CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Thursday 30 September 2021 at 9.00 am

Microsoft Teams and Meeting Room 9 St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG

		Info / Dec	LEAD		Page No.	Timing
1.	Welcome and Apologies	Information	Paul Burstow		*3*	*9.00*
Patient / Carer Voice						
2.	Divisional Presentation (including patient voice): 23a The Avenue (Deaf Service)	Information	Jess Lievesley *(Dr Alex Hamilton and Patient)*	✓	*4*	*9.01*
Administration						
3.	Declarations of Interest	Information	Paul Burstow		*5*	*9.30*
4.	Minutes from the Meeting in Public Board of Directors Meeting on 24 August 2021	Decision	Paul Burstow	✓	*6-15*	*9.32*
5.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*16-19*	*9.35*
Chair's Update						
6.	Chair Update	Information	Paul Burstow		*20*	*9.40*
Executive Update						
7.	CEO Report	Information	Katie Fisher	✓	*21*	*9.45*
Strategy						
8.	St Andrew's Healthcare 2021-2026 Strategy	Decision	Jess Lievesley	✓	*22-54*	*9.55*
Break 10.40						
Governance						
9.	Ernst & Young Governance Review Report & Implementation	Decision	Paul Burstow	✓	*55-154*	*10.50*
10.	Emergency Preparedness, Resilience and Response (EPRR) Submission	Decision	Jess Lievesley (Claire Jones)	✓	*155-162*	*11.30*
Assurance						
11.	**Committee Updates**				*163*	
	• People Committee	Information & Decision	Paul Burstow	✓	*164-234*	*11.40*
	• Quality & Safety Committee	Decision	David Sallah	✓	*235-289*	*11.50*
Operations						
12.	Board Performance Report	Information	John Clarke, Alex Owen & Dr Sanjith Kamath	✓	*290-300*	*12.00*
13.	Information Security Metrics	Review & Comment	John Clarke	✓	*301-315*	*12.15*

Quality						
14.	Continuous Quality Improvement Awareness Session	Information & Decision	Jess Lievesley (Michaela Roberts & Dr Ash Roychowdhury)	✓	*316-329*	*12.25*
Any Other Business						
15.	Questions from the Public for the Board	Information	Paul Burstow		*330*	*12.40*
16.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*331*	*12.44*
17.	Date of Next Meeting - Thursday 25 November 2021	Information	Paul Burstow		*332*	*12.45*
Meeting Closes at 12.45 pm						

Welcome and Apologies

(Paul Burstow – Verbal)

Divisional Presentation (including patient voice) 23a The Avenue (Deaf Service)

Jess Lievesley, Deputy CEO
Dr Alex Hamilton & Patient

(Presentation on the day)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 24 August 2021

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Microsoft Teams Meeting and Meeting Room 9, William Wake House, St Andrew's Healthcare, Northampton

Tuesday 24 August 2021 at 09.00 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
David Sallah (DS)	Non-Executive Director
Katie Fisher (KF)	Chief Executive Officer
Alex Owen (AO)	Chief Finance Officer
Andy Brogan (AB)	Chief Nurse
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director
In Attendance:	
John Clarke (JC)	Chief Information Officer
Alastair Clegg (AC)	Chief Operating Officer
Duncan Long (DL)	Company Secretary
Farshad Shaddel(FS) Item 1	Consultant Psychiatrist
Catherine Vichare (CV) Item 11	Clinical Director
Anne Utley (AU) Item 15	NHS Providers
Melanie Duncan (Minutes)	Board Secretary
Apologies Received:	
Jess Lievesley (JL)	Deputy Chief Executive Officer

Agenda Item No		Owner	Deadline
1.	**Welcome** PB (Chair) welcomed everyone to the first part of the Board of Directors (Board) meeting, which is a meeting held in public.		
DIVISIONAL UPDATE			
2.	**Divisional Presentation (including Patient Voice): Sycamore Service** AC and FS presented the session, outlining the challenges that have been faced in bringing this presentation to the Board. FS outlined the Model of Care within Sycamore, and explained that unfortunately the patient could not be interviewed directly ahead of this morning, but that he hoped that the patient's voice could still be heard via the presentation slides. FS gave a background to Sycamore and the enhanced medium secure unit run for patients with a primary diagnosis of Intellectual Disability and or Autistic Spectrum Disorder. FS explained the mission and vision for the service, which was to become one of the best specialist services in the field, as confirmed by external recognition. He then presented the Individualised Model of Care, which supported the discharge to 'best fit' approach. He further explained the difference that Sycamore gave; in that it developed the care requirements		

	within the hospital environment, which would then translate, to a community environment in order to foster confidence within the patients. FS outlined the criteria for admission to Sycamore, highlighting it was for patients who were unlikely to improve further by staying within a hospital setting, and where clear rehabilitation potential and the prospect of living in a bespoke community environment would be beneficial. The admission process was outlined to show the bespoke process of admission the patient is taken through, noting that the unanimous agreement of the team was required. The social aspects highlighted that whatever was done within the hospital setting was able to be replicated within the community. The Intelligent Kindness Model noted the cycle which aided in ceasing bad experiences and building trust. FS noted that the Patient's Voice was quoted in the presentation, and she was aware of that. FS then showed a SWOT analysis of the service and welcomed questions from the Board. PB thanked FS, and enquired regarding the model that identified when patients were ready to move onwards, and asked if there were any key markers which are looked for specifically. FS explained that within Sycamore they concentrated on why the patient was not improving within the hospital environment, and used that information. SN said that he would be interested to see the data in the coming years regarding length of stay and destinations. He also asked if the community resources were being developed, and were we involved in helping to develop that service. FS explained that the first patient was admitted 5 months ago, with an 18 month anticipated stay within the service. The patient's journey had showed that it should be achieved. The ongoing placement would be a bespoke situation which would replicate the hospital environment. The Commissioners and the team were working on the development of this from the start, making it specific to the patient. DS thanked FS, noting that he had experience of this group of patients. DS commented on the fact that one seclusion room was seen as a weakness, as he felt that seclusion should not be used any more. FS agreed with DS and was hoping not to use seclusion.. DS asked where the team were with regard to the overall vision. FS replied that this was a rare service, there had already been an inspection, and other external agencies had been involved with the development of the service. EL wanted to know about the levels of sickness with staff compared with the rest of the Charity and how staff were supported within this challenging environment. FS noted that sickness was slightly higher due to Covid and injuries received. He added that staff were supported and steps were taken to motivate staff via regular team days. He noted that there had been a lot of interest from staff regarding working within the service, however, the issue lay with retention of staff due to the patient. EL asked if staff turnover was higher than average compared to the rest of the Charity. FS replied that it was when the service began, however, staff turnover was beginning to decrease. EL commented that she understood that stability of staff was required within this environment. AL asked how conflicts of objective between the patient, family and staff were dealt with. AL also noted that the data presented referred to just one patient, and asked if commissioners reflected in a monetary way the acuity of the patients who required specialist care within St Andrew's. AO responded that a different day rate was in place for these patients, and the ward was based on single occupancy. As more patients would be admitted, the day rate would drop accordingly. RB appreciates the service was relatively new, and asked if it could be replicated for more patients and for differing reasons. FS explained that the		

	model showed that it was possible to roll out this type of service for other patients, and that it was hoped to expand it as there were other patients within this area who were still in hospital but had rehabilitation potential. FS agreed that there was demand and huge potential for this type of treatment. PB noted the valuable learning from this work, involving discharge into the community, and thanked FS and the patient for the presentation.		
ADMINISTRATION			
3.	**Declarations Of Interest** All members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose.		
4.	**Minutes Of The Board Of Directors Meeting, Part Two, on 27 May 2021** The minutes of the meeting held on the 27 May 2021 were **AGREED** as an accurate reflection of the discussion. • EL noted two points of clarity via email in advance of the meeting regarding the financial years noted within the ARC Chair report. DL confirmed that the changes had been made.	**DECISION**	
5.	**Action Log & Matters Arising** 24.09.20 **01** Board Development Plan - PB confirmed that a meeting was to be held later that day in order to address Board development. Action **CLOSED** 26.11.20 **04** NED Ward Visits - Action **CLOSED** 25.03.21 **02** Transformation Programme Update - It was **AGREED** to merge this action with the 28.01.21 **01** Division Lessons Learned action. 27.05.21 **02** NHS Benchmarking Network - SK will present to Board in November. PB suggested a Board seminar to discuss this further. 27.05.21 **04** Data Security - AL commented that JC attended the last Finance Committee, and that this work needed to be dealt with as part of the Governance Review, as the Board will require assurance that the risks are acceptable. JC added that part of this action involved reporting on the data security area within the IPR, which will be done for the September meeting. PB agreed that this would be resolved as part of Governance review implementation. Action to remain open. 27.05.21 **05** DBT Patient Video - Action **CLOSED** All other actions were **NOTED**.	**DECISION** **DECISION** **DECISION** **DECISION**	
CHAIR'S UPDATE			
6.	**Chair Update** PB gave a verbal update, noting that there had been a number of Extra-Ordinary Board meetings recently, covering the Quality Account and the CQC inspection. PB also noted that he had visited the Essex service and met with patients and staff. He also visited the gardens that had been highlighted during the Divisional Presentation to the May Board. PB also reported that he was also about to begin appraisal conversations with NED colleagues. The Board **NOTED** the update.		

EXECUTIVE UPDATE			
7.	**CEO's Report** KF presented the report which was taken as read. She updated on the recent CQC inspection where 25 wards were inspected, with further work being carried out with the CQC on 17 wards. KF was also delighted to report that as a result of a recent Ofsted inspection the St Andrew's College had achieved an overall rating of Good with Outstanding elements within the new framework. DS asked regarding the CQC report with regard to issues being fed through a Patient Safety Group, ensuring the group was separate and led by the CEO. DS was interested to hear KF's views on this. KF replied that she would address this further in part two of the Board meeting, however she agreed that the quality improvement programme would have dedicated focus. KF noted that no report had been received as yet, and may not be for a while. PB asked if a draft report would be available before the CQC report was published. KF confirmed that a draft would be available, with a formal factual accuracy process, noting that there would be 10 days for us to comment and that there would be 10 days after that for the CQC to respond to our factual accuracy check before the report was formally issued and published. The Board **NOTED** the update		
8.	**Performance Report (including Finance)** AC presented the report which was taken as read and noted that there had been a number of changes to the report, namely the inclusion of a target lines, and that the summary captured accurately the challenges that the charity was experiencing in Northampton in particular. He added that Covid had impacted most areas, including staffing and finances, with the ability to move patients onwards being affected as a result. He concluded that staff continued to do a wonderful job looking after patients under these circumstances and the safety data reflected that. SK further added outlines of the rationales behind the target lines. AL noted that the registered nurse fill ratio seemed specific and asked if the Board had been looking at these staff graphs for the previous 6 months, would they have clearly shown that something needed to have been done sooner. AC replied that registered nurses were highlighted as a statutory requirement. He added that other data was also looked at, and this indicated that historically, establishment figures had been taken against our base ward figures, which were then flexed against our bureau staff. This was now being looked at with HR. KF noted that the CQC had been made aware that we had staffing challenges, and have been doing so since before the pandemic. As well as flagging the challenge the CQC had also been kept informed about the steps being taken to address the situation. AB responded to AL, noting that the Charity did have early warning regarding this, however, further steps would be taken to provide the Board with the clearest possible line of sight. SN noted that he was glad to see the targets within the reporting and to hear that there would be further discussions at the Quality & Safety Committee. SN also noted within Patient experience that there were a number of patients ready for next steps. He asked how many exactly were ready for this. KF confirmed that the figures were between 5 and 50 and SK confirmed that regular patient reviews are undertaken with approximately 30 at any one time. SN said he would be looking for successful discharges and KF responded that it was a high number who moved on to a less restrictive environment. EL wanted to know why there were differing dates for differing metrics. She noted that the numbers for mandatory training were good, and asked what the training budget was, noting that if the ratios were so high why are there challenges with record keeping for example. MK replied that training budget was approximately £2m and covered all training not just clinical training. He added that there had not been as much face to face training as a result of		

	Covid. KF added that training was one aspect; random sampling and auditing of all ward areas were also being undertaken, along with random checks of CCTV with robust action being taken accordingly. AB confirmed and also shared his concerns regarding the basics. He noted that it was not a problem just for St Andrew's. He added that the Nursing Strategy focussed on the basics, and that it would be noted within the Quality Plan in order to indicate how targeted training would help. DS noted that quality needed to be factored into the integrated performance report as well as safety. He asked if the dashboard could show this in a clearer way, and where corrective action would need to be taken. PB suggested that more detailed discussions regarding this would be required outside of Board. EL thanked MK for the data regarding training budget which is approximately £500 per person per annum. She asked if a split between enabling functions and nursing could also be seen, and if AB was responsible for the Nursing Strategy would he also be responsible for the nursing training budget. MK confirmed that he had a training budget breakdown which could be shared. KF clarified that responsibility sat operationally with AC, working with AB and SK to ensure that standards were set and met. PB asked for a paper on the charity's training budget and how the impact of training was assessed to be submitted to the People Committee for consideration. PB thanked colleagues for the production of the report The Board **NOTED** the report	**AB, JL & DS** **MK**	**25.11.21** **30.09.21**
OPERATIONS			
9.	**Staffing Action Plan** AB presented the paper which was taken as read, and highlighted where progress was being made and what was planned for the future. The paper set out the key principles of the right staff in the right place at the right time. It was stressed that it was not just about numbers of staff, but the skill sets required and deployed appropriately. The current model used by the Charity was no longer fit for purpose, and was confusing to everyone. The requirements for NHS Trusts showed that Boards were expected to receive an annual review of staffing and sign off of the establishment. At the beginning of 2021 the Charity moved to new staffing terminology and measures, in-line with the approach widely adopted in the NHS. The charity is adopting the staffing model used by the majority of Mental Health Trusts known as MHOST. Also a new e-rostering tool, Allocate, which is very widely used by NHS Trusts and Mental Health trusts was being adopted. The business case was under development with preparatory work underway to facilitate a swift roll out, division by division. AB was seeking Board agreement that in future the staffing established would be signed off by the Board, with an update to each meeting of the Board. AC presented the draft action plan which drew together all the projects which were being undertaken to address the staffing challenges. AL asked if the actual outcomes could be recorded alongside the actions and proposed outcomes. AC agreed with this addition. RB also suggested the addition of a communications line to the action plan. RB asked if the data would be available which would allow the profiling of sickness absences against other events. With regard to staggered pay progression, RB also asked if all approaches had been considered in order to gain retention of staff. AC responded yes to both questions; data on absences was being triangulated and with regard to pay, AC was working with AO regarding retention payments.	**JL**	**25.11.21**

	SN noted the lack of an objective measure, and asked if dissatisfaction within nursing was being addressed. AB explained that there was an evidence based tool which looked at a range of issues, however, the base establishment was being set using MHOST which would allow visibility of the needs on the day, and would flex and give the planned level of care and planned hours of care per profession per day. SN noted that he was hoping to see how the dissatisfaction of the staff with staffing levels would be dealt with. AB replied that staffing boards outside wards would help as they gave transparency as to what staffing levels were planned. PB noted that People Committee had asked for all the projects be reported in one place to provide a clear line of sight. He noted that The QSC had also discussed the staffing pressures. AB stated that the Safer Staffing report should be presented to QSC, with training and recruitment presented to People Committee. DS agreed that it was important to agree what should be covered within People Committee, with the Safer Staffing Report coming to QSC. PB proposed that the recommendation be agreed to and that all matters be reported to both committees, with the draft Staff Action Plan being presented to both Committees for reporting, progress and assurance purposes. DL asked for clarity on reporting periods. AB confirmed that the two monthly reports would be combined for each bi-monthly Board meeting. DS felt that it was important that the information was dealt with at Committee level first and not at Board. PB noted that given how important HCAs were to the Charity, a lot of this work was going to be directed toward them. He asked that, that part be clearly broken out and shown on the action plan. He also asked how the strategy could be adapted in order to attract HCAs, adding that good reasons to work at St Andrew's needed to be highlighted. PB suggested agreement to each part and noted the involvement of QSC and the People Committee. The Board **APPROVED** the recommendations and **NOTED** the report	**AB** **DECISION**	**25.11.21**
QUALITY			
10.	**Mortality Surveillance Report** SK presented the report which was taken as read, He noted that there had unfortunately been 27 deaths in the past year, which showed how challenging the year had been. He further noted, that there had been no in-patient suicides in the year. PB asked about patient and carer involvement, asking if the Charity should be having conversations with carers and patients with regards to reports such as these. SK replied that we always involve the family when reviewing and reporting a patient death. Furthermore we also engage with the patients on the applicable ward, along with the staff. DS asked if it could be noted on future reports that cases have been discussed on an individual level with patients, carers and staff and added that he thought this was a very good assurance report. PB further added that these reports could be further explored within the BENS group. The Board **APPROVED** and **NOTED** the report	**DECISION**	
PEOPLE			
11.	**Armed Forces Covenant** CV presented the Covenant, which was taken as read and asked the Board to consider the wording of the Covenant. CV explained that this was a pledge that we made to support the armed services both serving and veteran. This would be signed by the CEO and re-visited every 5 years, with some administrative areas which would have to be addressed.		

