Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 25 July 2023

Subject	Well-led Development Plan Update
Supporting BoD Member	Kirsten Major, Chief Executive
Author	Sandi Carman, Assistant Chief Executive
Status[1]	Discuss and Approve

PURPOSE OF THE REPORT

To present the quarterly progress update on the Well-led Development Plan which was created following the publication of the Well-led Development Review in December 2022.

KEY POINTS

- In September 2022 the Board commissioned a best practice developmental review of governance and leadership to identify continuous improvement actions.
- The review undertaken by AuditOne was delivered between September and November 2022.
- In order to provide a joined-up approach to the Well-led development work, the Trust aligned the recommendations from the Healthcare Governance Review (June 2022) into the same plan. These recommendations have a prefix of 'R'. This approach supports delivery of sustained improvement while preventing duplication of effort.
- On completion of each action there is provided a rationale for closure in the context of the report findings, this will enable consideration to be given to ensuring the actions undertaken have the desired impact and are sustainable.
- Internal Audit resource will be utilised to provide assessment of effectiveness of the development work undertaken to complete the actions.
- It was agreed that an update to the Board of Directors will be provided after each quarter, this is the first of those updates.
- Of the 35 actions that fell due on the 30 June 2023, 24 are recommended for closure. Demonstrating excellent progress when considered against the operational pressures facing the Trust.
- Of the 11 actions that have not been completed revised deadlines have been agreed with the action owners.
- Appendix A provides detailed evidence of achievement for the actions due this quarter, and where necessary information on the revised deadlines.
- 39% of all the actions required to be completed by the end of the year are recommended for closure.

IMPLICATIONS

	Aim of the STHFT Corporate Strategy	✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

Members of the Board of Directors are asked to note and discuss the progress update on the Well-led Development Plan and APPROVE the closure of those actions that are recommended for closure.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	19 July 2023	
Board of Directors	25 July 2023	

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Well-led Development Plan Update
July 2023

A pictorial summary of the progress of the Well-led Development Plan actions is set out below. This shows progress of the 62 actions aligned to the eight Well-led Key Lines of Enquiry (KLoE), each action has been given a unique identifier. This identifier can be cross reference to Appendix A which provides detailed evidence of achievement of the actions due this quarter, and where necessary information on the revised deadline. A key is provided below.

KLoE 1: Leadership Capacity and Capability

A1 A2 A3 A4 A5 A6

KLoE 2: Vision and Strategy

B1 B2 B3 B4

KLoE 3: Organisational Culture

C1 C2 C3 C4 C5 C6 C7 C8 C9 C10 C11

KLoE 4: Roles and Responsibilities

D1 D2 D3 D4 D5 D6 D7 D8 D9 D10 D11 D12 D13 D14

KLoE 5: Risk and Performance

E1 E2 E3 E4 E5 E6 E7 E8 E9 E10 E11 E12

KLoE 6: Information

F1 F2 F3 F4

KLoE 7: Engagement

G1 G2 G3 G4 G5 G6 G7

KLoE 8: Learning, Continuous Improvement and Innovation

H1 H2 H3 H4

Key

	Action completed and recommended for closure	24
	Action overdue and revised deadline established	11
	Action not due this quarter	27
	Total actions / recommendations	62
	Percentage completed overall (including actions not due)	**39%**

Sheffield Teaching Hospitals NHS Foundation Trust
Well-led Development Plan - July 2023 - Appendix A

