Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	External Well-Led Review – Recommendations, Progress Report	**Date:** 7th March 2024	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
The purpose of this paper is for the Board to receive assurance that each of the recommendations identified in the final report from the Grant Thornton Well Led Review conducted in March 2022 has been actioned, to provide a current view on their embeddedness and to make recommendations about how an external follow up could be conducted.	**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	

Committees/groups where this item has been presented before

Trust Board

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, February 2023 and August 2023.

This report provides progress against all 15 recommendations, including Actions 13 and 15 that remained open at the time of the last report. Of these 15, three were medium level recommendations, 12 low level recommendations and none of a high-level. The progress made in respect of each Action is reported below for discussion and agreement by the Board.

Grant Thornton's 2022 report followed the 8 key lines of enquiry (KLOEs) from the NHSI Well-Led framework in use at that time. Since then, a single assessment framework has been developed by the CQC to streamline and simplify the assessment process with five quality statements – is the service safe, effective, caring, responsive, and well-led. It is, therefore, proposed that a follow-up external report is commissioned to assess the Trust's level of compliance focussed on "well-led" domain.

Recommendation

The Board is asked to:

- note the current status, including where work is on-going and the current state of embeddedness, in relation to the 15 Recommendations to enable the on-going monitoring of the actions from the 2022 Grant Thornton Report to be concluded, and,
- support the commissioning of a follow-up external Well-Led report in the context of the CQC's updated assessment framework.

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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** <u>March 2024 Update</u> No further joint post arrangements in place or planned. **Remains 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 the CEO – to	Chief Executive Officer	**Complete**	September 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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	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 **<u>March 2024 Update</u>** Update and assurance provided to the Remuneration Committee in May 2023 and an annual refresh and update agreed with the next report due April 2024. The Remuneration Committee received the CEO's report describing the overall performance of the Executive Team across 2022/23 and visibility of the Executive Team objectives for 2023/24. **Ongoing**			
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	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.	Chief Nurse	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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	**Complete** **<u>March 2024 Update</u>** The 15 Steps structured programme was relaunched and has been in place over the last 12 months. Process and SOP revised. Monthly visits incorporating NEDs, Executive team, governors and SLT covering both inpatient wards and departments but now widened to cover other key areas within the organisation. Observations and findings reported quarterly through the Quality Committee for triangulation. Also shared with CoG and patient experience forum for learning. **Complete and embedded.**			
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	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