	SRW asked how many veterans were in the Charity's care. CV replied that there were 350 currently with 8-15 referrals per month. She added that those levels were expected to increase, as the Charity covered East Midlands and East of England. SRW asked if they were all new referrals. CV confirmed that they were. PB commented that some veterans could be re-traumatised bearing in mind the current circumstances in Afghanistan. CV also added that the Charity should identify veteran ambassadors within the organisation and explained that within the current caseload she was starting to see changes in referrals. AO commented that if the Charity was looking at special paid leave, the impact of it would need to be understood. She also asked if there would be a risk if we were found to not be adhering to the principles. CV replied that the Charity would be taken off the register. However, there was an alliance which we could consider being a part of. RB asked if it was known how many staff would need to be released into serving if required. RB noted that she endorsed employing veterans, and the additional opportunities that arose from signing up to this. CV replied that it was not currently known who are veterans within staff, but it would be useful to know. MK added that there were a number of staff, but it was not recorded. AL asked regarding clinical admissions, and if the Covenant would affect these. CV confirmed that admissions would be on clinical need, not just the status of veteran. It was **AGREED** that People Committee would receive a report from MK regarding veterans with the Charity's workforce. The Board **APPROVED** the pledge and **NOTED** the Covenant	**MK** **DECISION**	**25.11.21**
REGULATORY			
12.	**Responsible Officer Regulations – Appraisal and Validation** SK presented the annual report which was taken as read, with all items having been completed. There had been an extension on validations due to Covid-19, and no doctors had been reported to the GMC within the reporting period. SK added that due to timing this report had been presented directly to the Board and will be further discussed at the People Committee. PB reiterated that the overall conclusion highlighted the positive way in which this activity is addressed and how well it is managed within the Charity. The Board **APPROVED** and **NOTED** the report	**DECISION**	
13.	**Caldicott Guardian & Senior Information Risk Owner (SIRO) Annual Report** JC presented the report for the year and noted the transfer of SIRO to SK from JC, to ensure there was no conflict of interest relating to day-to-day activity. He also noted that training numbers had been secured and that the removal of records which the Charity was no longer entitled to keep had been actioned. The Board **APPROVED** and **NOTED** the report	**DECISION**	
14.	**Modern Slavery Act Renewal** MK presented the paper which was taken as read, and noted that it was a requirement for it to be published publicly on the Charity website. The Board **APPROVED** and **NOTED** the paper	**DECISION**	

GOVERNANCE/ASSURANCE			
15.	**NHS PROVIDERS BOARD DEVELOPMENT PROGRAMME** Ann Utley (AU) joined the meeting. KF noted that as part of the Governance Review, a Board development programme had been recommended. NHS Providers had agreed to work with the Board, with this being the first session giving a high level overview. KF also confirmed that booking of development days was being undertaken. AU gave a short presentation outlining who NHS Providers were and an outline of the programme. AU further outlined the pre-work that would be required and then went on to show how the programme would develop over the course of 5 workshops. AL commented that the 5 workshops concentrated on skills and processes and noted that one thing that was crucial in order to do that effectively was to understand the person. He asked where understanding each other as people was built into the programme, as this could build trust within the team. AO asked if the workshops would be in person as this would be preferable. AL agreed, with PB endorsing the approach and DL confirmed that he had had prospective dates for workshops sent through. Initially they will be held virtually, moving to face to face when possible. PB noted the positivity within the Board regarding the programme and whilst there would be significant change across the Charity in terms of strategy and governance working through this programme would be very helpful. AU confirmed that the workshops would cover off exercises to get to know each other. AB had a MBTI question. He had done it previously, but found it difficult to remember and asked if there was a simpler model that could be used. AU confirmed that the first workshop highlighted where the MBTI preferences were in the room. PB extended the Board's thanks, and looked forward to the workshops.		
16.	**Sub Committee Updates** **Quality Safety Committee** DS highlighted that workforce issues and reporting lines had been discussed, and the Quality Account had been approved and submitted. One other area to highlight was the support being needed from IT for Community Services over patient records. The CQC inspection was also discussed. PB asked if the escalation points regarding Community Partnerships from the August meeting would be updated to Board. DS confirmed that an update would be presented to Board and that QSC would take responsibility for that item. SK confirmed that work was progressing in this regard. The Board **NOTED** the update **Pension Trustees** MK noted that the move to fiduciary management was going well. AL asked what was being hedged. SRW confirmed it was the hedging of interest and inflation rates. The Board **NOTED** the update **Audit & Risk Committee** EL highlighted the page turning session for the Annual Report, and noted the risk management portion of the meeting. She updated the Board that approval of the accounts had been postponed.	**DS & SK**	**25.11.21**

	The Board **NOTED** the update **Research Committee** SN commented that the work of the Committee was largely operational at this stage, with the key focus being the strategy which would be presented to CEC the following day. Further work on the strategy would progress after that meeting. AL asked if the Research Strategy needed to be independent of the Charity Strategy. SN noted that it needed to be integrated. The Board **NOTED** the update **People Committee** PB updated that the Committee had noted the staffing issues. The Board **NOTED** the update		
ANY OTHER BUSINESS			
17.	**Questions from the Public for the Board** No questions were received for the Board.		
18.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
19.	**Date of Next Meeting :** Board of Directors, Meeting in Public – 30 September 2021		

Approved – 30 September 2021

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

St Andrew's Healthcare Board of Directors MEETING IN PUBLIC Session Action List:

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
26.11.20 **01**	**Board Seminars** PB advised that he will explore the role of Board seminars as a means by which the Board can regularly discuss the strategic aspects of the Charity's work. PB will look to schedule these into the annual cycle of meetings in the New Year.	PB	25.03.21	Open	**Ongoing** - The role of seminars will be considered in the light of the governance review. Additional dates are being added to calendars for future board strategy sessions.
28.01.21 **06**	**Community Services** Following discussions on the CTS service the Board requested to have more information about the community services and for this to form part of the Board development sessions or the working plan, which will assist the Board in shaping a programme that will genuinely reflect and balance what we do.	JL & DL	27.05.21	Open	**Ongoing:** Community Services are reviewing their portfolio and future development plans. An opportunity to share the more detailed work of the service will take place at the September 2021 and March 2022 Board meetings, along with the plans for the expansion of the service in line with current strategic priorities. This will be factored into the Board forward agenda and dates are being agreed between the CoSec and service
27.05.21 **01**	**East Midlands Alliance** EL noted that it was good to see St Andrew's in the same forum with NHS providers and wondered if it would be beneficial to have a workshop for Board members in order to know more about partners. KF replied that she would be happy to support this. JL agreed that he would be happy to do a wider oversight of the different partners. JL took the ACTION to organise this session with PB and DL.	JL	30.09.21	Open	**24/08:** Workshops now underway across the alliance and single paper setting out the salient details of each partner is also in development. **30/09:** A joint paper has been proposed with partners to provide a summary of each of the organisations. This has been completed by some but not all of the partners and will be circulated to the board as soon as this is finalised.

27.05.21 **02**	**NHS Benchmarking Network** NHS Benchmarking have offered to present to QSC (and Board if required). PB noted the timescales involved and suggested a Board seminar session to look at the results so that we can spend more time than in a normal Board meeting. AB suggested that the timescales could be closer to the end of the year.	DL	25.11.21	Open	
27.05.21 **04**	**Data Security – Performance Report** AL requested a one-pager on Data Security be submitted to the Board on a regular basis. JC suggested to report quarterly with a performance report by including additions to existing reporting that was undertaken. A report had been included within the counter-fraud update to ARC and that something similar would be suitable for Board. PB added that it would be good to include this within the existing Performance Report so that additional work could be avoided.	JC	30.09.21	Open	**30/09:** The initial Information Security Metrics paper is included as agenda item 13.
24.08.21 **01**	**Lessons Learned and Transformation Programme update** (merger of actions 28.01.21 **01** and 25.03.21 **02**) Following the Mansfield closure and relocation of patients the Board is seeking assurance that lessons are learned across the Charity and lines of sight on this are to be maintained by the Quality Safety Committee (QSC) for future reporting to the Board. In addition, review and measurement of the impact of the Transformation Programme, based upon what is aimed to be achieved, is to be considered by the Quality & Safety Committee.	DS/AB & JL	25.11.21	Open	
24.08.21 **02**	**Integrated Performance Report - Quality** DS noted that quality needed to be factored into the integrated performance report as well as safety. He asked if the dashboard could show this in a clearer way, and where corrective action would need to be taken. PB suggested that more detailed discussions regarding this would be required outside of Board.	AB, JL & DS	25.11.21	Open	

24.08.21 **03**	**Integrated Performance Report – Training budgets** MK confirmed that he had a training budget breakdown which could be shared with the Board. PB asked for a paper on the charity's training budget and how the impact of training was assessed to be submitted to the People Committee for consideration.	MK	30.09.21	Open	**30/09:**
24.08.21 **04**	**Staffing action plan - Outcomes** AL asked if the actual outcomes could be recorded alongside the actions and proposed outcomes on the new Staffing Action Plan. RB also requested a communications line be added to the action plan	JL	25.11.21	Open	
24.08.21 **05**	**Safe Staffing Report – Committee oversight** It was agreed that the new Safe Staffing report would be presented to both the Quality & Safety Committee and the People Committee for reporting, progress and assurance purposes ahead of submission to the Board.	AB	25.11.21	Open	
24.08.21 **06**	**Armed Forces Covenant – People Committee Veterans Report** It was agreed that People Committee would receive a report from MK regarding veterans with the Charity's workforce.	MK	25.11.21	Open	
24.08.21 **07**	**Quality & Safety Committee – Community Partnership update** DS confirmed that the QSC would maintain oversight of the Community Partnerships IT issues and an update would be presented to Board.	DS & SK	25.11.21	Open	

Chair Update

(Paul Burstow – Verbal)

CEO Update

(Katie Fisher – Verbal)

Paper for Board of Directors	
Topic	2021-26 Board Strategy Outline & Objectives
Date of meeting	Thursday, 30 September 2021
Agenda item	**8**
Author	Edward Short, Head of Strategic Partnerships
Responsible Executive	Jess Lievesley, Deputy CEO
Discussed at previous Board meeting	Board Development Day July 2021
Patient and carer involvement	Engagement with service users and carers has commenced and will form part of wider implementation and delivery plans one approved by the Board.
Staff involvement	Engagement with colleagues across the Charity has commenced, both via senior leadership forums and also via planned engagement events. Further involvement will take place once strategy is approved by the Board.
Report purpose	Review and comment ☐ Information ☐ Decision or Approval ☒
Key Lines Of Enquiry:	**S ☒ E ☒ C ☒ R ☒ W ☒**
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☒ Innovation and Research ☒
Committee meetings where this item has been considered	This item has been considered in detail by the Board and extensively by the Charity Executive Committee prior to coming to the Board.

Report summary and key points to note

Having considered our future strategic intent as a board through the first half of 2021 and following wider engagement across the Charity, this paper sets out the further progression of our 2021-26 Charity Strategy, setting out the basis for the strategic objectives and outline for achieving these over the life time of the Strategy

Building on the work initially undertaken in partnership with EY consulting, developed through the subsequent Board meetings and workshops, the Board arrived at a clear central purpose for the Charity

with seven associated strategic priorities. With these priorities, underpinned by our guiding principles and key enablers, our Strategy sets a clear vision for the next five years of the organisation and beyond.

Each priority area has been assigned an Executive owner who have sought to further shape and develop their plans to ensure alignment between the Boards thinking, the guiding principles and the key enablers that ultimately will facilitate the delivery of our strategic ambitions. These plans will be considered by the appropriate sub committees and Board in accordance with the framework set out in slides 26-28.

This paper sets out this next phase of work to seek the wider Board's approval for the planned direction of travel in each of the strategic priority areas. The paper sets out those indicative levels of investment where these are identified and also clearly signals the rigour that will be in place to underpin any further investment in each of the priority areas, baking in Board level approvals and the production of business cases to support such plans in accordance with the investment framework previously agreed.

With the approval of the Board, each strategic priority executive owner will further progress the detailed implementation plans and business cases that will be required to facilitate the plans, including setting out the KPIs and phasing of the plans, ensuring delivery is achievable within the financial and operational bandwidth we have available.

Importantly, for the Board's consideration this plan sets out the prioritisation timetable across the five years of the strategy, recognising that not all will be desirable or indeed practical to implement immediately. Indeed the plans highlight a number of potential risks and challenges that will also be captured as part of the reporting, with these along with the KPIs and milestones being reported to the Board via the Board Assurance Framework. The BAF will also provide the Board with an overarching report to ensure the alignment of the strategy as a whole, drawing together the work within each of the seven strategic priority areas.

Recommendations & Considerations

This work along with the wider and more detailed planning assumptions have been considered in detail by the Charity Executive Committee and the Board are asked to;

- Support the vision and Direction of Travel set out for each of the Strategic Priorities
- Consider the level of overall indicative investment required as part of the overall achievability of the strategy
- Consider the prioritisation and phasing matrix
- Agree the reporting and oversight mechanism to the Board is via the BAF

Appendices - None

Our strategy
2021-2026

St Andrew's HEALTHCARE

Our Purpose

Our purpose as an organisation is the bedrock that succinctly outlines why we exist. Our charitable purpose has remained largely unchanged across our 183 year history with only how we express it evolving over time

To make explicit what is an implicit element of our 'why', our purpose will now read:

"A **charity** that promotes **wellbeing**, gives **hope** and enables **recovery**"

The 'how' we deliver our purpose will be determined by the expressed, observed and anticipated needs of people alongside the best available technologies, therapies and thinking

A significant element of healthcare are **preventative** interventions and as we move forward, the Charity will seek to ensure that prevention has a prominence in the work we do clinically and through our education and research

Our 2026 Vision

In 2026 St. Andrew's Healthcare are helping to change lives through a diverse range of care, support, research and educative services, working with people to achieve outcomes together that enable significant positive change for individuals and groups and that delivers value to those that commission and fund our work.

We have challenged ourselves to deliver our purpose through solutions that enable people to lead meaningful lives in their communities and now the majority of our care and support services are 'out of hospital'; we only deliver inpatient hospital care where it is the most appropriate way to support people and there is a need and desire for it to be delivered in that way.

A core element of all of our services is on prevention: Preventing the onset or decline of a persons condition or limiting any damaging impact it may have on their lives. We are using our knowledge, experience and insights into complex conditions to contribute to prevention at a population health level.

Our research & innovation and educative work has developed and supports preventative and enabling practices and learning opportunities that tackle these challenges with, and for, patients, professionals and the wider population.

We have a reputation for quality, innovation and research that is evident within all of the services that we offer and this helps to attract talent and investment towards the Charity. Our workforce is highly skilled and well trained, reports high levels of satisfaction and wellbeing and are rewarded competitively and through being challenged with interesting and worthwhile work.

We share our expertise, knowledge and insights with others through our collaborations, research publications and our paid for education and training offers.

Through this, St. Andrew's Healthcare are a highly regarded Charity providing leadership and resource in the communities we serve and we have a significant national profile as an organisation that advocates for and amplifies the voices of people with mental ill health, a learning disability or autism.

The work of the Charity is underpinned by a sustainable financial position, harnessing our unique charitable status and intelligent investment of resources that enables the ongoing delivery of our purpose.

The Guiding Principles for everything we do

*Everything we do must be grounded in a commitment to **quality** underpinned by our **CARE Values**, our **people**, and our **expertise***

- Trauma informed
- Least Restrictive
- Reducing Inequalities

- Collaboration & Partnership
- Outward Looking
- Long Term Benefit

- Co-production
- Promotes Prevention

- Quality Improvement
- Expertise
- Value
- Innovation Thinking

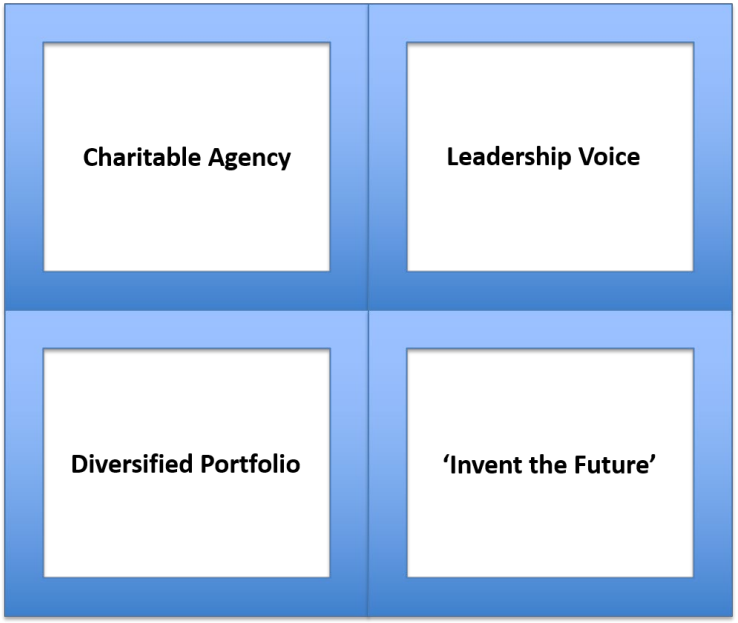
Whenever we develop new or improve existing aspects of the Charity, we must use these guiding principles as our focus and inform our changes

St Andrew's HEALTHCARE

Enabling our Purpose

Our purpose is to be ***a charity that promotes wellbeing, gives hope and enables recovery***. The following are the strategic enablers through which we will deliver that purpose:

- Using our **charitable agency** to challenge, promote and advocate as experts in our field
- A relevant and respected **leadership voice** in mental health and learning disabilities: locally, regionally, nationally, globally
- A **diversified portfolio** of services and income sources centred around the three strategic themes of: Service Innovation, Education & Training and Research & Innovation
- Innovation will be at the heart of our offer of quality care and treatment for mental health, learning disabilities and autism, across all our strategic priorities, charitable agency and our leadership voice: St. Andrew's take responsibility to help co-produce & '**invent the future**' of mental health and learning disabilities care & treatment



St Andrew's HEALTHCARE

Strategic Priorities

Our 7 strategic priorities will provide the focus for the transformational activity that will deliver the 2026 vision

Each priority is owned by an Executive Director who has set out the intent and direction for each area as set out in the following slides

St Andrew's HEALTHCARE

Quality (1)

Executive Lead: Chief Nurse

AIM

Deliver high quality care and recovery outcomes through our quality first ethos

BY WHICH WE MEAN…

A relentless focus on patient and staff safety , experience, and outcomes.

A collaborative approach with our patients to ensure sustained increases in patient reported experience (PREMS)

An evidenced based staffing model that provides the necessary flexibility and autonomy to provide quality care for our patients

We will have systems and processes including quality planning, quality control and quality improvement including risk management that make it easier for staff to work to achieve this shared quality vision

We will have developed to have a culture that is just and focused on continuous improvement and learning, enabling the identification of issues with a willingness and opportunity to innovate and experiment to find the best solutions

Quality (2)

Executive Lead: Chief Nurse

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

We will have an embedded Strategies that the workforce recognise and are engaged with

All of our staff will have the knowledge and skills to support patients and individuals we provide services for and allow them to achieve their full potential

We will have a fully embedded and nationally recognised co-production ethos

We will have Peer Support Workers on 100% of our wards

Key metrics will show sustained improvement in experience and outcomes for all patients and individuals we provide services for

There will be a sustained reduction in the level of harm experienced by patients and staff

We will have embedded initiatives that are aligned with the NHS and worked in collaboration with our NHS partners to make Quality changes and be fully involved in Quality systems

We will have achieved recognised Continuous Quality Improvement (CQI) accreditation and will have a functional faculty supporting the Charity and other providers with CQI

We will have National recognition for the quality of care and services delivered by Charity including Patient Safety, IPC, and physical health (Regulatory ratings, national awards, representation on national bodies, education opportunities)

StAH will be seen as a market leader in providing education and guidance to other providers including the NHS

Service Innovation (1)

Executive Lead: Executive Medical Director

AIM

To provide a range of care, support and treatment solutions that deliver the Charity's purpose and that meet the expressed, observed and anticipated future needs in the population from outcomes, experience and value perspectives.

BY WHICH WE MEAN…

In 2026 we will be continually innovating and evolving all existing service propositions to improve the outcomes and experience of those that use the services and to ensure value for those that commission and fund them. Every service will have an annual service development and innovation plan driving this, underpinned by Continuous Quality Improvement approaches and the work of our Research & Innovation Centre.

We will have identified and developed multiple new service opportunities that are meeting an identifiable need, primarily in 'out of hospital' settings. We will seek to reduce the inpatient provision for individuals with Learning Disability and Autism and will provide a niche service for those patients detained under criminal provisions of the MHA or present with forensic risk to others. We will provide community based services for individuals with Learning Disability and Autism aligned to the national agenda for Transforming Care.

Our services will either be complementing existing provisions (in a local, regional or national system), adding value as an alternate solution or offering truly 'new' and innovative approaches to solving problems for individuals, organisations, health and care systems or society.

We will have used our expertise, knowledge and experience in Dialectical Behavioural Therapy (DBT) and Trauma Informed care to become a national exemplar for these approaches across multiple service offerings including inpatient, community, digital health and training & education.

(continued)

Service Innovation (2)

Executive Lead: Executive Medical Director

We will have built on the Community Partnerships service offers, offering existing flagship services to new customers and, through responding to stated need (tenders and partnerships) and service design (prospective development), we will be offering additional solutions to existing and new customers. As part of this expansion of Community Partnerships we will have:

- Created a national network of accessible outpatient mental health services
- Developed a nationally recognised assessment centre / approach for neurodevelopmental disorders
- Developed approaches to agile and rapid mobilisation that can respond to emergent and changing needs in both geographies local to and beyond our traditional inpatient bases
- Doubled turnover to £10m

In addition to the Community Partnerships expansion, we will have explored and be delivering services that fall into the following categories; these will have also evolved either in response to tenders, partnership requirements or as prospective service developments:

- Accommodation based community services:
  - Complex social care
  - Specialist LDA and MH packages for complex needs
  - Step down accommodation & support
- Specialist addiction services (e.g. gambling, social media etc.)
- Digital health & wellbeing services
- Technology / Analytics / Artificial Intelligence prevention and management solutions
- Consultancy
- Patient transportation
- Workforce solutions (e.g. agency staffing)

We will be delivering services both ‘standalone’ as well as in partnership or collaboration with others. Where we were unable to grow the capabilities and capacities needed, we will have gained them through our collaborations, joint ventures or acquisitions. Gained capabilities will have been diffused throughout the Charity. We will have utilised our Research & Innovation work to have supported and been an initiator of our Service Innovations.

Service Innovation (3)

Executive Lead: Executive Medical Director

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

The diversity of our service portfolio can be counted and observed: there are a far greater number of services than in 2021 and our services directory and website visibly evidence that

Service utilisation will be at forecast levels with ‘visible’ ongoing demand

We will be able to see a causal link between our service innovations and the desired benefits in systems (e.g. prevention / reduction of harm, reduction in inpatient usage and length of stay etc.)