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
	KLoE 1: Leadership Capacity and Capability				
A1	1. The Trust should consider further development of its board development programme to encompass both human factors and improved linkage to addressing the identified needs of the board skills matrix and its strategic needs.	SC	30/06/2023	Strategy and Board Development forward plan in place that is informed by mandatory requirements, strategic context and priorities identified through Board of Director discussions. For 2024 this will also be informed by the outcome of the Board Skills Framework and Audit Cycle. **Evidence**: Board Skills Framework and Audit Cycle approved by the BoD Nomination Remuneration Committee, 26 June 2023 Strategy and Board Development forward plan **Impact**: Implementation of the forward plan will help to reduce any gaps between the skills of the Board and those required to achieve the Trust's strategic priorities. **Sustainability**: Incorporated into the annual workplan of the Board.	Recommend for closure
A2	2. The Trust should consider updating its executive succession planning arrangements including having development programmes for those identified in category B of the Trust's executive succession plan.	KM	29/9/2023 ~~30/06/2023~~	All Trust Executive Group individual appraisals to be undertaken during the spring/summer of 2023 include a discussion regarding future career options and potential succession plans. The last appraisal is due on the 31 July 2023. **Evidence**: Confidential briefing note held by the Chief Executive detailing succession and development plans. **Impact**: Effective succession plans in place to maintain leadership team **Sustainability**: Incorporated into the annual appraisal process.	Open
	KLoE 2: Vision and Strategy				
B1	5. The Trust should consider how it can strengthen line of sight of strategic objectives and priorities down to care group and directorate level to aid alignment of business plans.	MT	30/06/2023	We have considered how we link strategic objectives to care groups and directorates. Each Directorate's business plan includes articulation of the contribution to each of our six strategic objectives and we have introdcued a new element of setting out the longer term direction of Directorate's, in pursuit of our corproate strategy. Draft business planning audit has found high level of assurance with our approach. There will be ongoing work to develop our clinical blueprint which will provide a helpful intermediate point between our high level corproate strategy and individual directorates' plans. **Evidence**: Draft business planning audit; and 2023/24 business plans **Impact**: Impact will be felt over a longer timeframe, but it is expected more clarity and cohesion of purpose across our directorates **Sustainability**: Clinical blueprint will further strengthen this area. Revised, more strategic approach to business planning will continue	Recommend for closure

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
	KLoE 3: Organisational Culture				
C2	R2: A detailed review of the Trust's Freedom to Speak Up (FTSU) arrangements should be taken forward using the self-review tool published by NHSE/I and other available guidance.	MG	30/06/2023	A new model for FTSU was approved by the Trust Executive Group in October 2022. The membership of the FTSU Steering Group was broadened to include four management representatives (Nurse Director, Operations Director, Deputy Medical Director, Associate Head of EDI) and is now chaired by the Non - Executive Director Lead for FTSU. A substantive Lead Guardian 0.6wte and seven additional voluntary Guardians have been appointed bringing the total to 10 Guardians from a range of staff groups and Directorates (with backfill monies in place for the supporting Directorates). In addition to the 10 Guardians there are also a total of 59 trained FTSU Champions from across the Trust. **Impact**: In the 2022 Staff Survey all four FTSU questions scored better than the national average. A demographic analysis of concerns raised compared to the demographic for the Trust as a whole has been undertaken for two consecutive years (2021/22 and 2022/23) to help identify potential barriers to speaking up. The process for collecting demographic information has changed from Q1 of 2023/24 and is collected at the start of the process rather than the end to ensure we have a full data set to analyse for 2023/2024. An additional piece of analysis was undertaken from 2022/23 to look at the number of concerns raised openly, confidentially or anonymously for the Trust as a whole and by Directorate to help to identify further barriers to speaking up. This can be used to compare future years and provide an indication of our speaking up culture. **Evidence**: A new combined FTSU and Employee Relations casework report to support triangulation of data and identification of themes and patterns within Directorates was presented to TEG and the People Committee in Q3 of 2022/23 and will continue to be presented on a quarterly and annual basis by the Lead Guardian and Head of Operational HR. The recording process has been adjusted for 2023/24 to ensure all contacts with a Guardian or Champion are recorded on the National (NGO) portal and not just those that are 'cases' categorised under a Policy type, following clarification that this is how the national guidance is intended to be interpreted. **Sustainability**: The new FTSU Policy implemented in February 2022 has been reviewed against the new national Policy issued in June 2022 and some changes are being proposed which will be agreed through the FTSU Steering Group by December 2023. The national deadline set for all Trusts to complete this review is 31 January 2024. The Board Self Assessment was approved at the FTSU Steering Group in May 2023. A 6 month review update will be considered by the Operational Group in October 2023 and is scheduled to progress to the Steering Group for approval in November 2023 The national deadline set being the end of January 2024. The FTSU process is regularly reviewed at Operational and Steering Group meetings and continuously improved. Any additional recommendations made in the internal audit report scheduled for quarter 3 of 2023/24 to assess whether new arrangements are embedded and working will be implemented.	Recommend for closure
C3	R28: Reporting between assurance committees and the Board should be strengthened through the provision of a summary report in a consistent format.	SC	30/06/2023	Meeting Assurance Reports established for high level Committees and for groups within the Quality Governance structure. **Evidence**: Meeting Assurance Report template Relevant meeting agendas and papers **Impact**: Improvement in the effectiveness of assurance reports and escalation of matters. **Sustainability**: Approach embedded within ToR template and standing agenda items.	Recommend for closure
C4	R3: A succinct report from the Safety and Risk Forum to the Safety and Risk Committee setting out key matters that require alerting, assurance and advice should become part of the regular reporting cycle to the Committee.	JH	30/06/2023	A review of meetings under the Quality Committee disestablished the Safety and Risk Forum and introduced the Quality and Safety Executive Committee, chaired by the Medical Director. Meeting Assurance Reports established for high level Committees and for groups within the Quality Governance structure to enable rapid escalation of assurance and concerns. **Evidence**: Meeting Assurance Report template and relevant meeting agendas and papers **Impact**: Improvement in the effectiveness of assurance reports and escalation of matters. **Sustainability**: Approach embedded within ToR template and standing agenda items.	Recommend for closure