No.	Risk	Recommendation	Action	Lead		Timeline
		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 improvement methodology that is being rolled out within its campaign to strengthen and sustain a culture of continuous quality improvement and learning.	**March 2024 Update** The Quality Strategy, now in year 2, is progressed and tracked through the Quality Committee. The Executive Director of Strategy and Partnerships has come into post since the last review and holds Executive responsibility for improvement. The Improvement agenda reports directly into the Quality Committee for assurance. The SFHT Improvement faculty was launched in April 2023. The PSIRF framework launched in October 2023 with structured focus on learning and improvement. **Complete**			
	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	Regular meetings with all triumvirates have been scheduled. **Complete**	Director of Corporate Affairs	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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	**March 2024 Update** Meetings with Divisional Triumvirates have been diarised. However, as the operational focus of these meetings does not lend itself well to cultural matters it is now planned to include FTSU updates into the SLT / DPB setting, where updates about FTSU culture/feedback are more useful and appropriate. To date CSTO and Surgery have diarised plans taking this approach forward. **Ongoing.**			
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 FTSU Guardian does not meet with the Guardian of Safe Working Hours and this would be a useful link.	Regular meetings with the Guardian of Safe Working Hours have been scheduled. **Complete** **March 2024 Update** A new Guardian for Safe Working was appointed in Autumn 2023. The FTSUG has asked for regular 6 monthly contact to be established between him and herself. **Continued completion anticipated.**	Director of Corporate Affairs	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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** **<u>March 2024 Update</u>** The Speaking Up Policy was amended in July 2023 to include information and pathway regarding detriment from speaking up at SFH . The guideline informs staff the pathway to use if they feel any detriment from speaking up. The FTSUG sends, annually, a confidential questionnaire to those whose concerns were escalated via FTSU asking whether they have encountered any detriment. The FTSUG verbally discusses detriment with FTSU contacts whose concerns are escalated and asks for feedback if they feel detriment. The National Speaking Up Support Scheme (NHSE) for those affected by having raised formal processes, is circulated to the People Team for	Director of Corporate Affairs	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
			awareness of the application window and information regarding the scheme. **Remains complete and embedded.**			
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. **<u>March 2024 Update</u>** The FTSU Guardian's reports to the Board and People Committee now contain EDI information regarding ethnic group and gender of those using the FTSU service. **Remains complete and embedded.**	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	A quadrant template has been developed and has been implemented from April 2023 Committees. **Complete**	Director of Corporate Affairs	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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 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	**March 2024 Update** The use of the quadrant report across all Board Committees and the Council of Governors' meetings is well-embedded. In February 2024 it was enhanced to enable items to be recommended for consideration by other Committees thereby further enhancing its effectiveness. **Remains complete and embedded.**			
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	Committee Chairs have observed all key meetings which feed into their committee. **March 2024 Update** The recommended action continues to happen including since the recent changes of subcommittees chairs. **Remains complete**	Director of Corporate Affairs	**Complete**	September 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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 Committee should set up regular meetings with the lead Executive Directors	A schedule of regular meetings prior to committee meeting will be developed and implemented. **Complete** **<u>March 2024 Update</u>** The Chair of the People Committee and the Executive Director of People meet on a regular basis to discuss the Trust Strategy, People Strategy, and wider people agenda. These meetings are a combination of formal and informal discussions. In terms of scheduled meetings, the Chair of the People Committee and Executive Director of People meet to discuss the agenda for the People Committee and also have a meeting prior to the committee to discuss the content of the papers and any other relevant topics and discussion points. Furthermore, the Chair of the People Committee and Executive Director of People have a scheduled meeting before the Board of Directors to discuss the Board agenda, review papers and also highlight any people elements to the papers which are to be presented, and how these align to the Trust and People Strategy.	Director of People	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
			These meeting also allow the Chair of the People Committee and Executive Director of People to highlight any points of escalation or requests for support at the earliest opportunity. **Remains complete and embedded.**			
	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	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** **March 2024 Update** All Divisions now present a consistent performance scorecard and pack which includes sections for Quality, Finance, HR and Operational Performance. **Remains complete and embedded.**	Chief Operating Officer	**Complete**	June 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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. **<u>March 2024 Update</u>** The Data Quality Strategy has been revised and was presented at the Data Assurance Group in February 2024 for validation. This includes the formal responses to the September 2023 360 audit report.	Executive Medical Director	**On-going**	December 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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.	A revised Data Assurance Group has been formed to strengthen the management of data quality within the organisation. The group meets monthly and provides a quadrant report into the Digital Strategy Group The Deputy Chief Digital Information Officer has revised the group and been acting as the chair until the appointee to the new Head of Information post takes up their position on 4th March 2024. **On-going.**			
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.	**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: 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.	Executive Medical Director (previously Director of Corporate Affairs)	**On-going**	On-going

No.	Risk	Recommendation	Action	Lead		Timeline
		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.	**<u>March 2024 Update</u>** A Regional Data Quality Assessment Indicator Framework has been adopted by other providers in our System. This approach is under consideration with a view to SFH adopting it in 2024/25. **Remains on-going.**			
	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	**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,	Director of Strategy and Partnerships	**Complete**	September 2022

No.	Risk	Recommendation	Action	Lead		Timeline
		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 of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.	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.			

No.	Risk	Recommendation	Action	Lead		Timeline
			Development of the Improvement and Innovation strategy, as an enabler to the Trust strategy, will fully implement and embed the recommendation. **March 2024 update** The Improvement Faculty commenced in May 2023 bringing together quality improvement, clinical audit and PMO functions into a single space. Work has continued over 2023 to ensure there is a single approach undertaken across these functions. QSIR is the approved quality improvement methodology aligned with a robust approach to project and programme management (reporting structure). QSIR is also the approved approach across the Nottingham and Nottinghamshire ICS, with training sessions provided for ICS colleagues and delivered in part by SFH colleagues. In Q3 of 2023/24 Quality Improvement assurance transferred from the People Committee to the Quality Committee providing Board level assurance on improvement activities and outcomes across the range of activities including the Improvement Faculty, Pathway to Excellence, Advancing Quality			

No.	Risk	Recommendation	Action	Lead		Timeline
			Programme and Clinical Audit. A recent improvement agenda item at Quality committee was to share the approach to Trust wide engagement for the upcoming Continuous Quality Improvement Strategy which will be launched in Spring 2024. This new strategy will respond to the Trust strategic objective 4: Bring Improvement to Life and will link closely to the Quality strategy and Clinical Services strategy. A baseline of the Trust's quality improvement efforts has been undertaken as part of NHS Impact which the continuous quality improvement strategy will respond to. The QSIR requirements have changed in year and Trust's are expected to pay to register QSIR associates on an annual basis – SFH has agreed to pay this registration requirement for 2024/25 to continue providing this methodology. SFH has 3 QSIR associates. **Complete**			