Customers, service users, carers and other stakeholders report high levels of satisfaction with the services

Regulators (CQC and others) will assess that our services are high quality and high performing

We will have won awards (HSJ etc.), achieved accreditations and can observe other external validation (journal articles etc.) for the design, delivery and outcomes of individual services

We have achieved or exceeded the target for doubling Community Partnerships turnover

As a result of the diversification of our service offers, our funding streams will also be diverse: Government grants, NHS, Local Authority, Department for Education, Ministry of Justice, self funding etc.

St Andrew's HEALTHCARE

Research & Innovation (1)

Executive Lead: Deputy Chief Executive Officer

AIM

STAH's Research & Innovation will support the delivery of our strategic aims in a highly visible, reputation enhancing and financially sustainable way

Research & Innovation will become a far greater focus of the Charity's work & profile by 2026

BY WHICH WE MEAN…

In 2026 all functions within the Charity will have a 'Research & Innovation' mindset, with staff encouraged and enabled to conduct or consume relevant research and innovate clinical and operational practices, including testing new treatments, therapies and interventions and informing our service innovation endeavours.

We will have multiple partnerships across academia and industry, including joint academic posts, expanding and diversifying our research portfolio and visibility in the research space. We will be the location of choice for researchers to conduct their work and our positive research and innovation culture will support the recruitment, development and retention of talented individuals across the Charity.

The impact and value of these activities for patients and stakeholders alike will be clearly evidenced and, in combination with publications in respected journals and presentations at national and international fora, will support an enhanced reputation of St. Andrew's as a centre of world leading research and innovation.

All of our core research activities will be sustainably funded through a robust financial model built on long-term incomes streams whilst the required culture of Research & Innovation will be supported through a diverse range of learning and development opportunities across both the Research and Education and Training functions.

Research & Innovation (2)

Executive Lead: Deputy Chief Executive Officer

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

- We will have multiple partnerships in the development of joint posts, thus expanding our charity portfolio as well as developing our reputation as an academic research institution inventing the future:
- The Charity will be carrying out high-quality research as evidenced in peer-reviewed publications and presentations at national and international meetings
- Our academics in joint posts will participate in NIHR-funded clinical studies in collaboration with key players in the mental health research field.
- We will be funding our projects entirely though NIHR funding, external grants and donations allowing research and innovation to become self sustaining.
- High quality research insights and innovations in our clinical services will translate into a measurable impact on patient recovery.

St Andrew's HEALTHCARE

Education & Training (1)

Executive Lead: Executive Director of Human Resources

AIM

An established major player in providing education and training in mental wellbeing and leadership, providing patients and staff at StAH and beyond the opportunities to learn, achieve and maximise their potential

- Establish StAH as the premier mental health and learning disabilities education and training organisation
- Education & Training income to represent a significant % of the overall work of the charity by 2026

BY WHICH WE MEAN…

That every patient will have the opportunity to access education - we help them to gain qualifications and work experience and support them to cope with the demands of life in the community

We will transform and maximise the potential and enhance the wellbeing of our staff

We will advance education, training and development in the causes and treatment of mental disorder

We will generate a revenue stream to fund our investment in the education of patients, carers and the community

We will provide community based education where others can't

St Andrew's HEALTHCARE

Education & Training (2)

Executive Lead: Executive Director of Human Resources

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

In the Academic Centre: we will have achieved £2m income from tariffs and grants, placements for 600 students, expanded ASPIRE into the community and developed and run MSc and Diploma programmes with Buckingham University

For our staff: we will expand our Apprenticeships and develop new roles / skills and competencies to ensure the workforce is fit for the future

Externally: we will have acquired an L&D company by 2026. We will have expanded our apprenticeships to employers within the East Midlands generating a target revenue of £5M

In the community: we will run 1 school for young people with ASD / LD by 2026. Lightbulb, our MH School's Quality Mark will be expanded to 300 schools by 2026 and will be providing nurse scholarships

Our REDS Recovery College will be a centre of excellence offering opportunities to StAH and the wider community

We will run 4 trauma conferences per year and run 10 post graduate course

St Andrew's HEALTHCARE

Partnerships & Promotion (1)

Executive Lead: Deputy Chief Executive Officer

AIM

StAH is repositioned as an anchor institution and valued local asset in all populations we serve

BY WHICH WE MEAN…

In 2026 we will be using our assets – financial, physical – and capabilities to serve the citizens of the populations that we operate in, not only delivering relevant services and advocacy for people but supporting the wider wellbeing through contributions to local employment, education and knowledge development and environmental sustainability.

In our primary locations our relationship with the local 'systems' and people will be aligned. We will be seen as valued, respected and relevant partners with a trusted reputation for the work we do and the way in which we go about achieving our purpose.

- We will be a 'partner of choice' for local statutory agencies and other parties (3rd sector, private etc.)
- Our inpatient services will serve local / regional populations as their first priority
- The partners we work with will grow as we seek to diversify the portfolio of the work we do,
- Partnerships will support the achievement of our strategic priorities of Service Innovation, Research & Innovation and Education & Training
- We will be amplifying the campaigning voices of those we serve

St Andrew's HEALTHCARE

Partnerships & Promotion (2)

Executive Lead: Deputy Chief Executive Officer

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

We will be primary partners in all relevant regional Secure Care Provider Collaboratives

We will be partners in relevant local mental health collaborative (ICS's)

We will be able to demonstrate a numerical increase in the numbers of partners we are working with

Stakeholder dashboard:

- Stakeholder feedback will be in line with targets set following baseline assessment and annual review
- We will be measuring the reach of our leadership voice (campaigns) achieving pre-determined targets
- Organisational recognition / awareness of StAH as a Charity will be in line with targets set following baseline assessment
- Reputational feedback will be in line with targets set following baseline assessment

St Andrew's HEALTHCARE

Finance & Sustainability (1)

Executive Lead: Chief Finance Officer

AIM

Charitable and strategic aims are delivered through a values driven financial culture where income exceeds expenditure to enable the reinvestment the care and services we provide

Generate sufficient surplus to be invested in Research, Innovation and Services, all without the need of any cashflow funding. Sustaining this position to support and assist the achievement of all other elements of the strategy

BY WHICH WE MEAN…

We will generate sufficient cash to remove the need for any credit facility for BAU services (both operationally and to fund growth, innovation and diversification). We will have financial strength to source specific funding (all working capital and start up requirements) to allow investment in Charity strategic aims (each would be considered on a ROI basis to secure external funding/investment as required)

Standalone business units (inpatient/community services/education/ adjacent market new business) which each generate sufficient surplus and can be re-invested both at a service level and to support Charity-wide projects

Achieving a blended portfolio of services within each business unit of new/established/mature services to provide financial sustainability for each business unit and overall Charity

Every year achieving a % year on year efficiency saving (reducing operating costs)

Ongoing investment plans for IT/Estates/H&S to ensure maintenance of Charity critical assets on a cyclical program

Developed Partnerships and sector/service expertise to allow services used internally within St Andrews to generate revenue externally. This will be across Enabling Functions (move to generating income for services) and operations (selling expertise/knowledge to other organisation)

Robust and probability weighted new business pipeline with annual new business targets for both revenue and contribution (covering multiple future years) achieving sustainability for future services

Research & Innovation opportunities supported by funds obtained by Fundraising and Donations and also by any available Commissioner funding/grants/national resources (ensure the Charity has full access to all forms of funding opportunities)

The Charity achieves its carbon neutral, environmental and ecological targets to support a wider scope of sustainability

Finance & Sustainability (2)

Executive Lead: Chief Finance Officer

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

We are generating surplus at a business unit and total Charity level as set in the annual Charity forecast cycle

We have sufficient cash to remove all banking facilities and enable investment in innovation and strategy (growth/diversification/research). Also with ability to source additional funding (i.e. M&A requirements) subject to robust ROI

The Charity assets are fit for purpose and in a good state of repair, with a cyclical period of refresh and investment

We will have achieved diversified and balanced revenue streams and not reliant on purely NHS funding

We will be able to pay our people appropriate competitive market leading salaries

St Andrew's HEALTHCARE

Adapting Post Pandemic (1)

Executive Lead: Chief Information Officer

AIM

To be an organisation that focusses on the well-being and creativity of its staff and supportive eco-system to deliver an adaptive and resilient organisation and system capable of responding rapidly to new opportunities or threats

- Use the Covid-19 pandemic as an inflection point for new ways of operating
- Support service users, families, colleagues and wider system in post Covid-19 restoration & recovery
- Develop the workforce of the future

BY WHICH WE MEAN…

In 2026 we will be recognised as a leading organisation through the well-being of our staff, connected to our communities as well as being a learning organisation with clear mechanisms for ensuring we are prepared for any future issues

We will be able to demonstrate how we have harnessed the skills and experiences demonstrated through the Covid-19 pandemic and any future learning as an inflection point for new ways of operating

Our organisational culture (“the way we do things round here”) will have evolved out of the pandemic learning and will reflect tangibly and intangibly our values and beliefs about our charitable agency; innovation and creativity; agility; a Just Culture; as well as our CARE values and Guiding Principles

We will have created (and be realising the benefits of) both new types of roles that are delivering care and support to people as well as having inspired and encouraged more people to undertake training in traditional clinical roles

Adapting Post Pandemic (2)

Executive Lead: Chief Information Officer

WE WILL KNOW WE HAVE ACHIEVED THIS BECAUSE…

Achieving upper decile performance with recognised industry benchmarks for well-being, agility/adaptability, vision and preparedness

Identification of new ways of working is embedded in the organisation

Positive feedback from stakeholders around our placement on these activities

All long-term stakeholders (staff, service users, partners etc.) will be able to describe what is different in the way that people think and behave and how the Charity itself operates in 2026 compared to 2021

There will be different types of roles (accredited and non-accredited) that the Charity has recruited to alongside a pipeline of ‘clinicians in training’ for more traditional roles

St Andrew's HEALTHCARE

How will we get there? (1)

In summary

- Each Executive owner will create an annual implementation plan, setting out the key goals / deliverables for each priority; this will be a co-productive activity that supports engagement and strategy adoption
- The Charity Executive Committee will oversee the annual implementation plans, ensuring congruence between the priority areas and conformance to the Charity purpose, vision and values; plans will be presented to the Board once finalised
- In year 'course corrections' will be managed by the Charity Executive Committee with escalation to the Board where there is a material change signalled
- The Board Assurance Framework and Committee Structure will provide assurance to the Board around progress and risk etc. The Charity Executive Committee will have monthly oversight of progress and appropriate governance structures will be established beneath CEC level to oversee and manage the detailed work
- Indicative investment requirements have been outlined; further investment requirements are likely to emerge as the strategy is implemented. Every investment request will be subject to a strategic case and full business case and will be approved at the appropriate level in line with the scheme of delegation
- Strategy adoption will occur through engagement and planning activities as well as a structured programme of communications led by the Senior Leadership Team to provide visible and formal leadership and the cascade through the organisation

How will we get there? (2)

Following Board approval of the strategy, the next phase of our implementation plan is enabled to support full strategy adoption across the Charity

Successful achievement of the vision set out, will occur through everyone across the Charity embracing that vision and aligning their efforts to working towards it

We recognise this will not happen by chance. It will require a conscious effort which will be driven through intelligent engagement in both the detailed planning activities for each priority area as well as through a programme of communications that help bring the overall strategy vision to life

Our Executive & Senior Leadership Team will provide the visible and formal leadership around these communications and will also lead the cascade through the organisational hierarchy ensuring it has full reach in breadth and depth

Adoption

Each strategic priority owner will work with the relevant stakeholders (staff, service users, external partners etc.) to further develop and finalise their plans to achieve their strategic responsibilities.

These plans will be presented to the Board and refreshed annually as strategy adoption progresses

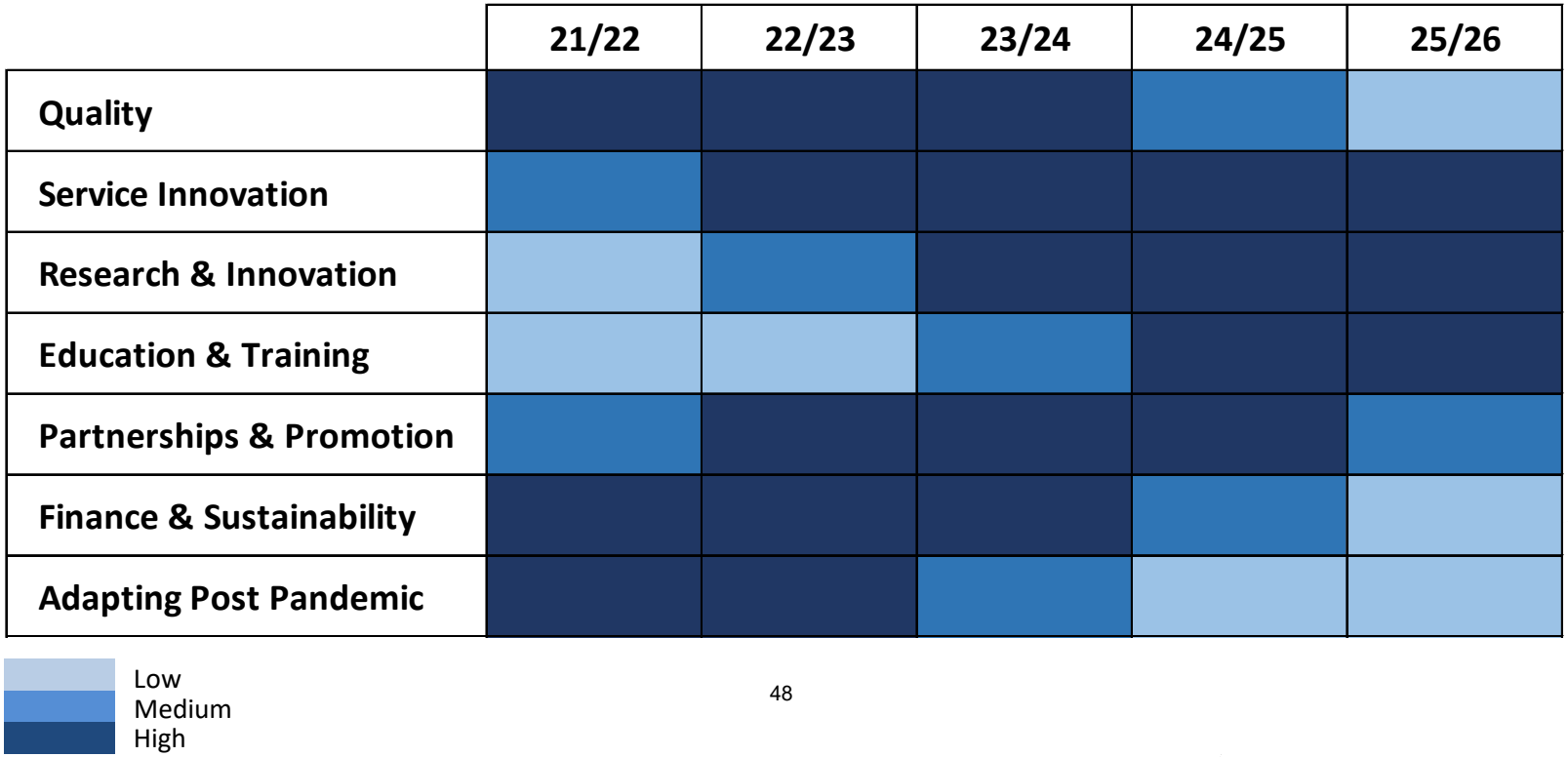
Strategic Priority owners have already prospectively commenced this activity and have begun to build their detailed 2021/22 plans

The Charity Executive Committee will ensure that there is congruence between the seven individual strategic priority plans, that they have conformance to the Charity purpose and values and in combination aggregate towards achieving the overall vision

Indicative Annual Focus

Recognising the ambitious nature of our strategy the following provides an indication of the focus that each priority area will need in the 5 year strategy timescale to enable a phasing that does not overwhelm our capacity to deliver

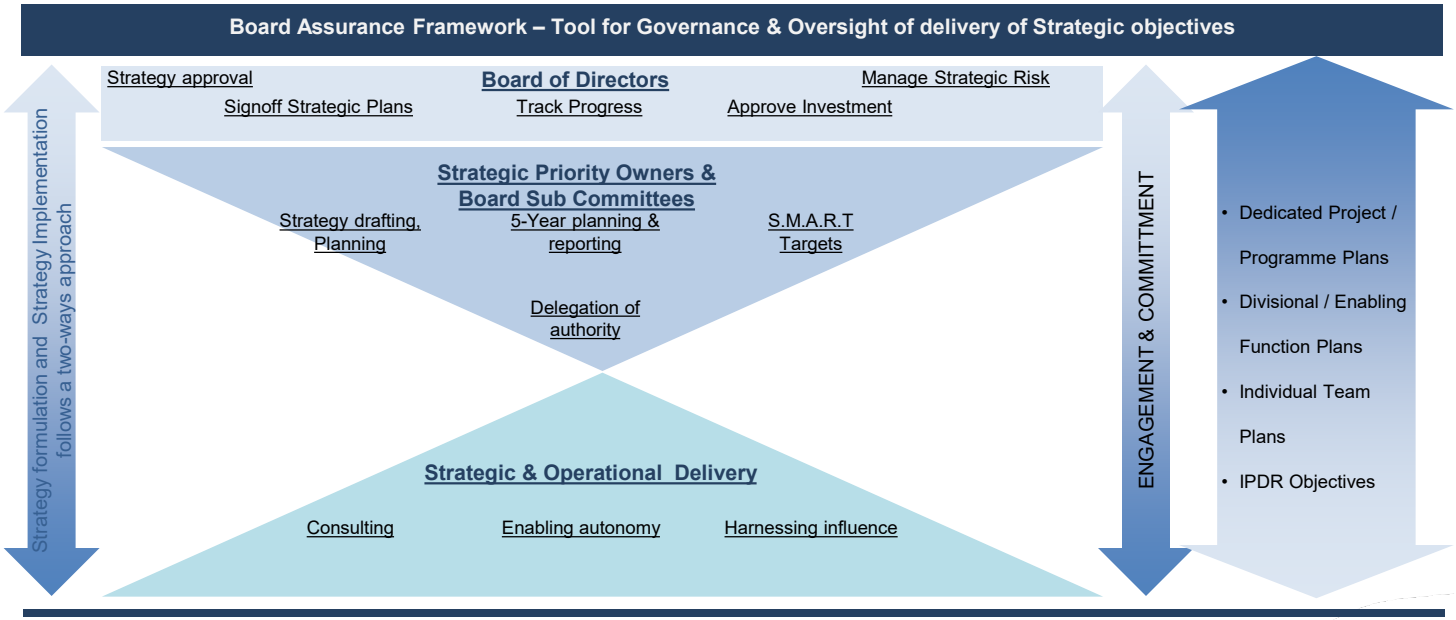
Each priority will have its own development cadence moving from foundational activities through to mature approaches (Darker denotes greater focus)



Strategy Governance – Our Approach, RACI and BAF (1)

Governance

The governance approach for the strategy will be based on a three part model that recognises the differing levels of authority, approval and adoption across the organisation. Broadly this can be depicted as represented below. The key link between adoption and governance is in the planning that develops the strategic plans to deliver the individual strategic priority area's intentions and that aggregate towards the overall strategic vision. The Charity Executive Committee have a critical role in ensuring that there is congruence between the seven individual strategic priority plans, that they have conformance to the Charity purpose and values and *do* aggregate towards the overall vision



Strategy Governance – Our Approach, RACI and BAF (2)

RACI MATRIX

To mitigate for potential failures in the execution of the strategy; we have defined the roles and responsibilities for the Board, CEC and Strategic Priority Owners. This is explicitly in place to avoid diffusion of responsibility and will follow a RACI methodology to support the Governance of the strategy and in line with the EY Governance review, will ensure Board oversight and grip on the development and delivery of the strategy.