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Well-led Development Plan - July 2023 - Appendix A

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
C5	R10: The Quality Committee should include a regular assurance report from the Patient Experience Committee.	CM	30/06/2023	Meeting Assurance Reports established for high level Committees and for groups within the Quality Governance structure. This specifically includes a Meeting Assurance Report from the Patient Experience and Engagement Executive Committee which is submitted to Trust Executive Group for information and Quality Committee for assurance. **Evidence**: Meeting Assurance Report templates Relevant meeting agendas and papers **Impact**: Improvement in the effectiveness of assurance reports and escalation of matters. **Sustainability**: Approach embedded within ToR template and standing agenda items.	Recommend for closure
C6	R4: The responsibility for each care group representative on the Safety and Risk Forum to share cross-cutting learning and good practice within their respective directorate governance meetings should be reinforced and reviewed on a regular basis.	JH	31/12/2023 ~~30/06/2023~~	An audit of directorate governance has been completed and will be presented in August 2023. This annual audit is a mechanism for reviewin how directorates share learning. As a result of this audit, the Quality Governance Framework will be revised. A review is to take place of the Safety and Risk Forum which will feed into a future workplan to ensure all directorates share learning. **Evidence**: Terms of Reference for the Safety and Risk Forum. Minutes of the Safety and Risk Forum. Highlight report from the Safety and Risk Forum to QSEC. Audit of Directorate Governance. Learning Newsletter launched **Impact**: Whilst some learning is being shared, a review will take place to map out which areas have not shared learning which will be developed into a new workplan. **Sustainability**: Once the new workplan is in place this will be sustainable	Open
C9	R7: The Mortality Governance Committee should receive a standardised quarterly/six-monthly update report (run as a rolling programme).	JH	30/06/2023	Each directorate presents a summary of themes and learning from Mortality and Morbidity meetings and Structured Judgement Reviews to the Mortality Governance Group (renamed following the meetings review) on a six monthly basis. This is then reported on to the Quality & Safety Executive Committe (QSEC) via the highlight reports. **Evidence**: Minutes of the Mortality Governance Group. Highlight reports from the Mortality Governance Group to QSEC. Reports from directorates to the Mortality Governance Group. **Impact**: Effective, the learning is discussed and a conversation had with members of QSEC to take back relevant learning to their Care Groups. **Sustainability**: Embedded and sustainable as part of the routine meeting process.	Recommend for closure
C10	R27: The Trust should ensure that regular data quality oversight and assurance reports are provided to TEG and to the Audit Committee and that a forward plan clearly outlining the priorities for data quality is completed and agreed.	SC	29/9/2023 ~~30/06/2023~~	The Data Quality Steering Group has assessed the key improvement workstreams in place and created a plan on a page. To strengthen the governance arrangements a meeting assurance reports is now submitted to TEG following each meeting. **Evidence**: Plan on a page completed. **Impact**: Improved assurance to TEG **Sustainability**:Audit Committee work plan includes annual report (Oct 23) Consider twice yearly to Audit Committee.	Open
C11	R29: Feedback on decisions taken by the Board to its assurance committees should be strengthened on matters escalated for discussion, action or decision.	SC	30/06/2023	Meeting Assurance Reports established for high level Committees and for groups within the Quality Governance structure. **Evidence**: Meeting Assurance Report template Relevant meeting agendas and papers **Impact**: Improvement in the effectiveness of assurance reports and escalation of matters. **Sustainability**: Approach embedded within ToR template and standing agenda items.	Recommend for closure

