcomes. To further support this the Clinical Audit and Effectiveness team have been realigned to the Trust Service Improvement team from 01/07/19 with a view to identifying and implementing quality improvement initiatives that will be monitored through the Trust Advancing quality Programme as part of the 2018/21 Quality Strategy.	
16	❸	**Data Quality Kitemark** The Trust has prepared a Data Quality Improvement Plan which seeks to improve overall data quality at the Trust by considering the following areas: •policies and procedures; •governance and leadership; •systems and processes; and; •people and skills This plan has clear ownership for each action, a timeline for achievement and a RAG rating to confirm progress. This is considered by the DQOG on a regular basis with updates provided to the Risk and Audit Committees. One area of future focus within this plan is potential Kitemarks for the SOF and other information reported to the Board we recommend that the Trust introduce these and have included examples of those used at other Trusts in Appendix 3 on page 63	The Board have reviewed this recommendation and concluded that a Data Quality Kitemark would not provide further assurance currently. This may be reviewed as the Trust moves forward with its data quality strategy.	**Completed**
KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?				
17	❸	**Exit interviews for leavers** The Trust undertakes exit interviews for those staff who chose to leave the organisation. In our Board level survey some members stated they were unaware of any themed analysis in this area, and it may be beneficial to report this information more widely. As previously stated in this report the Trust does not currently have a Workforce sub-committee of the Board. If this is established then items such as thematic analysis of exit interviews and progress with plans to address any outcomes could be considered at that Committee.	The Trust formally introduced a committee of the Board (People Culture and OD Committee), April 2019. Part of the annual work cycle are the Quarterly Culture reports which includes the themes and feedback from exit interviews.. Across 2018/19 thematic analysis of exit interviews have been provided on a quarterly basis to Trust board.	**Completed**

18	❷	**Council of Governors –training and development** The Trust has introduced initiatives that are considered best practice. For example, the Board has invited two members from the CoG to observe the Board sub-committees. This adds to their experience and assists in their role of holding the Non-Executive Directors individually and collectively accountable for the performance of the Board of Directors. However, this is a relatively new process and requires further work to define and embed the approach in order for it to maximise benefits. The role of the Governor requires further clarification, and training should be undertaken to define the role and set expectations. There is a significant opportunity for the Trust to refocus and strengthen the Governor role as there are a number of Governor positions that are due for election in April 2019, and the role should be redefined at that time.	Fifteen newly elected governors have received an induction training session which clearly defined their role and time commitment expectations. Appointed governors have also received induction training. Governors have expressed an interest in the committees they would like to observe going forward and this will be agreed at the next Council of Governors in August 2019.	**Completed**
19	❷	**Council of Governors–NED 'buddy' scheme** The Board had previously introduced a NED/Governor 'buddy' scheme, however this was not sustained. The Trust should consider relaunching the 'buddy' scheme as this may assist with consistency of approach in the Governor role and assist in embedding and reinforce the learning from the proposed training. (Recommendation 18)	The process for the governors to engage with NEDs has improved and includes governor observers meeting with the chairs of the board committees they observe, as well as contact with the NEDs who are members of those committees. All NEDs also attend CoG. The buddy scheme will be constantly reviewed however the scheme was not effective at developing relationships previously.	**Completed**
KLOE 8: Are there robust systems and processes for learning continuous improvement and innovation?				
20	❷	**Quality Improvement methodology** The Trust is working towards developing and training staff in a single Quality Improvement (QI) methodology, and for this to be rolled out across the organisation. The QI programme will require implementation and embedding across the Trust's services	The Sherwood Six Step QI Approach was launched in July 2018, based on the internationally noted and evidenced 'Model for Improvement' developed by the Institute of Healthcare Improvement – the IHI). It is available to all SFHFT staff on the e-learning system, and to June 2019, 124 staff have been trained at 'bronze' level in improvement knowledge, tools and application. The SFHFT QI Capability Model recognises the fact that not every member of staff needs to be an expert in service improvement, and the training is designed to provide the right level of improvement training required for that specific role.	**In progress**