RACI MATRIX FOR GOVERNANCE OF OUR STRATEGY				
	Board of Directors	BoD Nominated Sub-Committees	Executive team	Operational teams
Setting the tone at the Top for the strategy implementation	A&R	C	C	
Formulation of the strategy	C&I	A	R	C&I
Review and approval of the New Strategy 2021-2026	A&R	C	I	I
Phased implementation of the New Strategy 2021-26	C&I	A	R	R
Periodic review, monitoring of the progress towards the New Strategy 2021-26	A	R	C	
Periodic reporting of the progress towards the New Strategy 2021-26	C	A	R	
Process establishment	A&R	I	A	R

Legend:
1. R - Responsible: The team member(s) doing the actual work to complete the task.
2. A - Accountable: This person delegates work and is the last one to review the task or deliverable before it's deemed complete. Being Accountable means you must answer for and/or sign off on the deliverable and deal with the consequences if it falls short of goals.
3. C - Consulted: Consulted parties are typically the people who provide input based on either how it will impact their future project work or their domain of expertise on the deliverable itself.
4. I - Informed: These members need to be informed on major developments, rather than roped into the details of every deliverable.

Strategy Governance – Our Approach, RACI and BAF (3)

BOARD ASSURANCE FRAMEWORK

A Board Assurance Framework (BAF) will be used to record the key strategic risks which could prevent the delivery of the organisation's strategic objectives, as well as the key controls and assurances which demonstrate that these risks are effectively managed. The BAF also records actions to address any gaps in controls and assurances so that implementation can be monitored by senior management.

Taking on previous Board direction into account and adapting the principles set out in the EY Governance review, the BAF will:

- Facilitate escalation of risks and controls along with agreed actions requiring visibility and attention by the Board
- Provide an opportunity to identify gaps in assurance that strategic objectives will be achieved, so that they can be addressed in a timely and effective manner
- Strengthen accountability of ownership of controls, actions and assurance
- Consolidate multiple assurance inputs, providing greater oversight of assurance activities for the Board, Audit & Risk Committee and the Charity Executive Committee (CEC).

Explanation of the BAF process

1. Through BAF, the Charity obtains an assurance over whether key risks that could prevent the delivery of the strategic objectives are being effectively managed.
2. Strategic risks will be scored using an agreed methodology in line with the Charity's Risk Management Policy and Procedure.
3. The Audit and Risk Committee (ARC) will review whether the format of the BAF and the way it is drawn up and used (in particular its maintenance and updating) are 'fit for purpose'. The ARC may achieve this by commissioning an annual review of the BAF from Internal Audit (frequency to be determined).
4. Board Committees will review assigned Strategic Risks within the BAF on a regular basis, including oversight of remediation of gaps in controls / assurance that threaten the delivery of the strategic objectives (i.e. by strengthening internal controls, or commissioning internal audits to provide assurance over the internal controls / functions that are critical to the achievement of individual strategic objectives).
5. As the CEC is central to the successful delivery of the Strategy, they will compile the BAF collectively, for consistency of assurance levels and for shared learning on risks, controls and opportunities.
6. The Board will review the BAF each meeting initially and will 'confirm and challenge' the overall assurance rating for each BAF risk as part of this review
7. The Charity's Strategy will be reviewed and updated on an annual basis to ensure that it remains appropriate, with the BAF updated to reflect any changes.

Strategic Risks

STRATEGIC RISKS

Strategic risks are those that are inherent to the delivery of the organisation's strategic objectives, that should not change significantly over time. It is likely to result in c10 – 15 risks being identified and recorded, .

EXAMPLES OF STRATEGY ADOPTION, STRATEGIC AND OPERATIONAL RISKS

Strategy Adoption Risks

The risks directly associated with the adoption / implementation of the strategy and achievement of the vision set out; a cultural and programme management perspective on risk:

- Misalignment with vision
- Stakeholder pressure
- Resource constraints
- Individual Strategic Priority risks

Strategic Risks

The (largely) external uncertainties that can bring about harmful impacts but equally present opportunity in relation to achieving the strategic ambitions

- Demand
- New services
- Competition
- Workforce
- Technology
- Reputation
- Mergers & Acquisitions
- Senior Management Turnover

Operational Risks

The critical Business As Usual risks that may have a 'knock on' effect on the achieving the ambitions of the Strategy:

- Quality
- Workforce / morale
- Finances
- Speed & clarity of decision making

Indicative 5 year Investment Requirements

(all new specific service developments will be subject to a separate business case for investment beyond this amount)

Strategic Priority	Investment Requirement	Notes
Quality	£2.3M	Funded from Charity Resources
Service Innovation	£2.1M New services beyond this will be subject to Business Case	Funded from current resources to double turnover to 10M and includes Business Development Team
Research & Innovation	£1M	Funded from fundraising & development fund
Education & Training	New Income subject to Business Case	
Partnerships & Promotion	-	
Finance & Sustainability	-	
Adapting Post Pandemic	£500K	Focus on staff wellbeing & culture
TOTAL	**£5.5M**	

St Andrew's HEALTHCARE

St Andrew's Strategy on a Page: 2021 - 2026

Our Purpose

A charity that promotes **wellbeing**, gives **hope** and enables **recovery**

Ambitions

1- Deliver recovery & **quality** outcomes for people we support

2 -To co-produce **innovation** delivering new therapies and treatments

3 - To be a recognised **champion** for those we help

4 - To be a **rewarding** and safe place to work

Our Strategic Priorities

- Quality
- Service Innovation
- Research & Innovation
- Education & Training
- Partnerships & Promotion
- Finance & Sustainability
- Adapting Post Pandemic

Our Enablers

- **Our Charitable Status**
- **Promoting our Leadership Voice**
- **Provide a Wider Range of Services**
- **Co-Producing the Future of Care & Support**

CARE VALUES & GUIDING PRINCIPLES

Paper for Board of Directors	
Topic	Ernst & Young – Final Report of Governance and Risk
Date of meeting	Thursday, 30 September 2021
Agenda item	**09**
Author	Duncan Long, Company Secretary
Responsible Executive	Paul Burstow, Charity Chair
Discussed at previous Board meeting	24 August 2021 27 May 2021 25 March 2021
Patient and carer involvement	Not appropriate in this instance
Staff involvement	Discussed with a selection of staff for feedback during the review, via focus groups, surveys and meetings.
Report purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Charity Executive Committee Court of Governors

Report summary and key points to note

Ernst and Young (EY) have concluded their broad and detailed review of Governance and Risk within St Andrew's Healthcare and have summarised their findings and recommendations within the attached final report in line with the previously agreed scope. EY were appointed following a comprehensive procurement process to review the Charity's governance framework, including the arrangements over risk management, providing appropriate recommendations to allow the Charity to clarify, simplify and streamline all aspects of its governance taking account of the complex regulatory environment and commissioning landscape in which the Charity operates.

The attached report outlines the key findings and key recommendations in five overarching areas:

1 – Board effectiveness

2 – Committee structures

3 – Risk and Assurance Framework

4 – Governor effectiveness

5 – Smart Governance

The EY report also includes indicative costs for implementation of its recommendations, along with an indication of on-going operational costs associated with maintaining the expected governance and risk structure and processes. A Board workshop session considered and debated the EY report in draft to inform the final proposals. Our covering report includes an initial summary of costs and resource requirements, along with suggested timelines and oversight processes.

The Board is asked to consider the report and its findings, taking into account the outline of our initial plans for implementation and if in agreement, approve the final EY report and the proposed implementation approach as detailed in the attached paper.

RECOMMENDATIONS

That the Board:

1. Adopt the EY Report proposals as its framework for updating the Charity's governance and risk management arrangements;
2. Approve the programme management arrangements set out in the report;
3. Establish a Governance Oversight Group to oversee the implementation and programme management;
4. Notes that a draft Terms of Reference of the Governance Oversight Group will be considered at the first meeting of the Group and submitted to the Board for approval;
5. Notes the financial implications of implementing the proposed changes and running costs thereafter.

Appendices

Appendix 1 – StAH Governance Review Terms of Reference (November 2020)

Appendix 2 – EY Governance and Risk Review Final Report

Ernst & Young – Final Report of Governance and Risk

Introduction

Ernst and Young (EY) were appointed following a comprehensive procurement process to review the Charity's governance framework, including the arrangements over risk management, providing appropriate recommendations to allow the Charity to clarify, simplify and streamline all aspects of its governance taking account of the complex regulatory environment and commissioning landscape in which the Charity operates. The original terms of reference for the review are attached (appendix 1).

EY have concluded their broad and detailed review of Governance and Risk within St Andrew's Healthcare and have summarised their findings and recommendations within the attached final report in line with the previously agreed scope.

The attached report outlines the key findings and key recommendations in five overarching areas:

1 – Board effectiveness

2 – Committee structures

3 – Risk and Assurance Framework

4 – Governor effectiveness

5 – Smart Governance

The EY report also includes indicative costs for implementation of its recommendations, along with an indication of on-going operational costs associated with maintaining the expected governance and risk structure and processes. Furthermore the report also contains an improvement roadmap, providing and initial and high level timeline for the implementation and embedding of recommendations as well as a suggested phasing of the five overarching recommendation areas.

Implementation

Senior Responsible Officer - The Chief Executive Officer will act as the Senior Responsible Officer and in line with EY's recommendations we have looked to appoint a Programme Director to oversee the implementation and embedding of the Governance Review recommendations.

An existing experienced member of staff, who has held Community Services Programme Director and Interim Hospital Manager posts within the Charity will commence in the role in October if approved, accountable to both the Chair and Chief Executive Officer for the delivery of the Governance Review Project. The individual has a wealth of programme management and major healthcare project experience to the role and the appointment does not result in any additional costs, as there is no need to back-fill their substantive role.

In addition to the programme Director, we would be looking to appoint a small support team to assist in the project implementation. It is still to be determined if these roles will be a new appointment or will be filled by existing employees from within the Charity.

Board Governance Oversight Group – It is proposed to form a specific and time bound Board Governance Oversight Group of up to 5 members to provide oversight and gain assurance on the overall project and implementation of recommendations. This group should include both Non-Executive and Executive Directors and meet outside of the scheduled Board meetings to agree the project timeline, key milestones and performance indicators, reporting to Board on progress and the level of assurance gained in the effective implementation of the recommendations. The group should be chaired by the Chair of the Board. The first meeting of the Group will consider and recommend a Terms of Reference to the Board.

Board colleagues are asked to inform the Chair if they are interested in being part of this oversight group.

Timeline

The Programme Director will maintain and update the agreed project timeline, with regular updates to the Board via the proposed Board Governance Oversight Groups.

It is expected that the overall implementation and embedding of the recommendations is an 18 to 24 month project. This is in keeping with EY's indicative timeline/roadmap. Whilst it is our intention to broadly follow the roadmap laid out by EY, we are planning on a number of alternate approaches:

Risk and Assurance Framework – we propose that the implementation of these recommendations will be covered in a separate and later paper to the Board so that the impact of the recently introduced new Risk Management system and process can be ascertained.

The new Datix risk system and supporting process was being introduced at the time of EY's review and is already incorporating a number of the EY recommendations, such as clarity over risk register responsibilities (individual and at committee level); aggregation of risks and new risk classifications; development of BAF and supporting assurance processes; changes to risk matrix and scoring; risk data cleansing and accessibility of risk information. As such further time is required to assess how the new system embeds and how the EY recommendations can be accommodated within the new risk system, as well as understanding if there are any changes required to the Datix risk architecture in order to effectively implement the EY improvements and recommendations.

The EY report includes 22 specific risk management recommendations and whilst it is recommended that the system and process related ones are reviewed and assessed in context of the new Datix risk process, a number can be readily introduced, such as the introduction of Risk Champions; development of risk appetite; and the integrating of the risk management and assurance governance structures.

Governor effectiveness – in their report EY have suggested that the suite of recommendations relating to the Governor effectiveness could commence in the later stages of the project. We propose that these recommendations are initiated within a similar timescale to those laid out within the Board Effectiveness section so that the overall effectiveness of governance and oversight and links between the Court of Governors and Board is addressed together. This further underpins the commitment to provide effective and holistic governance throughout the Charity.

The Chair has been in discussions with members of the Court of Governors and it is proposed that the 15th October which had been scheduled for the Charity AGM is repurposed as a development day for both the Court and Board.

Indicative Costs

The EY report includes a number of indicative cost options for the implementation of recommendations, along with an indication of on-going operational costs associated with maintaining the expected governance and risk structure and processes. EY have provided a low to high range of the expected costs for Transformation and On-going Operational costs. We are currently reviewing the level of internal resource that is both required to successfully implement the recommendations, as well as maintain the revised governance processes and practices, comparing available resource to what has been suggested by EY.

An initial study has been completed on the administration and management time currently spent on the Court of Governors, Board of Directors, as well as the key Board and Executive Committees and Groups and an initial indication of these ongoing costs will be covered in a separate paper for the Board.

Conclusion

The Final EY report provides the Charity with a comprehensive action plan and roadmap that outlines what is needed and when, to implement and maintain the necessary governance and risk management processes.

The Board is asked to consider the report and its findings, considering the outline of our initial plans for implementation and if in agreement, approve the final EY report and the proposed implementation approach as outlined in this paper.

RECOMMENDATIONS

That the Board

1. Adopt the EY Report proposals as its framework for updating the Charity's governance and risk management arrangements;
2. Approve the programme management arrangements set out in the report;
3. Establish a Governance Oversight Group to oversee the implementation and programme management;
4. Notes that a draft Terms of Reference of the Governance Oversight Group will be considered at the first meeting of the Group and submitted to the Board for approval;
5. Notes the financial implications of implementing the proposed changes and running costs thereafter.

Appendices:

Appendix 1 – StAH Governance Review Terms of Reference (November 2020)

Appendix 2 – EY Governance and Risk Review Final Report

Terms of Reference for the Charity External Governance Review

Background

In January 2020 the CQC undertook a well-led inspection of St Andrews Healthcare ("the Charity'). The inspection found a number of concerns about the arrangements the Charity had in place to ensure appropriate levels of check, challenge and assurance at the Board.

Since the inspection the Charity has initiated a number of changes to its governance processes. The Charity is also embarked upon a major change programme culturally, commercially and organisationally to equip it to respond to the changing needs and expectations of our patients, carers and our commissioners.

During 2020 the Non-Executive membership of the Board has been refreshed and a new Chair has been appointed.

The Board has concluded that further amendment and adaptation of the current governance arrangements of the Charity will not prove sufficient to support its ambition to become an outstanding provider of recovery orientated specialist mental health services for patients with complex needs. A reset of all aspects of the Charity's governance arrangements will best support the transformation that is required.

Purpose

The Board is seeking an independent, external (the "supplier") provider to support to design and implement a new set of governance arrangements covering its corporate, regulatory and clinical governance responsibilities (the "project").

Sponsors

The project will be sponsored by the Chairman and Chief Executive with support from the Company Secretary.

Scope

The supplier will develop proposals that clarify, simplify and streamline all aspects of governance taking account of the complex regulatory environment and commissioning landscape in which the charity operates.

The proposals should:

1. Enable the Board to discharge its statutory duties, set and oversee strategy and fulfil the Objects of the Charity;
2. Provide the Board with the necessary lines of sight and reporting to ensure follow through on its decisions, to offer timely challenge and be assured on all aspects of the Charity's work and in particular to ensure service quality and safety and financial sustainability;
3. Ensure there is a clear demarcation of responsibilities between the Board and the Executive, including a statement of matters reserved to the Board and those delegated to the Chief Executive and the Executive;
4. Establish the necessary Board Committees to support the Board to ensure that an integrated assessment of the Charity's performance can be presented to the Board;
5. Ensure that the Executive has the appropriate sub-committee and other arrangements such that it can discharge its responsibilities to manage all aspects of the Charity's activities;
6. Ensure that the Board is able to make informed judgements about material risks and has in place a robust set of arrangements for identifying, holding and mitigating risk at every level and is able to set its risk appetite policy accordingly;
7. Provide the Board with an annual business cycle and standardised reporting including the appropriate level and style of information for each layer of the Charity's governance;
8. Ensure that the role of the Court of Governors and its relationship with the Board are clear;
9. Enable Non-Executive Directors and Governors to discharge their respective roles;
10. Provide the Board with a suite of self-assessment tools and training to support the Charity become an 'outstanding' well led organisation;
11. Support the Board and its Directors to model the seven principles of public life in all aspects of the Charity's work.

Method

In developing their proposals the supplier will:

1. Undertake a desk-top assessment of the current governance arrangements to identify those aspects that could be incorporated into the new governance model;
2. Have regard for the findings of the CQC well led inspection and its well led framework;
3. Seek suitable comparator healthcare organisations against which to benchmark its emerging proposals;
4. Interview members of the Board and Court of Governors and such other persons as are necessary to develop and test the new governance model;
5. Consider the order of priority in which the new governance model is implemented and establish a risk register for the change programme including how risks caused by the introduction of a new model are monitored and mitigated.

Output and Reporting

The supplier will present their emerging findings and proposals to the sponsors in the first instance. The supplier's proposals should include

1. An assessment of the current state of the Charity's governance;
2. A clear and accessible description of each element of the new governance model and which aspects of current arrangements are retained;
3. Costed proposals for the management and administrative support necessary for the day to day operation of the new model
4. A costed implementation plan to support the transition from the current to new governance model, including the necessary organisation and Board development programme to embed the new model.

November 2020

St Andrew's Healthcare

Final Report - Review of Governance and Risk

August 2021

Building a better working world

Private and Confidential *31st August 2021*

St Andrew's Healthcare

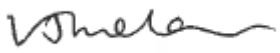
Governance and Risk Review

We have now completed our work and enclose our report of key findings and recommendations in relation to the above mentioned project as agreed and detailed in our scope dated April 2021.

We would like to take this opportunity to thank the management and staff of St Andrew's Healthcare that we liaised with during this project for their cooperation and support.

Should you have any questions in relation to this report please do not hesitate to contact a member of the engagement team.

Yours sincerely,



Vicky Whelan
Ernst & Young LLP

Contents

St Andrew's Healthcare

Governance and Risk Review

Audit information

Date of fieldwork:	26th April 2021 – 11th June 2021
Issue date of final report:	31st August 2021

Distribution

To:	Paul Burstow Katie Fisher
Cc:	Board of Trustees

1. Introduction

1. Introduction

1.1 Background and context

As a charity with a long-standing history and a core vision to 'relieve suffering, give hope and promote recovery', you pride yourself in having ambitions to be not only a high-quality local provider for patients and their families, with complex mental health needs, but also a national centre of excellence driving research and education. A key foundation of any high performing organisation is robust integrated governance and risk management arrangements. It is essential to have the right structures in place to enable the Board to direct and oversee the organisation's business, and to assure itself (and governors) it is sighted on the key issues, risks and mitigations.

Since the Charity's Well Led inspection in January 2020, you have responded to some of the recommendations made by the Care Quality Commission (CQC) including appointing a new chair and five non-executive directors, but are clear that you need to go further. You are seeking to transform your governance arrangements through a series of recommendations, bringing both experience and leading practice insight.

1.2 Scope and Approach

EY was appointed to work with you to perform a review of your governance framework, including arrangements for risk management, and to make recommendations of improvement which will allow you to meet the needs of your stakeholders and deliver a leading class governance framework for the charity. Our scope of work included the following areas:

- An assessment and commentary of the Charity's existing governance framework, including arrangements for risk management. This will include assessment of governance and risk management against the Charity's regulatory requirements and in the context of the findings from the recent CQC review.
- Benchmarking of the Charity's Board and Executive governance framework, including architecture, against industry practice and peers (three organisations to be agreed with you). We will also undertake a desk top review of the legal form of three agreed organisations and provide commentary on the potential benefits of these if applied to the Charity.
- Definition of a set of underpinning principles of governance for the Charity from which a revised model of governance can be derived.
- Development of a governance architecture for the organisation alongside a broader set of recommendations for improvement of the governance and risk management frameworks. This will be supported by examples of industry practice in areas highlighted for improvement.
- The development of a prioritised implementation plan for the Charity.

We have delivered our work through a combined team delivering under an integrated approach across two workstreams (Governance and Risk). We undertook a current state assessment involving field work (interviews, documentation review and meeting observation) coupled with specific benchmarking to inform the final improvement road map and supporting outputs.