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
	KLoE 4: Roles and Responsibilities				
D1	10. The Trust should ensure that Board committee membership is in line with Sch7, NHS Act 2006.	SC	28/04/2023	All Terms of Reference updated to alight with Sch7, NHS Act 2006, to ensure that only Board members are members of Board Committees. April - June 2023 minutes demonstrate compliance. **Evidence**: Board Committees Terms of Reference Minutes of Board Committees **Impact**: Practice aligns with statutory requirements. **Sustainability**: Incorporated within Trust templates	Recommend for closure
D4	13. The Trust should consider the role of Management Board and its relations with Trust Executive Group.	KM/SC	29/9/2023 ~~30/06/2023~~	All members of the Trust Executive Group are members of the Management Board and Clinical Management Board. Attendance at the meeting or receipt of the papers enables TEG members to be fully appraised of the meeting content. Both Boards receive briefings from Executive and Management Board colleagues and act as a forum for discussion and debate. It is therefore considered that there are sufficiently effective arrangements in place between TEG, Management and Clinical Management Board. **Sustainability**: Given this clarity of approach this will be reflected in the next scheduled review of the terms of reference for both the Management and Clinical Management Board and clarified within the Management Arrangements.	Open
D5	14. The Trust should convene its proposed Digital, Data and Technology Board and consider forming a Research Committee to oversee and focus efforts on these strategic priorities.	DB	30/06/2023	Approval from the Board of Directors obtained to establish two new Board Commitees - Digital Committee and Research and Innovation Committee. **Evidence**: Board of Director meeting papers Relevant Committee meeting agendas and papers Terms of Reference **Impact:** Improvement in the focus and scrutiny of both Digital and Research and Innovation to support the delivery of high quality patient care **Sustainability**: Approach embedded within ToR template and standing agenda items. For both committees meeting dates have been established for 2024. Three Digital Committee meetings to be held in 2023 and the first meeting of the Research and Innovation Strategy to be progressed on completion of the Strategy. Research governance internal audit planned for 2023/24 Q4 to test arrangements.	Recommend for Closure
D7	R18: An engagement programme to roll out the Quality Governance Policy and Framework and promote collective working across the Trust should be developed and implemented.	JH	31/12/2023 ~~30/06/2023~~	The policy and framework were launched and this audited. The report on the audit has been written but not yet presented. The Quality Governance framework is being revised based on the findings **Evidence**: Quality Governance Policy, Quality Governance Framework, Audit report, **Impact**: This will improve the quality and scope of directorate governance meetings **Sustainability**: A reaudit in December 2024 will ensure sustainability of this.	Open
D8	R13: The quality governance structure should be reviewed to reduce the number of trust-wide and specialist quality governance groups reporting directly to the Trust Executive Group for management purposes and to the Quality Committee for assurance purposes.	JH	30/06/2023	A review took place of all meetings reporting directly into Quality Committee and a revised structure approved by TEG for launch in April 2023. This structure is now in place and working. **Evidence**: Structure, presentation on structure to MBB, highlight reports, meeting papers and reports. **Impact:** Good, highlight reports are flowing, information shared is more manageble. **Sustainability**: Good, embedded into business as usual processes.	Recommend for Closure