Specifically, our approach included and was informed by:

- Desktop review (appendix C)
- Interviews, focus groups and committee attendance (appendix B)
- Survey
- Benchmarking (appendix D)
- Observations and feedback

The full scope, limitations and our approach are set out in our Statement of Work. A summary of the scope of work and reference to relevant sections in this report is included at Appendix A.

2. Key Findings

2. Key Findings

2.1 Executive Summary

The review has made a number of positive observations of the charity's governance framework, demonstrating improvement following the CQC's Well Led review in some areas. We also noted a number of ongoing initiatives which are aligned to the findings and recommendations of our work.

However, we have also made a number of observations which must be addressed for the charity to establish effective and efficient governance across the organisation. These findings and the associated recommendations have been identified with reference to Charity's regulatory requirements (specifically in terms of compliance with the Charity's Governance Code), best practice as identified in similar organisations and also with reference to the findings of the CQC's Well Led review.

The detailed findings of our work are outlined in sections 3 to 5. However, this section consolidates the recommendations from our work and sets these out in a prioritised improvement roadmap.

Key recommendations

This review makes a number of key recommendations in support of improved governance and risk management for the Charity, some of which will require significant changes to governance structures and processes currently in place. Our key recommendations include, but are not limited to:

1) Role and effectiveness of Governors – the role of the Governors in holding the Board to account should be significantly strengthened and formally enshrined in the Charity's Articles of Association. However, the role must be clearly demarcated from that of Non-Executive Directors (NEDs) and Governors involvement in the delivery of effective governance at a Board and Executive / tactical level should be limited.
2) Board Effectiveness – a focus is required at Board level to both develop and agree a clear and unequivocal mandate for the Board and for the constituent members of the Board in terms of roles and responsibilities between NEDs and Executive Directors. However, to achieve this the Board as a whole should examine its ways of working with a view to developing a more positive teaming culture and dynamic.
3) Board and Sub-Committee Structures – the Charity's governance structure and associated assurance map should be developed to provide clear demarcation of responsibilities of the Board (assurance) and executive management fora and committees. This should establish clear 'lines of sight' for reporting and assurance flows across the Charity.
4) Board Assurance and Underpinning Assurance Frameworks – the Charity should develop a single articulation of its assurance framework across the Board Assurance Framework (BAF) and all other supporting elements. To do this the Charity should utilise the Five Lines of Assurance model in order to elevate and clarify the role of both the Board and Executive in the management of risk and associated assurances. The Five Lines of Assurance model is set out in summary in appendix I.
5) Risk Appetite – the Board should clearly articulate the Charity's risk appetite as a means to inform the revised BAF and risk-based decision making more broadly. This should be considered in line with the other broader recommendations on risk management included in this report.

We have also made a number of detailed supporting recommendations across both risk management and governance. These recommendations are set out in detail in the body of our report. The following pages set out our findings in summary and also include an articulation of the potential future state governance architecture for the Charity. We also set out in this section a high-level implementation plan, risks and next steps in the Charity's transformation of its governance arrangements.

In developing our recommendations and the associated improvement roadmap, we have focussed on a number of underlying principles for the future state governance model of the Charity which have been developed alongside the Chair and CEO. These principles are set out on page 8.

Section 3 of this report sets out detailed findings in respect of the Charity's governance framework. Section 5 sets out detailed findings in respect of risk management arrangements.

Section 4 outlines a proposed governance structure for the Charity. It aims to address the Charity's governance and risk management needs as they exist today, and will require ongoing review and revision where appropriate.

2. Key Findings

2.2 Board Structure

As part of our review we have considered the current Board structure for its suitability and alignment to the requirements of the Charity's regulators as well as expectations of key stakeholders. We have concluded that the current structure of a Unitary Board is the most appropriate for the Charity. This assessment is aligned to best practice including:

- The UK Corporate Governance Code (2018) requires the existence of a Unitary Board at the head of an organisation. Principle 2G states *'The board should include an appropriate combination of executive and non-executive (and, in particular, independent non-executive) directors, such that no one individual or small group of individuals dominates the board's decision-making. There should be a clear division of responsibilities between the leadership of the board and the executive leadership of the company's business'.* Unitary Boards, accountable for the quality of services, are also a foundational requirement of NHS FT status.
- NHS's Providers 2015 report on Board structures concluded that the Unitary Board model provides a better prospect of good governance than any other model of leadership and direction in the context of being answerable to the people that use the services of a healthcare providers.
- The Charities Governance Code requires that '*The board makes objective decisions about delivering the charity's purposes. It is not unduly influenced by those who may have special or personal interests. This applies whether trustees are elected, nominated, or appointed. Collectively, the board is independent in its decision making'.*

We believe that the current structure meets and aligns to the requirements of all of the above. We also note that the CQC use the Well Led framework, which advocates a Unitary Board.

In line with the considerations above we have recommended no changes to the existing Unitary Board structure.

2.3 Governance Principles

We have worked with the CEO and Chair to agree a set of underlying principles for the revised governance structure which have informed our recommendations, prioritisation and roadmap. These principles have been used as a reference point rather than a checklist and should be developed over time as the Charity embarks and takes forward the transformation of the Governance framework.

1	**Patient driven** – governance will put (puts) patients at the centre and quality at the forefront of our decision making.
2	**Empowered –** governance will (does) encourage and empower colleagues to make decisions in the pursuance of our objectives in a way which they feel supported and assured.
3	**Transparent** – decision making throughout the organisation will be (is) transparent, imparting confidence in the decision-making and management of the charity across all stakeholder groups.
4	**Accountable** – accountability will be (is) at the heart of our governance framework, supported by the Charities articles, policies and procedures.
5	**Fair** – governance will ensure equal treatment across all stakeholder groups promoting equality and diversity of thought in all decisions.
6	**Integrity** – as a charity we will act with integrity when dealing with our patients, partners and colleagues.

We have considered each of these principles in forming the actions and recommendations required to support the delivery of the future state. We have refined these into five priority areas under which we have categorised the key Recommendations which will drive the transformation of the Governance framework. The key Recommendations are set out overleaf as part of the improvement roadmap.

2. Key Findings

2.4 Priority Areas and Recommendations

We have used the principles set out on the previous page to identify five priority areas which can be used to structure and take forward a project to deliver the future state governance model for the Charity. These are intended to set-out the most important areas the Charity should address in the short-term. For each priority area, a list of initial sub-actions is included and referenced to the main findings of our report which sets these out in more detail. These have been reviewed and tested with members of the Charity's executive team and the Chair.

Overarching these specific recommendations the Charity must also take initial steps to form a programme around how the development of Governance will be taken forward. To this end we would recommend:

1) The formation of a timebound committee of the Board to steer the formation and implementation of the governance improvement plan to deliver the change required to improve governance arrangements. This has not been included on Governance structures due to the timebound nature. This should consist of a sub-set of Non-Executive and Executive Directors as well as representation from the Court of Governors. Membership should be a maximum of 7 members.
2) The formation of an overarching business case, endorsed by the Board, setting out the future state and expected outcomes / objectives of the improvement programme. This should include an assessment of capacity and capability to manage and deliver the transformation programme.
3) The formation of a short-term improvement plan focussing on 'quick wins' and improvements.
4) The formation of improvement plans for both governance and risk management to take forward the wider improvement work to reach 'future state'.

A Board Effectiveness	**Recommendations:** **3.2.1 Board Dynamics** - The Board should undertake / engage in a programme of development including team building and effectiveness in order to address issues around dynamics within the team. However, this can ultimately only be successful if other areas of weakness outlined in this report are also considered in the context of how these will assist in building trust and confidence across the Board. **3.2.2 Board Ways of Working** - A Board Code of Conduct should be developed to include clear guidance relating to the expectations on engagement between NEDs and Execs as well as NEDs and operational business areas. Whilst this should not be restrictive it should set expectations on behaviours and protocols around 'ways of working' which should be followed, with ultimate escalation to the Chair as required. **3.2.3 Matters Reserved** - The Board ToR and Matters Reserved should be reviewed with a focus on the roles and responsibilities of the NED vs. Executive. This review should be a pre-requisite of and inform the broader review of ToRs pursuant to recommendations of this report. We have included references to examples of good practice in respect of Matters reserved at appendix K. **3.2.4 Approval of Policy** - The Matters Reserved for the Board should include the approval of all new or amended policies deemed to be material to the delivery of the Charity's aims and objectives. The definition of and taxonomy for 'material' policies should be established by the Board and may include consideration of 'Corporate' vs. 'Operational' policies. However, the Board should have ultimate sign-off on the list of policies which it reserves approval of. The Board may choose to delegate the review of specific policies to its sub-committees as appropriate. The list of policies for which the Board retains approval should be subject to review on an ongoing basis. The policy register should also be reviewed by the Board on at least an annual basis, with a more regular update to the applicable committee regarding policies relating to specific aspects of the Charity's work; for example policy relating to the establishment of an assurance framework should be reviewed by the ARC. **3.2.5 Approval of Enabling Strategies** - In line with the approval of the overarching strategy for the Charity, the Board should retain, through its committees, the approval of material enabling strategies. Similarly to policies above consideration should be given to the taxonomy of strategies for which the Board retain approval.

2. Key Findings

2.4 Priority Areas and Recommendations

B Committee Structures

Recommendations:

3.3.1 Role and Objectives - The role and objectives of the Board's sub-committees as assurance committees should be clarified and strengthened. Operational decision making responsibilities should be removed and membership should be restricted to members of the Board of Directors of the Charity (although others may be invited in attendance). The number of Board sub-committees should be reduced from 10 to 6 in line with the below.

3.3.2 Charity Executive Committee - The Charity Executive Committee should no longer be considered a Board sub-committee. Lines of reporting should be clearly established and differentiated for assurance and management reporting.

3.3.3 People Committee - The **People Committee** remit is unclear and expansive, leading to scope creep and overlap in places. We would recommend the People committee's scope and remit be materially revised to focus on workforce related issues at a Board level.

We recommend that elements of the People Committee scope should be re-distributed to Board committees and elements be reported through the Executive Committee and Chief Executive's report to the Board directly. This includes:

- H&S – Optionality exists for where H&S reports for assurance purposes, this should be discussed further as no consensus exists at a Board or Exec level. We wold recommend a reporting line through QSC or Finance and Performance (alongside estates), however, based on interviews this may require a broader consensus to be reached by the Board.
- Elements of patient and carer engagement currently included in People ToR. The Board away day on 5th July 2021 agreed that the reporting line should be via the QSC, we would support this conclusion.

The ToR should be reviewed and clarified in terms of the remit of the people committee, specifically to ensure a clear demarcation of its responsibilities around workforce and OD issues and not across all 'people' related issues (patient, carers etc.). The membership of the committee should be reduced to NEDs and relevant Executive members, with other relevant stakeholders in attendance.

3.3.4 Audit & Risk Committee (ARC) - The ARC should have no specific functional reporting or assurance reporting line. The ToR of the ARC should be focussed on the provision of broad assurance as well as effective systems of governance, risk management and control. The ARC should also retain its responsibilities in respect of accounting policy and financial reporting. The role of the ARC in terms of financial controls should be clarified in line with 3.3.6.

3.3.5 Quality & Safety Committee - Quality & Safety Committee should be consulted in respect of optionality around H&S. Further steps should be considered in line with 3.10 to streamline and improve effectiveness of meetings.

3.3.6 Finance Committee - We would recommend that the Finance committee should be materially reviewed and its scope and objectives amended as follows:

- Elevate the committee to be an assurance committee, removing tactical monitoring and 2nd LoD oversight functions including the monitoring of financial controls (to be retained within the scope of the ARC as far as is included presently).
- The addition of a formal role in the monitoring of the Charity's performance in key areas of the IPR for which there is a direct financial impact, including occupancy and the use of agency staff.
- The addition of a formal role to provide assurance to Board in respect of estates and facilities strategies and performance.
- The Investment Committee should be retained as a sub-committee of the Finance and Performance Committee.

3.3.7 St Andrew's College - Consideration of St Andrew's College should be made in light of OFSTED findings from their June / July 2021 visit. Whilst the independent standing of the Governing Body is a key consideration, the College exists within a Group structure which is not uncommon for educational institutions. As such a reporting line for assurance and performance purposes through Executive and Board is deemed appropriate and not mutually exclusive with the requirements of OFSTED.

2. Key Findings

2.4 Priority Areas and Recommendations

B **Committee Structures**	**Recommendations:** **3.3.8 Research Committee** – Once a strategy and direction for research has been agreed and approved by the Board, and implementation of the strategy commenced, the Research Committee should be revised to act as a Board assurance committee, with responsibility including the approval and oversight of the Charity's research strategy on an ongoing basis. An Executive sub-group should be established to manage the delivery and operational elements of research for the Charity. **3.3.9 Review of ToRs** - A full and holistic review of ToRs should be undertaken prior to the finalisation of the revised structure to ensure coverage and overlap is aligned. **3.3.10 ToR Document Control Page** - A document control page should be added to all ToRs setting out requirements for review and approval and referral of changes. An example is included at appendix L. **3.3.11 Consistent ToR Structure** - A consistent ToR structure should be adopted across all Board sub-committees.
C **Risk and Assurance Framework**	**Recommendations:** **5.3.1 Risk Champions** - Divisional / functional risk champions should be appointed to support the imbedding of risk at an operational level. This would also facilitate the embedding of risk within organisational culture. A Risk Champion network would consists of Risk Champions, one selected from each division or function, who interact with both the risk team and their respective organisation. **5.4.1 Risk Appetite Framework** - We would recommend the development of a clearly defined and well-documented Risk Appetite Approach / Framework. This could be a standalone document, or be embedded within the updated Risk Strategy. **5.4.2 Risk Appetite Communications** - Refreshed guidance on the use and application of risk appetite should be clearly communicated throughout the organisation. **5.7.1 Board Assurance Framework** – We recommend that the BAF, upon the completion of the upcoming revisions by the relevant stakeholders, be fully communicated and its importance reinforced to stakeholders, to ensure that at its first quarterly review, it is sufficiently embedded and all quarterly updates appropriately made. **5.7.2 Assurance Policy and Strategy** – An accompanying Board assurance policy and strategy should be developed to clearly articulate key assurance activities and to ensure that they are aligned to the core business objectives and strategy of the charity. This policy and strategy should also clearly set out the expectations for how information should flow between the BAF and the other risk registers / elements of the assurance framework. The strategy should also include an articulation of annual / cyclical assurance provided to the Board. Example contents of an integrated assurance manual are included in appendix M. **5.8.1 Assurance Model** - St Andrew's reviews and clarifies its assurance structures as part of its broader governance structure realignment. This assurance model could be based around the 5 Lines of Defence as set out in Appendix J. **5.10.4 Risk Training** - We recommend that a dedicated risk management training programme be implemented throughout the organisation, as well as for new joiners. This should be tailored to the needs of specific ranks, and specifically address the potential knowledge gap between those with clinical and operational backgrounds. **Risk Improvement –** The business case and project plan for project Pegasus should be revisited and updated following consideration of section 5 of the report.

2.4 Priority Areas and Recommendations

D Governor Effectiveness

Recommendations:

3.1.1 Court of Governors in Charity's Article - The Court of Governors should be formally established in the Charity's Articles. The Articles should be updated to clarify the role of the Governors, which should include a clear remit to hold the Board to account on the performance of the Charity in addition to their role at the AGM. Specific legal advice should be sought where necessary.

3.1.2 Chair Performance Assessment - A Lead Governor should be appointed from the Court of Governors – the role of the Lead Governor should be to act as the key point of contact between the Board of Directors and the Court of Governors, the Lead Governor should act as the key liaison to the Board with regards to the improvements and changes outlined in this report / through the improvement plan agreed by Board. The Articles should be updated to provide for this and for the method of selection of the Lead Governor being by a vote of the Governors at the AGM. A term limit should be established for the role.

The Lead Governor should also be responsible for the performance assessment of the Chair in conjunction with the appointment of a Senior Independent Director* who should also support in this role. A formal and repeatable mechanism should be established to support this process with the results of the assessment reported to the Court of Governors as well as the Board. (also see 3.6)

3.1.3 Court of Governors Meetings - The Court of Governors should meet at least once a year in a closed session, without members of the Board (other than the chair) or Executive Directors present, in order to assess the performance of the Board. The outputs from this session should be provided to the Board and a formal action plan established through which any issues can be addressed; this should be monitored on an ongoing basis. The Charity should consider publishing the outcome of these assessments along with actions publicly.

3.1.4 Governor Turnover - A term limit should be established for the role of Governor to encourage turnover in the skills and experience of those in post. Where a Governor wishes to remain engaged by the Charity beyond their term limit, provision should be made for them to be appointed as Honorary Governors for which there should be no maximum in terms or number of posts. This post should be established as a 'friend of the Charity' with no formal governance role. Specific legal advice should be sought where necessary and the Charity's Articles updated as required.

The appointment of Governors should be aligned to the skills and experience required at a given point in time to support delivery of the Charity's aims and objectives as well as the skills and experience required to effectively challenge the Board. The appointment process should also have consideration of diversity of membership, including alignment of the membership to the community served.

Hereditary Governor positions could be retained as Honorary Governors should they / the Charity wish. Additionally, those in hereditary positions could be retained as governors on the basis of the skills and contributions made, but would not pass on the role on standing down.

3.1.5 Independence of Governors - As the role of the Governors is to hold the Board to account, there is a threat to independence from having Governors as members of Committees of the Board; this is exacerbated further by having Governors as members of operational committees. However, it is recognised that Governors possess skills and experience which are of great value to the Board, its committees and to management. The following steps should be considered to allow structured engagement of the Governors without impairment to independence and objectivity:

a) The Charity should establish expert advisory groups to be made up of Governors with specific skills and interests. This could include, for example, Finance and Investments, Clinical Quality, Research, Nominations and Appointments and Governance. Advisory groups should be constituted either at the request of the Charity Board or on a standing basis and act as a source of skills and expertise in areas which the Charity requires guidance.

   However, advisory groups do not make-up a formal part of the governance framework and should not be expected to meet formally to make or support decisions. They should therefore require minimal secretarial support from the Charity in the form of papers and minutes.

b) Governors should not hold membership of any Board or management sub-committee. However, where appropriate Board-Committees should be empowered to request the advice and guidance of an advisory group. This could also include Governors joining meetings of committees 'in attendance' to fulfil a non-voting advisory role.

2.4 Priority Areas and Recommendations

D **Governor Effectiveness (continued)**	**Recommendations (continued):** **3.1.6 Engagement in Appointment of Trustees -** Governors should be engaged in the process for appointment of Trustees in an advisory manner, this could be through the formation of an appropriate advisory group (see 3.1.5). This should have the aim of strengthening the role of Governors in terms of article 11.11.4 'appoint or reappoint Trustees'. **3.1.7 Constituency Roles of Governors -** The mechanism through which Governors' roles in respect of ward visits and the role of constituency Governors should be formally established and supported by the Charity. This should include a clear procedure for the collation, analysis and dissemination of feedback with subsequent feedback through the Court of Governors where relevant. **3.1.8 Reporting to the Court of Governors** - The Charity should align the nature of reporting to the Court of Governors with the formalised role of the Governors. This should include engagement with the Court of Governors as to the adequacy of the information currently provided as well as views on information requirements aligned to roles and responsibilities. This might normally include: ▸ Board / Chair Report ▸ CEO Report ▸ Lead Governor Report ▸ Performance Update (vs. annual / strategic objectives) ▸ Report on significant / material risks or issues ▸ Reports from constituency Governors ▸ Any other business relevant to the activities of the Court of Governors (such as appointments of NEDs)

2. Key Findings

2.4 Priority Areas and Recommendations

E Smart Governance

Recommendations:

3.5.1 Governance 'Drumbeat' and Alignment with Business Cycles - The revised committee structure should be set up alongside a clear sequencing of decisions and assurance required for the Board and its committees. Additionally, the sequencing and frequency of meetings should accommodate the alignment of sub-committees to the Board cycle. This could include, for example:

- Key points in the business cycle such as approval of budgets and business plans;
- Significant half-year or quarterly financial and performance reporting; and
- Significant regulatory deadlines and submissions including Quality Report submission, Annual Accounts and Audit Report submission and DSPT submission.