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
D9	R22: A Trust Risk Group, reporting to the Safety and Risk Committee, should be added to the governance structure with responsibility for reviewing and scrutinising the ongoing management of the Trust's operational risks.	JH	30/06/2023	Risk Management Executive Committee is in place with Trust Executive Group membership. This met for the first time in May 2023 and is due to meet again in July 2023 **Evidence**: Meeting agenda, meeting minutes **Impact**: this has already improved engagement and robustness of risk registers **Sustainability**: Good - this will ensure regular reviews and challenge to ensure risks are escalated, addressed and reduced.	Recommend for Closure
D10	R15: The Quality Committee should receive a monthly report on the relevant sections of the Integrated Performance Report at both an organisational and directorate level. This should include metrics associated with delivery of the best clinical outcomes and providing patient centred care.	JH	30/06/2023	A review has been completed and relevant indicators are now included in the Integrated Quality and Safety Report. This has been the case for over 6 months **Evidence**: Integrated Quality and Safety Report, meeting papers **Impact**: Good - improved dicsussion at Committee level and visibility of the areas in place **Sustainability**: Embedded - this has been running monthly for over six months	Recommend for Closure
D11	R16: Action trackers should be introduced for directorate performance meetings that show the status of completion against agreed Actions and record their impact upon performance.	MH	30/06/2023	**Evidence**: Action Logs are now in place since February 2023 in Level 1, 2 and 3 Performance Management Framework meetings. Ownership of the Action Logs by Performance and Information Director and managed at each meeting with the directorate. **Impact**: Business rhythm of performance management meetings established. **Sustainability**: Process is embedded and becoming core business.	Recommend for closure
D13	R32: The Trust should add the requirement to complete an action log for all directorate executive and governance meetings as part of the Directorate Healthcare Governance Framework, together with a standard template.	JH	31/12/2023 ~~30/06/2023~~	The action log has been shared and is in use to enable robust oversight of all actions by directorates. This will feature in the revised Quality Governance Framework which will be published by October 2023.	Open
D14	R17: A review of resourcing of quality and safety governance across the Trust, including the central team, directorates and care groups, should be undertaken to ensure appropriate resourcing is in place.	JH	29/9/2023 ~~30/06/2023~~	A review took place, there was increased resource for Medical Quality Leads, new posts are now in place in the central Patient and Healthcare Governance Team. The directorate review has been completed and is out for comment with the Nurse Directors. **Evidence**: Review of Medical Quality Leads, Review of central Patient and Healthcare Governance, Directorate Resource review **Impact**: The increased Medical Quality Leads and central resource has improved the ability to effectively lead quality locally and to better support the national patient safety strategy in improving safety and quality **Sustainability**: WIth the posts in place the improvements will be sustainable	Open

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
	KLoE 5: Risk and Performance				
E2	R8: The Directorate Healthcare Governance Framework should set out how directorate governance meetings will be expected to have oversight for Mortality and Morbidity learning and resulting actions.	JH	30/06/2023	The Quality Governance Framework included responsibilities for Mortality and Morbidity (M&M) meetings, and the effectiveness of the M&M meetings is monitored via the Mortality Governance Group. A review of directorate governance has taken place and the Quality Governance framework is being updated as a result. This includes further strengthening responsibilities on M&M to ensure directorate governance monitors the delivery of actions from M&M. **Evidence**: Quality Governance Framework, presentation on Mortality to Quality Committee by Charlotte Ruse, meeting papers. **Impact:** Improved M&M meetings with better actions and learning. **Sustainability:** The revised framework will further increase sustainability	**Recommend for closure**
E3	R23: All clinical directorate governance meetings should use the model agenda which is included in the Directorate Healthcare Governance Framework to increase the consistency of risk management discussion and actions in directorate management meetings.	JH	30/06/2023	The Quality Governance policy and framework were launched and a review against this has taken place. A report has been produced. This report notes that 64% of clinical directorates used the model agenda. This has been fed back to directorates and will be reaudited in December 2024 **Evidence**: Quality Governance Policy, Quality Governance framework, Directorate Governance Clinical Audit report 2023 (ref 11433) **Impact**: The central team are attending governance meetings and also feeding back directly. It is anticipated that the Dec 2024 audit will show 100% compliance. **Sustainability:** The reaudit supports long term sustainability and long term improvement	**Recommend for closure**
E4	R26: An implementation timetable and plan should be agreed for roll out and review of the draft Directorate Healthcare Governance Framework across the organisation, together with the standardised agenda.	JH	30/06/2023	Both the Quality Governance policy and framework were launched and rolled out. An audit of compliance against this has now taken place. **Evidence**: Quality Governance Policy, Quality Governance framework, Directorate Governance Clinical Audit report 2023 (ref 11433) **Impact**: The report shows positive impact from the introduction of the framework **Sustainability**: This will be reaudited in December 2024 which supports embedded sustainability	**Recommend for closure**
E5	16. The Trust should consider how it can improve the timeliness of reporting and discussions.	MH	29/9/2023 ~~30/06/2023~~	Discussions with Public View have taken place and currently in processes of pulling together a proposed structure for consideration over the summer. **Evidence**: Overview of live performance activity is now available in CXAir, this information is used in all activity performance discussions. The use of CXAir has also improved the timeliness of data reported to Finance and Performance Committee and TEG. **Impact**: CXAir has allowed Weekly Recovery Meetings and directorates to have timely views of up to date activity information. **Sustainabilit**y: Work continues with Public View to develop an interactive IPR with timely information.	**Open**