The Charity should also consider structuring the Board and committee planner to accommodate both 'full' Board and committee meetings at which all business is discussed, as well as 'special' meetings convened for specific purposes; whilst being cognisant that meetings do not have to be held at a uniform frequency, rather should be aligned to the assurance requirements of the Board.

3.6.1 Board and Committee Effectiveness Review - The process for review of the effectiveness of the Board and committees and individual NEDs should be reviewed and strengthened. Responsibility for monitoring and assuring the completion and compliance with requirements around Board evaluation should be included in the remit of the Nomination & Remuneration Committee. Objectives for all Board members should be linked to the Charity's strategy and key risks, opportunities and uncertainties.

In line with the requirements of the Charities Governance Code this should be an annual process, with an externally facilitated process on a triennial basis, and undertaken on a comply or explain basis.

There are various examples of parameters in assessing the Board and committee effectiveness. Regulatory / External inspections and support, such as CQC well led inspections and Healthcare Financial Management Association (HMFA), should be leveraged in the self-assessment activities.

In terms of developing the assessment framework the Charity should consider the following key steps:.

1) Define the objectives of the process
2) Determine who and what is subject to evaluation
3) Identify and prioritise evaluation topics (these could be cyclical over the three year cycle)

1) Establish a clear methodology (one-to-one interviews, questionnaires, peer evaluation, self-assessment etc.)
2) Establish governance over outcomes and actions

The Charity may also wish to refer to applicable thought leadership available through EY's webpage here and here. Guidance available from the FRC in relation to assessing Board effectiveness under the UK Corporate Governance Code is available here.

3.7.1 Delegation of Authority for Decision Making - The Charity should implement a clear scheme of delegated authority for decision-making. This should include a system of delegation of authority from the Board through the committees, CEO, senior management team(s) and to individual leaders and should be maintained in a single accessible document.

The delegation of authority from the Board to the executive through the matters reserved should explicitly set out those matters which are reserved for the Board and by extension how authority is delegated to the Executive both in respect of other matters and in respect of the matters reserved. We have included an example format and structure at appendix L. (Also see 3.2)

2. Key Findings

2.4 Priority Areas and Recommendations

E Smart Governance (continued)

Recommendations (continued):

3.8.1 Internal Audit Function - The Charity should ensure the IA and Risk Manager reports functionally to the Board (or ARC), with direct and unrestricted access and visibility across the Charity and sub-committees. The Charity should consider the interim arrangement and reporting arrangements for the IA and Risk Manager in the context of independence and alignment to the applicable IA Standards and IA Code of Practice

The Charity should consider commissioning an external effectiveness review of Internal Audit, to assess their conformance with the International Professional Practices Framework (IPPF) of the Institute of Internal Auditors (IIA). The IIA Standard requires that external assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation.

3.9.1 Governance Support - The Charity should agree the role which it wishes the Company Secretariat to play in supporting the effective operation of the governance framework. This role can be purely administrative or can be used to drive value and effectiveness of the framework as a whole.

If the latter is the preference of the Charity, we recommend that the charity centralise secretariat support into a single team, with a tightly defined remit. This should include both administrative support for the Board, its committees and the executive committee as well as being empowered to challenge and shape the effectiveness of Governance as a whole including alignment of agendas, requests for information and reports.

The corpocracy, behaviours and engagement of leaders and the organisation as a whole is also important in underpinning the effectiveness of the overall corporate governance framework (see 3.2). Well managed governance support is a key enabler for this.

3.10.1 Integrated Performance Review (IPR) - Work already ongoing within the Charity to develop an integrated performance review at Divisional level, as opposed to reporting based on functional area, should be prioritised. The existing reporting arrangements appear to be a legacy of the IPU structure which have not been removed as part of the transformation. This is driving inefficiency in information flows from ward to Board, particularly when considered alongside issues previously referred to.

3.10.2 Delegation Executive subcommittees - Where authority to manage, review and assure specific functional areas is delegated to Executive sub-committees, elements of the IPR relevant to those areas should be reported in line with this, either on a consolidated or Divisional basis.

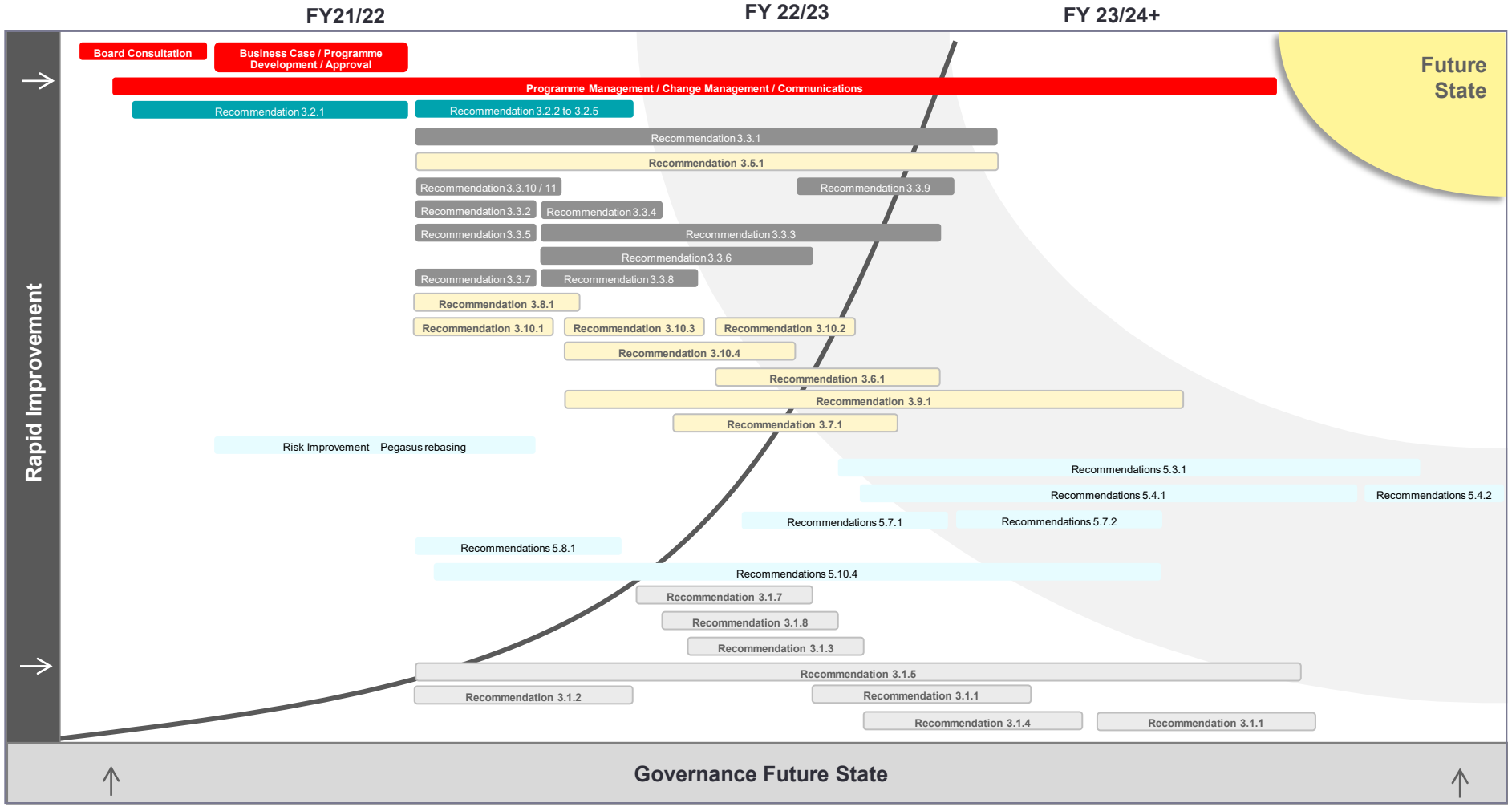
3.10.3 Standardised Management Information - Minimum data-sets should be established for Board committees with a view to identifying what 'standard' information should be reported to committees as a standing item or at a given point in the year. The Board and Committee 'ways of working' as set out in 3.2 should also set our protocols for requests for additional information to the committee either within or outside the committee cycle.

3.10.4 Writing Guidance - A writing guide should be established to act as a guide to those drafting papers and reports for committees. This should set out principles and guidance on the purpose of reporting (assurance vs. management for example) along with examples of structures and formats to aid the development of concise and effective papers.

2. Key Findings

2.5 Improvement Roadmap

- The below improvement plan sets out key Recommendations and prioritisation for the transformation of the Governance framework.
- Recommendations are categorised under five key priority areas and are plotted against two axis, 'Rapid Improvement' and 'Governance Future State'.



2. Key Findings

2.6 Indicative Costs

We have set out indicative (high-level) costs below based on our experience of governance improvement from similar sized organisations. However, these are based on a number of material assumptions which will require discussion and iteration as part of Board consultations. Assumptions include:

- The Charity does not have the capacity to deliver the transformation within the timeframe outlined in section 2.5. This assumption is based on interviews carried out throughout our work.
- The Charity has an ambition to complete the material areas of work within 18 months from June 2021.
- All recommendations are taken forward.
- Support costs, including HR, Finance etc. are not include.
- Without access to staff costs we have made a number of assumptions on salary and on-costs for St Andrew's staff.

We have also assumed an element of ongoing cost relating to the support and continuous improvement of the Governance and Risk frameworks. These costs will be subject to decisions made as part of Board consultation and business case approval. These have also not been benchmarked against St Andrews salary bands, but are based on our experience in the market.

Transformation Costs

Category	Overview	Low	High
Programme	PMO consisting of 1.5 FTE (grade x, grade y) Responsible for coordination of workstreams, management of contingency and production of papers. Assumed to be live for 14 months.	£60,000	£90,000
Delivery Team (St Andrews)	SRO, Governance Lead, Risk Lead and task and finish support (2FTE)	£110,000	£170,000
Contractor / Consultancy Support	Total of 4FTE across Governance and Risk for a total of 6-months.	£300,000	£450,000
Other 3rd party costs	Including legal and support re Board Dynamics.	£37,500	£150,000
Contingency	10% across all categories	£50,750	£86,000
Total		**£558,250**	**£946,000**

Ongoing Operational Costs

Category	Overview	Low	High
Risk Management	Additional 1FTE	£40,000	£60,000
Internal Audit	Additional 1FTE	£40,000	£60,000
Governance Support	2FTE (these may be existing, rather than additional, posts across the Charity)	£64,000	£96,000
Governors Support	0.2FTE (this may be existing, rather than an additional, post)	£6,400	£9,600
Total		**£150,400**	**£225,600**

2.7 Key Risks and Next Steps

Risks

We have identified a number of key risks to the successful implementation of the improvements outlined in this report. Whilst not exhaustive these represent initial areas of risk which must be addressed by the Charity as part of the next steps and throughout delivery of the programme of change.

Key Risks:

1) There is a risk that the Charity does not fully define and agree a full blueprint or defined target state, leading to poor articulation of requirements, unclear business ownership, misalignment of expectations and low return on investment.
2) There is a risk that the Charity cannot obtain a consensus and buy-in to the future governance requirements of the organisation, leading to an inability to reach a fully defines blueprint and target state.
3) There is a risk that the charity does not have the capacity and capability to take forward a transformation of the Governance framework at this time or to deliver on a BAU basis, leading to a piecemeal implementation of change with no clear improvement in outcomes.
4) There is a risk that effective and pro-active engagement and communications with both internal and external stakeholders are not established, leading to unclear and ambiguous sharing of information, failure to generate buy-in and misalignment of the Charity with its patients and stakeholders expectations.
5) There is a risk that effective change management around the programme of transformation and improvement is ineffective, leading to an inability to maintain and imbed the future-state and a failure to extract expected benefits.

Next Steps

Initial next steps are outlined below, fundamentally though the improvement and transformation of governance on this scale must be delivered in a manner which is itself subject to robust governance and quality assessment. The establishment of the framework through which this will be achieved should be considered a priority. Key next steps include:

1) The formation of a timebound committee of the Board to steer the formation and implementation of the governance improvement plan to deliver the change required to improve governance arrangements. This has not been included on Governance structures due to the timebound nature.
2) The formation of an overarching business case, endorsed by the Board, setting out the future state and expected outcomes / objectives of the improvement programme. This should include an assessment of capacity and capability to manage and deliver the transformation programme.
3) The formation of a short-term improvement plan focussing on ‘quick wins’ and improvements.
4) The formation of improvement plans for both governance and risk management to take forward the wider improvement work to reach ‘future state’.

These next steps should be completed prior to the commencement of significant change activity.

2. Key Findings

2.8 Reference to Detailed Findings

The tables below set out our key findings and include a reference to the relevant area of the report. We have also referenced each finding into the relevant principles of the Charities Governance Code at appendix E.

Summary of findings are in the next pages. Detailed findings and recommendations are included in sections 3, 4 and 5.

2.8.1 Governance Findings

Ref	Finding
3.1	Court of Governors
3.2	Board Effectiveness
3.3	Board and Sub-Committees
3.4	Board Assurance and Underpinning Assurance Frameworks
3.5	Governance 'Drumbeat' and Alignment with Business Cycles
3.6	Board and Committee Effectiveness Review
3.7	Delegation of Authority for Decision Making
3.8	Internal Audit Function
3.9	Governance Support
3.10	Management Information

2.8.2 Risk Findings

Ref	Finding
5.1	Risk Strategy
5.2	Risk Governance – Oversight, Accountability
5.3	Risk Governance – Risk Function Resourcing
5.4	Risk Appetite
5.5	Risk Management Process – Risk Identification and Assessment
5.6	Risk Management Process – Risk Monitoring and Review
5.7	Risk Assurance – Assurance Framework
5.8	Risk Assurance – Assurance Model
5.9	Risk Assurance – Additional Assurance Provision
5.10	Risk Culture
5.11	Technology Enablement

3. Detailed Findings - Governance

3. Detailed Findings – Governance

3.1 Court of Governors

Summary

The role of the Governors is generally unclear. Although a high-level role is set out on the Charity's website, our Board, Executive and Governors survey shows that only 11% of respondents think the role of Governors is clear and consistently understood. Additionally, structures established to support the Governors in fulfilling their role are unclear and ineffective; for example, clear terms of reference for the Court, guidance on engagement between Governors and the Charity, arrangements to support constituency governs and mechanisms for feedback from site visits. The role of the Governors as provided in the Charity's Articles of Association (the Articles) is relatively limited and has been developed in an iterative manner over time to include elements such as the Court of Governors and Constituency Governors. However, there is a general lack of clarity across the Trustees in terms of what they want and expect the Governors to provide. We also found some members of the management team to be dismissive of the role and value of the Governors in some respects.

The Charity has an opportunity to more effectively leverage the skills and experience offered by the Governors, however, this will require a commitment to the defined role and the value that this brings.

Oversight / Structure

The Governors do not have a clearly established role and remit as a mechanism for governance and accountability within the Charity. Articles section 11.11 provides for a relatively limited role for Governors focussed on the adoption and approval of matters as presented to the Annual General Meeting (AGM). However, as the role has developed over time this role has grown and been shaped without the Articles being amended.

Only 46% of respondents from our Board, Executive and Governors Survey agree or strongly agree that there is clear separation between the role of the Governors and NEDs. This was also reflected in our interviews and focus groups. In particular, the Governor's role in holding the Board to account was not clearly understood, nor the mechanisms through which the Governor's achieved this.

Previous attempts to strengthen or clarify the role of the Governors, including in 2018 through the introduction of constituency Governors, had not been successful. We did note a number of positive examples where Governors had been successfully engaged in the governance framework, this included the engagement of Governors on the Investment Committee, which all stakeholders agreed made positive use of the skills and experiences of Governors.

However, we made a number of observations in respect of Governors and their role:

1) The Articles of Association are vague as to the role of the Governors, with most of the established roles and activities of the Governors being constructs of changes to the role being made over time. These are currently outlined on the Charity's website but are not referred to in practice.
2) The Governor's do not have sufficient mechanisms to hold the Board to account. Whilst the role of the Governors in respect of complaints was well established, this on its own does not provide the Governors with sufficient opportunity to hold the Board to account. Meetings of the Court are seen as being a formality, with an abundance of information but with no ability to direct questioning or challenge the Board on the delivery of objectives or outcomes.
3) The practice of Governors sitting on Board Committees was viewed inconsistently across the organisation. We found one instance where a Governor was engaged through sitting on an operational committee. The same Governor also sits on the Audit and Risk Committee (ARC), creating a lack of effective separation between the role of the Governors in providing assurance through the 3rd Line of Defence (LoD) and acting as management in the 2nd LoD.
4) Although the role of the Governors in respect of carrying out ward visits was well established, the mechanism for the outcomes of these visits to be fed-back to the Charity is largely informal and there is no mechanism to ensure subsequent follow-up or reporting of actions taken as a result of issues being identified.
5) Whilst the Articles provide for the Governors appointing Directors and the Chair, in practice this is exercised through the membership of a Governor on the Nominations and Remuneration Committee. However, communication to the Court of Governors on a timely basis does not appear to be consistent. The Charities Governance Code identifies good practice as being that 'If a charity's governing document provides for one or more trustees to be nominated and elected by a wider membership, or elected by a wider membership after nomination or recommendation by the Board, the charity supports the members to play an informed role in these processes'.

3. Detailed Findings – Governance

3.1 Court of Governors (cont.)

6) There is an opportunity, and an imperative, to increase the focus on diversity of the Governors to ensure the membership is representative of the community served; consistent with requirements of NHS Foundation Trust Governors. Although we noted positive action in that a Carer and a Staff Governor were appointed in 2019.

7) The method for appointment of Governors, including the appropriateness of 'hereditary' positions was viewed inconsistently. Whilst a number of stakeholders pointed to the quality of certain hereditary Governors and their valued input to the Charity, others also noted instances where Governors did not engage effectively.

8) Notwithstanding the above, the views of stakeholders on the role and helpfulness of the Governor position was inconsistent, with some management dismissive of the role and value of the Governors in some respects. Whilst NEDs were not clear on the role and how it is delivered at present, they were broadly supportive of the Governors and the importance of the role on the whole.

Fundamentally the Charity has to decide what the role of the Governors should be and how it can best engage Governors to the benefit of the Charity and its patients. Governor's should also be engaged throughout this process to ensure full understanding of the role and how this will change in support of the Charity and its objectives.

Recommendations

3.1.1 The Court of Governors should be formally established in the Charity's Articles. The Articles should be updated to clarify the role of the Governors, which should include a clear remit to hold the Board to account on the performance of the Charity in addition to their role at the AGM. Specific legal advice should be sought where necessary.

3.1.2 A Lead Governor should be appointed from the Court of Governors – the role of the Lead Governor should be to act as the key point of contact between the Board of Directors and the Court of Governors, the Lead Governor should act as the key liaison to the Board with regards to the improvements and changes outlined in this report / through the improvement plan agreed by Board. The Articles should be updated to provide for this and for the method of selection of the Lead Governor being by a vote of the Governors at the AGM. A term limit should be established for the role.

The Lead Governor should also be responsible for the performance assessment of the Chair in conjunction with the appointment of a Senior Independent Director* who should also support in this role. A formal and repeatable mechanism should be established to support this process with the results of the assessment reported to the Court of Governors as well as the Board. (also see 3.6)

3.1.3 The Court of Governors should meet at least once a year in a closed session, without members of the Board (other than the chair) or Executive Directors present, in order to assess the performance of the Board. The outputs from this session should be provided to the Board and a formal action plan established through which any issues can be addressed; this should be monitored on an ongoing basis. The Charity should consider publishing the outcome of these assessments along with actions publicly.

3.1.4 A term limit should be established for the role of Governor to encourage turnover in the skills and experience of those in post. Where a Governor wishes to remain engaged by the Charity beyond their term limit, provision should be made for them to be appointed as Honorary Governors for which there should be no maximum in terms or number of posts. This post should be established as a 'friend of the Charity' with no formal governance role. Specific legal advice should be sought where necessary and the Charity's Articles updated as required.

The appointment of Governors should be aligned to the skills and experience required at a given point in time to support delivery of the Charity's aims and objectives as well as the skills and experience required to effectively challenge the Board. The appointment process should also have consideration of diversity of membership, including alignment of the membership to the community served.

Hereditary Governor positions could be retained as Honorary Governors should they / the Charity wish. Additionally, those in hereditary positions could be retained as governors on the basis of the skills and contributions made, but would not pass on the role on standing down.

** The UK Corporate Governance Code requires that 'The board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chair and serve as an intermediary for the other directors and shareholders. Led by the senior independent director, the non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary. We would deem this to be good practice across sectors.*

3. Detailed Findings – Governance

3.1 Court of Governors (cont.)

Recommendations (cont.)

3.1.5 As the role of the Governors is to hold the Board to account, there is a threat to independence from having Governors as members of Committees of the Board; this is exacerbated further by having Governors as members of operational committees. However, it is recognised that Governors possess skills and experience which are of great value to the Board, its committees and to management. The following steps should be considered to allow structured engagement of the Governors without impairment to independence and objectivity:

a) The Charity should establish expert advisory groups to be made up of Governors with specific skills and interests. This could include, for example, Finance and Investments, Clinical Quality, Research, Nominations and Appointments and Governance. Advisory groups should be constituted either at the request of the Charity Board or on a standing basis and act as a source of skills and expertise in areas which the Charity requires guidance.

However, advisory groups do not make-up a formal part of the governance framework and should not be expected to meet formally to make or support decisions. They should therefore require minimal secretarial support from the Charity in the form of papers and minutes.

b) Governors should not hold membership of any Board or management sub-committee. However, where appropriate Board-Committees should be empowered to request the advice and guidance of an advisory group. This could also include Governors joining meetings of committees 'in attendance' to fulfil a non-voting advisory role.

3.1.6 Governors should be engaged in the process for appointment of Trustees in an advisory manner, this could be through the formation of an appropriate advisory group (see 3.1.5). This should have the aim of strengthening the role of Governors in terms of article 11.11.4 'appoint or reappoint Trustees'.

3.1.7 The mechanism through which Governors' roles in respect of ward visits and the role of constituency Governors should be formally established and supported by the Charity. This should include a clear procedure for the collation, analysis and dissemination of feedback with subsequent feedback through the Court of Governors where relevant.

3.1.8 The Charity should align the nature of reporting to the Court of Governors with the formalised role of the Governors. This should include engagement with the Court of Governors as to the adequacy of the information currently provided as well as views on information requirements aligned to roles and responsibilities. This might normally include:

- Board / Chair Report
- CEO Report
- Lead Governor Report
- Performance Update (vs. annual / strategic objectives)
- Report on significant / material risks or issues
- Reports from constituency Governors
- Any other business relevant to the activities of the Court of Governors (such as appointments of NEDs)

3. Detailed Findings – Governance

3.2 Board Effectiveness

Summary

We have noted a number of areas where the effectiveness of the St Andrew's Board has been restricted. There are a number of common drivers across sectors which contribute to the effectiveness of Boards and there are various models which point to the relative importance of these drivers. However, what is consistently recognised is the importance of a clear and unequivocal mandate for a Board to enable it to discharge its responsibilities in respect of the stewardship of the organisation it serves.

Our interviews identified a shared view that the Charity's Board is not operating effectively. Interviewees and focus groups noted; a lack of trust and confidence between the Executive Leadership of the Charity and the Non-Executive Board members, difficulty navigating and understanding Board delegations and inconsistency in accountability vs. responsibility for key aspects of governance and supporting frameworks.

Points raised in this section are often inter-related and contributory to one-another and as such cannot be addressed in isolation. We have also identified a number of areas where points noted under Board effectiveness are contributing factors or root causes for issues which manifest further down the governance framework. These have been cross referenced through the report to section 3.2 where appropriate. Board dynamics is often discussed in terms of Board Capital which can be defined as the 'sum of the human and social capital of the Board, and its proxy for the Board's ability to provide resources to the organisation'. Figure A below outlines some of the contributing elements of Board Capital and effective Board dynamics, elements of this model are addressed throughout finding 3.2 and 3.3.

Capability / Culture

Interviewees unanimously agreed that the Board is not currently operating as a highest performing team, citing a lack of trust and confidence between the Executive and Non-Executive members as a key driver for ongoing issues around the effectiveness of governance and decision making across the charity. This included a view from a number of NEDs that the Executive members were not transparent and indeed that at times information was not shared with the Board in a timely enough manner, and a view held by the Executive that the Non-Executives were frequently acting beyond their remit and outside their documented responsibilities. Through observation of Board committees and from interviews with stakeholders, we have noted a number of instances where the dynamics of the Board have not been conducive to effective teaming.

The drivers for lack of cohesiveness in the Boardroom were generally well understood and included:

- The appointment of a significant number of NEDs and a new Chair in a single year;
- An ineffective and fragmented onboarding process;
- The inability to form effective relationships across the Board due to the restrictions in place as a result of COVID-19, meaning individuals could not form personal relationships and / or build trust and confidence across the group;
- The inability to form a tactile understanding of the charity, its people and its work due to COVID-19 restrictions;
- The absence of a Board engagement and development plan (see 3.6); and
- The absence of clear objectives and expectations setting for NEDs as well as the absence of formal performance reviews for NEDs, Committees and the Board.

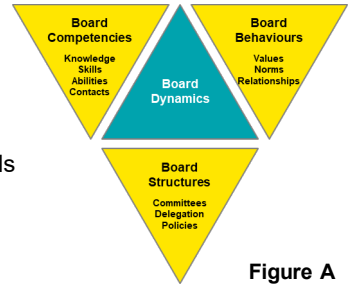


Figure A

However, although these factors were broadly understood and agreed, limited tangible action has been taken to date to address and resolve the issues relating to dynamics at a Board level. However, the CEO and Chair are now in discussion with NHS improvement regarding facilitated sessions and workshops to support teaming and dynamics.

We have found a number of structural and other issues which also contribute to the lack of cohesiveness and team dynamics at a Board level (outlined below and on the following pages). However, the issues regarding dynamics at a Board level are driving or contributing to a number of other issues throughout the Governance framework. As consensus and support from the Board will be required to successfully deliver a revised governance framework for the Charity, Board dynamics should be the key priority for the Board to address following the completion of our review.

3. Detailed Findings – Governance

3.2 Board Effectiveness (cont.)

Recommendations

3.2.1 The Board should undertake / engage in a programme of Board development including team building and effectiveness in order to address issues around dynamics within the team. However, this can ultimately only be successful if other areas of weakness outlined in this report are also considered in the context of how these will assist in building trust and confidence across the Board.

3.2.2 A Board Code of Conduct should be developed to include clear guidance relating to the expectations on engagement between NEDs and Execs as well as NEDs and operational business areas. Whilst this should not be restrictive it should set expectations on behaviours and protocols around 'ways of working' which should be followed, with ultimate escalation to the Chair as required.

Also see 3.2.3 to 3.2.5 Structures and Oversight and 3.10 Management Information.

Structures

A number of artefacts which outline the role and remit of the Board, establishing its mandate, are out of date and have not been reviewed since the appointment of a new set of NEDs and the Chair; including Board ToR and Matters Reserved.

The terms of reference for the Board and its delegation of authority to its Committees (see 3.2) and the Executive (see 3.3) should not be viewed as a static document. As the priorities of the Charity change and the Charity moves through its strategic and business cycle, the terms and delegations may require review to ensure that they align to the prevailing views of the Board as well as its risk appetite. As the new Board has not had a chance to review, challenge and update its ToR and the matters which it reserves for itself and its committees, it should not be unexpected that the Board tests or challenges the boundaries established by these documents.

Additionally, there are no clear protocols or 'rules of engagement' established for how the Non-Executive Directors should engage with the organisation, including with Executives and non-executive directors; this also extends to Governors (see 3.1). Whilst informal and ongoing engagement and dialogue with the business is an essential part of how NEDs support, challenge and hold to account, there should also be established norms and agreed protocols relating to how this is managed. This is critical to avoid blurring of the lines between Executive and Non-Executive roles and responsibilities as well as well to avoid misunderstanding and confusion on key issues.

Interviewees noted a number of instances where Non-Executives and Governors have engaged individuals within the business directly to provide information on specific issues.

Oversight

The Board reserves oversight of and responsibility for the approval for a number of policy areas as established through the matters reserved and committee ToRs, this includes:

- Reserves
- Remuneration
- Accounting policies
- Non-Audit Services
- 'Key' Finance Policies

We observed a general view that the role of the Board and NEDs is based in the items included in the matters reserved. Executive interviewees highlighted a widely held view that the Board has no authority or approval of the policies of the Charity and that the approval of policies is and should be reserved for the Charity Executive.

3. Detailed Findings – Governance

3.2 Board Effectiveness (cont.)

Oversight (cont.)

Although we noted the People Strategy was reviewed by the People Committee, the view in relation to policy is also evident for enabling strategies. ToRs do not provide for the Board or committee approval of such strategies, although NEDs held the view that they should. This view is not consistent with the view of the Executive Directors who held a general view that enabling strategies relate to the running of the Charity and as such were not for the attention of the Board. We noted one instance referenced by a number of NEDs relating to changes to the Charity's policy regarding redundancy where this had led to disagreement.

As the Board has no oversight or approval, or visibility of, the Charity's policy framework, individual Non-Executive Directors have sought assurances over some aspects of this framework in order to gain comfort over their own accountability and role as a Non-Executive Director. This has been viewed as intrusive by members of the Executive and an example of the NEDs acting outside their remit and role.

As the policies are a material mechanism through which the Charity's strategic aims, charitable objectives and regulatory obligations are met and delivered these are a critical area of oversight for the Board in order for the Board to discharge its responsibilities. The current position on policy is inconsistent with established practice in the sector and guidance included in the applicable regulatory guidance. The Charities Governance Code which states in section 4.5.5 that - *'The board regularly reviews the charity's key policies and procedures to ensure that they continue to support, and are adequate for, the delivery of the charity's aims. This includes policies and procedures dealing with board strategies, functions and responsibilities, finances (including reserves), service or quality standards, good employment practices, and encouraging and using volunteers, as well as key areas of activity such as fundraising and data protection'*.

Recommendations

3.2.3 The Board ToR and Matters Reserved should be reviewed with a focus on the roles and responsibilities of the NED vs. Executive. This review should be a pre-requisite of and inform the broader review of ToRs pursuant to recommendations of this report. We have included references to examples of good practice in respect of Matters reserved at appendix K.

3.2.4 The Matters Reserved for the Board should include the approval of all new or amended policies deemed to be material to the delivery of the Charity's aims and objectives. The definition of and taxonomy for 'material' policies should be established by the Board and may include consideration of 'Corporate' vs. 'Operational' policies. However, the Board should have ultimate sign-off on the list of policies which it reserves approval of. The Board may choose to delegate the review of specific policies to its sub-committees as appropriate.

The list of policies for which the Board retains approval should be subject to review on an ongoing basis. The policy register should also be reviewed by the Board on at least an annual basis, with a more regular update to the applicable committee regarding policies relating to specific aspects of the Charity's work; for example policy relating to the establishment of an assurance framework should be reviewed by the ARC.

3.2.5 In line with the approval of the overarching strategy for the Charity, the Board should retain, through its committees, the approval of material enabling strategies. Similarly to policies above consideration should be given to the taxonomy of strategies for which the Board retain approval.

3. Detailed Findings – Governance

3.3 Board and Sub-Committees

Summary

The Charity's governance structure and associated assurance map do not provide for clear demarcation of responsibilities of the Board (assurance) and executive management. As a result, the 'lines of sight' and reporting are not consistently understood or articulated to Board members or to members of the Charity Executive Committee (CEC). The role of the CEC as a Board sub-committee was consistently noted as an area which required clarity in terms of the purpose and scope.

We also noted that the Board committee structure has developed over time without a formal and wholesale review of the delegation of authority from the Board and the associated terms of reference of committees. As such there are areas of overlap which add further complication and reduce clarity of reporting lines further. This extends to the committee sub-groups which appear to be in an interim state following the move from an Integrated Practice Units (IPU) structure to a Divisional triumvirate structure.

As a result, the information and assurance flows are not clearly established, efficient and effective. The volume of papers being produced, and the resulting administrative and support requirements are placing significant pressure on the organisation. Additionally, Non-Executive Directors do not have a clear view of assurance flows and as such are relying on enquiry and ad-hoc requests to fulfil their needs (also see 3.4).

Benchmarking also identified that the Charity has a significantly higher number of Board committees when compared to peers; with the average number of committees across peers being four. An overview of the organisations against which benchmarking was completed is included in appendix D.

Structure / Oversight

There is overlap and confusion in the alignment of scope and responsibilities of committees. The terms of reference for committees have not been reviewed and aligned following significant changes to leadership and the architecture of the committee structure. Whilst some positive steps have been taken to strengthen and align the work of committees, this is a fundamental step in removing overlap and clarifying reporting lines. Only 40% of respondents from our Board, Executive and Governors Survey agree that the Board committees are well established and provide an effective assurance framework.

We have also noted a number of areas where the sub-committees of the Board appear to be fulfilling a dual role as both assurance committees and management committees, supporting 2nd LoD activity in some instances. We have also found a number of areas where the scopes of committees overlap and / or where specific items do not have a clear ownership. These include:

1) Charity Executive Committee – Although the CEC is considered as a Board sub-committee, it does not perform the function of a Board assurance committee, operating rather as a senior leadership forum for the CEO and Executive, similar to a Trust Leadership Team in an NHS context. This is causing widespread confusion and frustration, both in terms of the committee's purpose and role as well as in terms of the reporting lines which exist as a result of it being constituted as an assurance committee as opposed to the charity's main leadership and management forum as at an executive level. (see also 3.3)

2) People Committee – Interviews consistently identified the People committee as having a broad and poorly-defined remit. Interviewees also noted that the committee often overlapped with other committees in terms of ad-hoc requests for information, for example around quality and safety incidents, due to the associated impact of these incidents on the Charity's employees, patients and other stakeholders. Our review of the ToR and associated papers and minutes identified that the scope effectively covers all aspects of the Charity which require engagement with 'people'. Given the nature of the Charity's work this effectively gives the committee a remit across a wide range of areas and issues, causing confusion on reporting lines and assurance flows; and also driving duplication of papers in some cases. We also noted that the membership of the People committee was not commensurate with a Board Governance Committee, raising potential independence threats around separation of duties as well as around quorum.

   We also noted that Health & Safety (H&S) reports through the People Committee. There were divergent views as to where H&S should report, it was noted that it no longer reports to QSC at the express request of the Chair. We see a number of different approaches in relation to the ownership of H&S, this often sits alongside estates, people or quality and safety depending on; a. how H&S issues most regularly manifest and impact the organisation, and / or b. how the H&S strategy or improvement plan will be taken forward functionally (i.e. as part of a wider estates strategy or masterplan).

   What should be understood regardless of reporting line is that the committee receiving reporting on H&S should not as a default expect to receive reporting on all related outcomes; for example, for an H&S breach which leads to a significant quality incident, reporting on quality aspects should be reported through the appropriate quality fora. With the nature, root cause and remediation of the H&S incident being the focus of any assurance offered through the H&S reporting line.

3. Detailed Findings – Governance

3.3 Board and Sub-Committees (cont'd)

Recommendations (summary) – Proposed changes to the committee structure are set out further in section 4.

3.3.3 The **People Committee** remit is unclear and expansive, leading to scope creep and overlap in places. We would recommend the People committee's scope and remit be materially revised to focus on workforce related issues at a Board level.

We recommend that elements of the People Committee scope should be re-distributed to Board committees and elements be reported through the Executive Committee and Chief Executive's report to the Board directly. This includes:

- H&S – Optionality exists for where H&S reports for assurance purposes
- Elements of patient and carer engagement currently included in People ToR. The Board away day on 5th July 2021 agreed that the reporting line should be via the QSC, we would support this conclusion.

The ToR should be reviewed and clarified in terms of the remit of the people committee, specifically to ensure a clear demarcation of its responsibilities around workforce and OD issues and not across all 'people' related issues (patient, carers etc.). The membership of the committee should be reduced to NEDs and relevant Executive members, with other relevant stakeholders in attendance.

3.3.4 The **ARC** should have no specific functional reporting or assurance reporting line. The ToR of the ARC should be focussed on the provision of broad assurance as well as effective systems of governance, risk management and control. The ARC should also retain its responsibilities in respect of accounting policy and financial reporting. The role of the ARC in terms of financial controls should be clarified in line with 3.3.6.

3.3.5 **Quality & Safety Committee** should be responsible for the provision of assurance in relation to H&S matters at a Board level. (see 3.3.3 above)

3.3.6 We would recommend that the **Finance committee** should be replaced by a Finance and Performance Committee, with the following key changes and areas in scope:

- Elevate the committee to be an assurance committee, removing tactical monitoring and 2nd LoD oversight functions including the monitoring of financial controls (to be retained within the scope of the ARC as far as is included presently).
- The addition of a formal role in the monitoring of the Charity's performance in key areas of the IPR for which there is a direct financial impact, including occupancy and the use of agency staff.
- The addition of a formal role to provide assurance to Board in respect of estates and facilities strategies and performance.
- To provide assurance to the Board in respect of Information Technology and Information Governance matters.
- The Investment Committee should be retained as a sub-committee of the Finance and Performance Committee.

3.3.7 Consideration of St Andrew's College should be made in light of OFSTED findings from their June / July 2021 visit. Whilst the independent standing of the Governing Body is a key consideration, the College exists within a Group structure which is not uncommon for educational institutions. As such a reporting line for assurance and performance purposes through Executive and Board is deemed appropriate and not mutually exclusive with the requirements of OFSTED.

3.3.8 Once a strategy and direction for research has been agreed and approved by the Board, and implementation of the strategy commenced, the **Research Committee** should be revised to act as a Board assurance committee, with responsibility including the approval and oversight of the Charity's research strategy on an ongoing basis. An Executive sub-group should be established to manage the delivery and operational elements of research for the Charity.

Note – no changes to scope are recommended in respect of the **Nominations & Remuneration Committee.**

3. Detailed Findings – Governance

3.3 Board and Sub-Committees (cont'd)

3) Finance Committee – The Finance committee's remit and terms encompass both assurance and managerial (2nd LoD) elements. There is also considerable overlap with the work on the ARC, both in terms of financial control and a perceived overlap in terms of accounting policy. We also noted that critical areas of operational performance were not within the scope of the Finance committee; this would be seen as a key area for consideration given the Charity's significant year-on-year deficit. Interviews also identified a view that the Finance committee acts as a functional reporting line for finance issues within its scope and that this reporting line for finance must be observed prior to issues being reported to ARC for assurance purposes. This is not consistent with the normal operation of a Board and sub-committee structure or a Board assurance framework; further conflating the role of Board and managerial structures.

4) ARC – The ToR for the ARC were not aligned to the operation of the ARC in practice, they had not been reviewed formally since 2017. Interviews noted that steps had been taken to remove some functional assurance roles from the ARC and re-distribute these to the other committees. This includes Health & Safety and Information Governance, but that the ToR had not been updated to reflect this. We also observed that ownership of specific risks on the Charity's risk register had been re-distributed to relevant committees to own, with a view to ARC not being the owner of any risks not specifically aligned to its scope.

Although the ToR for ARC have not been updated, we broadly agree with and support the steps which have been taken in regards to the committee's remit outlined above. The role of the ARC should be focussed on the provision of broad assurance as well as effective systems of governance, assurance, risk management and control. The ARC should also retain its responsibilities in respect of accounting policy and financial reporting.

5) Nominations and Remuneration Committee – This committee is operating in line with expectations and we would not recommend any changes to its scope or purpose.

6) Investment Committee – This committee is operating largely in line with expectations, although it is unclear how the role of the Fundraising & Donations group overlaps with the remit of the Investment Committee in terms of non-pension investments.

7) Quality and Safety Committee – This committee is broadly operating in line with expectations, although we would recommend consideration of changes to the scope and objectives as a result of broader changes to the structure; including consideration on the reporting line for H&S. More broadly, points regarding the volume and quality of papers are applicable here (See 3.10).

8) Although not a focus of our review, St Andrew's College Governing Body is not deemed to be operating as an assurance committee to the Board and as such should be re-constituted under the Executive Committee structure.