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
E6	17. The Trust should consider how it operationalises risk appetite into its risk reporting and decision-making processes.	SC	30/06/2023	Informed by application of the Board's newly updated Risk Appetite Statement, the reintroduction of risk scores onto the Board Assurance Framework (BAF) from May 2023 will support the Board to identify where mitigating actions need to be driven to reduce risk likelihood in line with risk appetite. **Evidence**: The inclusion on the May 2023 BAF of measurement of variance between current risk score and target risk score for each Strategic Risk and reference to Risk Appetite definitions. **Impact**: Increased scrutiny on BAF Strategic Risk action plans in areas where the variance between current risk score and target risk score is greatest. **Sustainability**: Updated BAF Strategic Risk templates.	Recommend for closure
E7	18. The Trust should ensure that the Corporate Risk Register continues to evolve to provide insight to Board over the management of the Trust's most significant operational risks.	SC/JH	30/06/2023	Opinions on risk management arrangements included within end of year reports issued by Internal Audit and External Audit. Significant opinion issued on the Board Assurance Framework within Head of Internal Audit Opinion. ISA 260 issued by External Auditors (KPMG) referenced in-year strengthening of risk management arrangements including establishment of Risk Management Executive Committee and noted no significant weaknesses in control around risk management, however highlighted a risk regarding overdue risk assessments at a directorate level. **Evidence**: Corporate Risk Register Report (CRRR) presented to May 2023 BoD **Impact**: Greater oversight and triangulation of significant operational risks. **Sustainability**: Presentation of CRRR alongside BAF scheduled on Board workplan for 2023/24. Deep Dive template and BAF proforma triangulate operational and strategic risks.	Recommend for closure
E8	R21: The Quality Committee should receive a regular report outlining the highest operational risks relating to quality and safety.	JH	30/06/2023	A deep dive schedule is in place and the Quality Committee has been reviewing these deep dives which include the highest operational risks to quality and safety. **Evidence**: Deep dive reports on the Board Assurance Framework (BAF) to the Quality Committee, workplan of the Quality Committee **Impact**: The Non-exective Directors have assurance on the link between extreme risks to the BAF and on the work in progress to address the strategic risks **Sustainabilit**y: Regular item on the Board and Committee workplan	Recommend for closure
E12	R20: The Quality Committee should receive a report each quarter summarising the position of the principal risks that the committee provides oversight for.	SC	30/06/2023	Through the implementation of the deep dive schedule the Quality Committee receives a report at least twice a year summarising the position of the Strategic Risks the Committee provides oversight for, enabling members to obtain assurance on how the strategic risks are being managed. The standing operating procedure for the Board Assurance Framework requires the inclusion of relevant Extreme Risks recorded on the Corporate Risk Register Report (CRRR) to be appended to the paper supporting Committee Deep Dives. **Evidence**: Board Assurance Framework (BAF) Strategic Risk 1: Quality of Care Deep Dive includes extract from CRRR (Nov 2022) **Impact**: Greater oversight and triangulation of significant operational risks relating to Quality of Care by the Quality Committee. **Sustainability**: Deep Dive template and BAF proforma triangulate operational and strategic risks.	Recommend for closure

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
	KLoE 6: Information				
F4	22. The Trust should ensure that its IT infrastructure and system interoperability support safe, high-quality healthcare.	DB	30/06/2023	Extensive IT programme in place to monitor risks, refresh and modernise key IT infrastructure to ensure it is secure and sufficient for Trust needs. Reporting will be to new Digital Committee which will provide assurance and oversight of key risks. The programme includes work to reduce the burden of accessing so many systems for clinicians. Programme for deliver of fully functional Electronic Patient Record (EPR) and South Yorkshire wide Laboratory and Infomation Management System (LIMS) established and running and will report into Digital Committee. **Evidence**: Board of Director meeting papers Relevant Committee meeting agendas and papers **Impact**: Improvement in the focus and scrutiny on the delivery of key digital projects and oversight of development and fitness of the Trust IT infrastructure **Sustainability**: Approach embedded within ToR template and standing agenda items IT business continuity internal audit arranged to commence in 2024.	Recommend for Closure
	KLoE 7: Engagement				
G1	23. The Trust should ensure how it captures all patient engagement activity and shares the learning cross Trust where appropriate.	CM	30/06/2023	The Integrated Quality and Safety Report has been enhanced to include more detailed information on patient experience, this information is drawn from the Patient Experience Group. The Patient Experience Group is also the forum used to share learning across the Trust. Some of this learning will be bought to the Quality Committee in the form of a Deep Dive, and recent examples include the learning shared from work done in A & E to enhance the experience of people who are deaf. The Patient Experience and Engagement Executive Committee has been established to oversee the Patient Experience and Engagement element of the Quality Strategy. **Evidence**: Integrated Quality and Safety Report, Deep Dives in the Quality Committee, Meeting Assurance Report templates Relevant meeting agendas and papers **Impact**: Demonstrating the areas where patient engagement activity has been captured and shared. **Sustainability**: Approach embedded within ToR template and standing agenda items.	Recommend for closure
G2	R9: The Board should adopt a clear engagement and involvement strategy to support the involvement of patients and carers in the design of its services and its decision making processes.	JH	30/06/2023	The Board has agreed a new Quality Strategy, with one of three themes in this strategy specifically focuses on Patient Experience and Engagement. The new Strategy includes the involvement of patients and carers in co design and co production. An action plan for year 1 has been approved at Patient Experience and Engagement Executive Committee. **Impact**: Services that are better informed and designed through input from patients **Evidence**: Quality Strategy, Patient Experience and Engagement timeline, Year 1 action plan, Patient Experience and Engagement Executive Committee (PEEEC) minutes and PEEEC highlight report to Quality Committee **Sustainability:** The timeline and action plan with monitoring arrangements at PEEEC will ensure this is delivered. Its inclusion as a key strand of the new straetgy, which runs to 2028 gives us confidence of this focus being sustained	Recommend for closure
G3	R11: Each care group should present a standardised quarterly / six monthly update report (run as a rolling programme) to the Patient Experience Committee.	CM	29/9/2023 ~~30/06/2023~~	Progress to date: The first cycle of all Care Groups attending should complete in September 2023. Next steps: Review of effectiveness and impact scheduled for the September 2023 meeting as long as the first cycle completes to time. The outcome of which will be reported in the meeting minutes.	Open

	Recommendation	Lead	Timescale/ Deadline	Update and where relevant rationale for closure	Open/ Close
	KLoE 8: Learning, Continuous Improvement and Innovation				
H1	27. The Trust should consider how it can release or ring fence time and provide the necessary permissions for directorates to undertake improvement activities.	KM (PW)	29/9/2023 ~~30/06/2023~~	Corporate objective created and approved. Review of performance against key metrics e.g. staff survey data in relation to involvement in improvement over time and building capability. Conducted an internal review against the national Delivery and Continuous Improvement Review and Recommendations (including NHS Impact) and 'Improving Improvement at STH' confirmed on the Trust Executive Group agenda for 09/08/23 incorporating the report in relation to this plus action at Action H2. Innovation Group and Dragons Den launched. **Evidence**: 2022 Change Maker review and report has been published **Impact**: Stocktake complete and will ensure shared understanding of position, risks and opportunities **Sustainability**: Agreed Corporate Objective and ringfenced time and funding for innovation agreed	Open
H2	28. The Trust should consider how it can leverage greater value from its ODD and QI investment and capacity.	KM (PW)	29/9/2023 ~~30/06/2023~~	2023 (calendar year) review concluded to temporarily redeploy resource to priorities in response to the reduction in capacity in the Organisational Development Directorate. Comprehensive assessment of current and future demand for Organisational Development and Quality Improvement intervention has been undertaken to enable evaluation of the work plan and ensure a focus on the areas that matter most to the success of the organisation. This will be discussed at Trust Executive Group on 09/08/23 as part of the 'Improving Improvement at STH' item	Open