9) Reporting on IT risk, issues and strategy is currently reported to the Board through CEC as opposed to through a sub-committee. We would propose that IT and IG matters are reported through the Finance and Performance Committee.

10) The Research Committee appears to act as both a Board sub-committee for assurance purposes and the main management forum for research in the Charity, primarily as the Research agenda is developing and forming under the revised strategy. This structure should be revised in the fullness of time as the strategy and operational delivery model for research becomes clear and developed and implementation activity commences.

In addition to the above we have been unable to identify a clear structure for oversight and assurance to the Board on the Charity's estates and facilities.

Recommendations (summary) – Proposed changes to the committee structure are set out further in section 4.

3.3.1 The role and objectives of the Board's sub-committees as assurance committees should be clarified and strengthened. Operational decision making responsibilities should be removed and membership should be restricted to members of the Board of Directors of the Charity (although others may be invited in attendance). The number of Board sub-committees should be reduced from 10 to 6 in line with the below.

3.3.2 The Charity Executive Committee should no longer be considered a Board sub-committee. Lines of reporting should be clearly established and differentiated for assurance and management reporting.

3.3 Board and Sub-Committees (cont'd)

Oversight / Policy & Procedure

We have also found a number of other factors in regards to the Board and Sub-Committees which contribute to findings in 3.2 as well a broader lack of clarity, understanding and effectiveness / efficiency of governance:

- As noted in 3.2, several artefacts which outline the role and remit of the board, establishing its mandate, and its scheme of delegation are out of date and have not been reviewed since the appointment of a new set of NEDs and the Chair or following changes to the wider governance framework. This includes:
  - ToRs which have not been subject to annual review and updates:
    - Board ToR last reviewed and updated – May 2018
    - Matters reserved for the Board last reviewed and updated – July 2019
    - ARC ToR – Last reviewed May 2017
    - Investment Committee – July 2017
  - ToRs which have been reviewed and updated / created in a piecemeal manner and have not been aligned with other committees:
    - People Committee – November 2020
    - Quality and Safety Committee – April 2021
    - Finance Committee – July 2020

We also found various templates to be in use for ToRs across the Charity, including different headers and sections across each. This drives further confusion across the sub-committee structure as articulation of role, responsibilities etc. is not consistent.

Recommendations

3.3.9 Pursuant to the recommendations made on the previous page, a full and holistic review of ToRs should be undertaken prior to the finalisation of the revised structure to ensure coverage and overlap is aligned.

3.3.10 A document control page should be added to all ToRs setting out requirements for review and approval and referral of changes. An example is included at appendix L.

3.3.11 A consistent ToR structure should be adopted across all Board sub-committees. (see appendix L)

Also see 3.9 and 3.10.

3.4 Board Assurance and Underpinning Assurance Frameworks

The Charity does not have a coherent articulation of the assurance framework which can be referenced and relied upon by the Board and NEDs. As a result, interviews have identified individuals are at times seeking assurance directly from source, driving some concerns around behaviours and dynamics as outlined in 3.2. We understand that the Board has previously maintained a strategic assurance framework and more recently sought to implement a Board Assurance Framework (BAF). Work on the BAF stalled in April 2021 and it is being re-worked presently.

The clear articulation of the assurance framework, both the BAF and the broader integrated assurance landscape, is a fundamental element of the governance framework and articulation of this should form a central part of the work to embed trust and confidence across the Board.

See finding 5.8 for detailed findings and recommendations in respect of assurance.

3. Detailed Findings – Governance

3.5 Governance 'Drumbeat' and Alignment with Business Cycles

Summary

The timing of Board committee meetings is driving inefficiencies in the reporting and production of management information. We noted that there is no clear sequencing of Board committee meetings to provide assurance and support decision making at the Board level, meaning that the management information flow of assurance and accountability through the Charity is not clear or effective.

The 'drumbeat' of the Board and its committees is a fundamental part of an effective governance structure and plays a key role in delegation of authority and accountability for decision making. Board committees should meet at appropriate times to provide assurance to the Board, this should be aligned as closely as possible to the business' reporting cycles.

The drum-beat of committees is also a key driver of effective committee and governance support and should be considered in terms of response to 3.9.

Structure / Management Information

The 'drumbeat' and information flow for the Board and committees are ineffective and are not aligned to business cycles, and the Board meeting calendar is not driven by regulatory submission requirements. This also extends to the ward to Board flows due to the conflation of management and assurance committees per 3.3.

Although our survey results show that 70% of the respondents from our Leadership Forum Survey understand how information flows up to the Board through relevant meetings, we noted the Board and committee meetings are planned with various frequencies and are not designed to tie up with the cycle. Interviews also identified a general theme in regards to timing of meetings with consistent feedback that the status-quo was not effectively aligned. This includes:

- Board of Directors, Quality and Safety Committee (QSC), People Committee, Nomination & Remuneration Committee – Bi-monthly
- Audit & Risk Committee (ARC), Finance Committee, Investment Committee – Quarterly
- Charity Executive Committee (CEC) – Weekly

Due to the variation in frequency across the sub-committee structure the assurance flow to the Board will never fully align. We made three specific observations in relation to ineffective Board committee sequencing as follows:

1) Board and CEC Performance meetings for integrated performance reports – The performance of the Charity is being reported separately in different formats to the Board and CEC Performance meetings, due to the timing of the meetings. The CEC Performance meeting, with more detailed performance reporting, is scheduled for the 4th week of a month meaning they are, from time to time, held after the Board meeting in a month. This approach results in data not being aligned between Board and CEC reports as well as potential for lag in Board reporting.
2) Board and QSC meetings for the Quality Account submission – The Charity is required to publish a Quality Account before end of June each year. Approval at the QSC is required prior to sharing with the Board for final approval. In the 2021 Board meetings planner, the QSC is scheduled in early June but the Board is planned bi-monthly in May and July. As such, the Quality Account submission can only be approved after the QSC in June through an additional extraordinary Board for the submission.
3) Board and ARC meetings for the NHS Data Security and Protection Toolkit (DSPT) submission – The Charity is required to complete the DSPT submission by end of June 2021. ARC review is required prior to the Board approval for submission. However, we noted that the DSPT submission that was approved in the May Board meeting has not gone through the ARC review, as the ARC was planned quarterly in April and July and did not tie up with the submission cycle.

We also previously noted anomalies in timing and associated assurance and reporting between Finance Committee and ARC resulting in information waiting an entire meeting cycle to be reported to the ARC.

3. Detailed Findings – Governance

3.5 Governance 'Drumbeat' and Alignment with Business Cycles (cont'd)

Recommendations

3.5.1 The revised committee structure should be set up alongside a clear sequencing of decisions and assurance required for the Board and its committees. Additionally, the sequencing and frequency of meetings should accommodate the alignment of sub-committees to the Board cycle. This could include, for example:

- Key points in the business cycle such as approval of budgets and business plans;
- Significant half-year or quarterly financial and performance reporting; and
- Significant regulatory deadlines and submissions including Quality Report submission, Annual Accounts and Audit Report submission and DSPT submission.

The Charity should also consider structuring the Board and committee planner to accommodate both 'full' Board and committee meetings at which all business is discussed as well as 'special' meetings convened for specific purposes; whilst being cognisant that meetings do not have to be held at a uniform frequency, rathe should be aligned to the assurance requirements of the Board.

3. Detailed Findings – Governance

3.6 Board and Committee Effectiveness Review

Summary

The Charity has no formal process for Board effectiveness review, or performance review for Non-Executive Directors. Additionally, there is no formal development plan in place for Board members. Appropriate Board and committee assessments are essential to strengthening board effectiveness.

Section 5 of the Charities Governance Code states '*It is important to have a rigorous approach to trustee recruitment, performance and development, and to the board's conduct.'*

Capability / Culture

Board and committee effectiveness reviews are not in place to create a culture of continuous improvement for the Board and Trustees. Objectives are not set to evaluate Board members' performances, and Board members do not routinely share and receive open and transparent feedback. As a result there is no formal and consistent structure through which the performance of the Board can be effectively challenged and improved.

Paragraph 5.8.2 of the Charities Governance Code requires that – *'The board reviews its own performance and that of individual trustees, including the chair. This happens every year, with an external evaluation every three years. Such evaluation typically considers the board's balance of skills, experience and knowledge, its diversity in the widest sense, how the board works together and other factors relevant to its effectiveness.'*

Our survey results from our Board, Executive and Governors Survey show that respondents have varied views on the Charity's Board effectiveness:

- 61% of the respondents feel the Board has appropriate number of directors
- 50% of the respondents feel the Board has right balance of Executive and NEDs
- 45% of the respondents feel the Board has right balance of skills, experiences and backgrounds of Directors
- 48% of the respondents feel the Board has diversity (including gender) of its membership

We understand that work to address this is ongoing, including the instigation of NED one-to-ones with the Chair. However, this represents a significant gap against good practice and in terms of compliance with regulatory requirements (see Appendix E).

Recommendations

3.6.1 The process for review of the effectiveness of the Board and committees and individual NEDs should be reviewed and strengthened. Responsibility for monitoring and assuring the completion and compliance with requirements around Board evaluation should be included in the remit of the Nomination & Remuneration Committee. Objectives for all Board members should be linked to the Charity's strategy and key risks, opportunities and uncertainties.

In line with the requirements of the Charities Governance Code this should be an annual process, with an externally facilitated process on a triennial basis on a comply or explain basis.

There are various examples of parameters in assessing the Board and committee effectiveness. Regulatory / External inspections and support, such as CQC well led inspections and Healthcare Financial Management Association (HMFA), should be leveraged in the self-assessment activities.

In terms of developing the assessment framework the Charity should consider the following key steps:

1) Define the objectives of the process
2) Determine who and what is subject to evaluation
3) Identify and prioritise evaluation topics (these could be cyclical over the three year cycle)
1) Establish a clear methodology (one-to-one interviews, questionnaires, peer evaluation, self-assessment etc.)
2) Establish governance over outcomes and actions

The Charity may also wish to refer to applicable thought leadership available through EY's webpage here and here. Guidance available from the FRC in relation to assessing Board effectiveness under the UK Corporate Governance Code is available here.

3. Detailed Findings – Governance

3.7 Delegation of Authority for Decision Making

Summary

Our interviews and surveys identified a degree of confusion as to the authority, responsibility and accountability for decision making and delivery of objectives across the charity. Authority, responsibility and accountability for tasks change hands when a board, committee, manager, or superior, delegate a task down the hierarchy. In the absence of clear delegation of authority, the level of the organisation at which decision making takes place is often inconsistent. Large volumes of decisions may flow up to the Board or Executive, resulting in congested or overwhelmed governance structures, or decisions could be taken which are not consistent with the expectations of leadership.

- Authority - power given to a person or group to act and make decisions within boundaries. Authority typically flows downwards through the governance framework.
- Responsibility – an obligation to perform a specific task, an obligation is typically established through guidelines issued by a superior.
- Accountability – the act of being liable for actions or decisions. Often this is based on the obligation of an individual or group to report formally to a superior on the work to discharge a responsibility. Accountability always flows upwards through the governance framework.

Oversight - There is no articulation of delegation of authority in the context of the governance framework as a whole as a single scheme for the Delegations of Authority for the Charity. Delegations are articulated through various committee Terms of References as well as through the Financial Authorisation Policy. As delegation is not articulated in an accessible way, people are unclear where decisions should be made and / or the level of delegation which exists outside the committee structure.

Our survey results show that only 45% of the respondents from our Leadership Forum Survey feel empowered to make decisions on a day-to-day basis and /or that decision-making is clearly delegated. Interviewees expressed a lack of empowerment and it was felt that decisions that could be managed through the day-to-day work of a business unit are required to be tabled for consideration or approval by the CEC, Board committee or both.

Recommendations

3.7.1 The Charity should implement a clear scheme of delegated authority for decision-making. This should include a system of delegation of authority from the Board through the committees, CEO, senior management team(s) and to individual leaders and should be maintained in a single accessible document.

The delegation of authority from the Board to the Executive through the matters reserved should explicitly set out those matters which are reserved for the Board and by extension how authority is delegated to the Executive both in respect of other matters and in respect of the matters reserved. We have included an example format and structure at appendix L. (Also see 3.2)

3. Detailed Findings – Governance

3.8 Internal Audit Function

Summary

Due to capacity and resource constraints within the management of IA, Risk and Governance an interim change was made to management reporting lines. However, the interim reporting line established for Internal Audit is not in line with good practice and does not promote the independence of the service. The Institute of Internal Audit Code of Practice states that – 'If internal audit has a secondary reporting line, this should be to someone who promotes, supports and protects internal audit's independent and objective voice. Ordinarily this should be the CEO in order to preserve independence from any particular business area or function and to establish the standing of internal audit alongside the executive committee members'. The primary reporting line should be to the Chair of the Audit and Risk Committee. Currently the Internal Audit and Risk Manager reports the internal audit matters to the Chief Financial Officer (CFO), reports functionally to the Chief Nurse on risk management and has a line management reporting line to the Company Secretary; he does not communicate and interact directly with the Chair of the Audit and Risk Committee or the Board on a regular basis.

The independence of internal audit is essential to support robust challenge and effective and objective assurance to the Audit Committee and Board.

Oversight / Structure – The interim arrangement and reporting lines for the supervision of internal audit are not in line with good practice established to maintain the independence of the internal audit function. The IA and Risk Manager reports the internal audit matters to the Chief Financial Officer (CFO), and does not communicate and interact directly with the Chair of the Audit and Risk Committee or the Board. Good practices demonstrate that organisational independence is effectively achieved when the Head of Internal Audit reports functionally to the Board (or ARC) to fulfil its responsibilities and be free from interference in determining the scope of internal auditing, performing work, and communicating results.

Additionally, we noted that Internal Audit's access to key forums is limited to the ARC. The ability of an IA function to be effective is contingent on the Head of Internal Audit (or equivalent), and the internal audit service as a whole, having both the standing and access required to make impactful and value adding recommendations on decision-making, and governance, risk and compliance issues identified. Having direct and unrestricted access to senior management and the Board allows the Head of Internal Audit (or equivalent) to report any independence threats to the Board.

We also noted that the IA and Risk Manager is expected to have ongoing risk management responsibilities in addition to internal audit. Internal audit must place reliance on arrangements for risk management to form the annual plan and IA strategy, as such it would be normal for IA to review the arrangements for risk management on a cyclical basis. Under current arrangements this review cannot be objective.

While this is not uncommon, safeguards should be in place to limit impairments to independence or objectivity for any roles and responsibilities that fall outside of internal audit. These are often oversight activities undertaken by the Board, to address these potential impairments, periodically evaluate reporting lines and develop alternative processes to obtain assurance related to the areas of additional responsibility. Our review of the Board papers did not note any discussions in relation to this area, and the Board Terms of Reference does not include such oversight responsibility.

Recommendations

3.8.1 The Charity should ensure the IA and Risk Manager reports functionally to the Board (or ARC), with direct and unrestricted access and visibility across the Charity and sub-committees. The Charity should consider the interim arrangement and reporting arrangements for the IA and Risk Manager in the context of independence and alignment to the applicable IA Standards and IA Code of Practice.

The Charity should consider commissioning an external effectiveness review of Internal Audit, to assess their conformance with the International Professional Practices Framework (IPPF) of the Institute of Internal Auditors (IIA). The IIA Standard requires that external assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation.

3.8.2 The Charity should consider splitting the role of Head of IA and Head of Risk to support independence of the IA function.

3.9 Governance Support

Summary

Accountability and responsibility for the implementation, improvement and administration of the governance framework is not clearly established. Although the Company Secretary is deemed to be responsible for the framework as a whole, aspects of the administration of the framework are disparate across the organisation. Additionally, the role and function of committee and Board secretariat is seen as administrative by some stakeholders and as a key strategic and value adding service by others.

Creating clarity of role and empowering those charged with supporting the governance framework to challenge key stakeholders is an essential element in establishing effective and efficient arrangements for governance across the charity. Effective support for governance is an essential element of embedding a robust and value adding governance framework. Although traditionally viewed as an administrative function, as regulatory responsibilities and the environment within which organisations operate becomes more complex, the role and influence of the Company Secretary's office (or Governance office) has changed to become a critical and strategic partner to the CEO and Board for driving good governance and effective decision making through organisations.

Structure /Oversight

Aspects of the administration and support of the governance framework are disparate across the charity. Although the Company Secretary is responsible for supporting the Board, CEC and Audit and Risk Committee, other elements of the governance framework are administered elsewhere. This includes administration of the Nominations and Remuneration Committee, Investment Committee and People Committee sitting within Human Resources, and administration of the Finance committee residing within Finance. Interviews identified that the root cause of this decentralised approach appears to be a view that the Company Secretary's office does / did not have the capacity or capability to effectively support the framework as a whole.

We frequently see the decentralisation of these arrangements having a number of impacts on the efficiency and effectiveness of the framework as a whole, these include:

- Difficulty or inability to align the drum-beat of meetings and associated agenda to ensure information flow between key meetings and fora;
- Duplication of requests for information as no line of sight exists between those administrating key governance fora;
- Difficulty aligning delegation across governance fora as ToRs are updated iteratively without due consideration to overlap or scope creep;
- Inconsistency in the quality and timeliness of information provided to key committees and fora, leading to frustration on the part of members due to inconsistency in the quality of service provision and support;
- Disparate lines of accountability and responsibility for other aspects of the governance framework including elements such as the Board Assurance Framework, Risk management and broader assurance and compliance reporting.

All of the above challenges are extant within the Charity; although the absence of an effective and aligned governance office is not the only (or primary) cause in many cases. However, due to the decentralised nature of the Charity's governance support, as well as a view that the Company Secretary function is largely administrative, there is no single point of reference within the Charity through which these challenges can be addressed.

Recommendations

3.9.1 The Charity should agree the role which it wishes the Company Secretariat to play in supporting the effective operation of the governance framework. This role can be purely administrative or can be used to drive value and effectiveness of the framework as a whole.

If the latter is the preference of the Charity, we recommend that the charity centralise secretariat support into a single team, with a tightly defined remit. This should include both administrative support for the Board, its committees and the executive committee as well as being empowered to challenge and shape the effectiveness of Governance as a whole including alignment of agendas, requests for information and reports.

The corpocracy, behaviours and engagement of leaders and the organisation as a whole is also important in underpinning the effectiveness of the overall corporate governance framework (see 3.2). Well managed governance support is a key enabler for this.

3. Detailed Findings – Governance

3.10 Management Information

Summary

We have found the quality of papers, including paper summaries and cover sheets, to be of varying quality across the committees. Both the volume of papers being produced (often in excess of 200 pages) and the lack of clarity in places of reporting lines are key drivers for quality. Additionally, the role and remit of committee support functions and alignment of these functions may contribute to this.

There is a large volume of management information being produced to support the committee structure. A number of stakeholders have noted that there is a high volume of 'ad-hoc' information requests from committees and the Board; driving a high volume of papers and additional information. This is driven by a number of root causes 'upstream' in the governance framework; including the lack of clarity around roles and responsibilities, overlap in committee remits and the points around Board Dynamics.

Management Information (MI)

The observations throughout this section are ultimately driving inefficiency in regards to the volume of MI being produced, this has an adverse impact on the quality of MI produced; regardless of the levels of training and capability. We frequently observe issues regarding MI as being symptomatic of wider issues with governance framework and structures.

Our survey results show that Board members and leadership teams are expecting improved MI to support their decision making. For example, only 39% of respondents from our Board, Executive and Governors Survey feel that CEC members receive adequate information in the right format and at the right time in order to make informed decisions, and only 32% of respondents from our Leadership Forum Survey agree that the MI provided to committees is robust and supports effective decision making. This was also reflected in our interviews and focus groups. Interviews also identified a view that managers and senior leaders in the business had not received sufficient guidance and training regarding business writing and reporting styles.

We also noted in relation to this that there had been no formal or structured exercise to engage in setting 'minimum data-sets' or standing report formats for each committee. However, work is taking place operationally to streamline reporting in areas such as performance reporting and our recommendations in regards to structure and architecture for governance assume that work ongoing to deliver an integrated performance review process is completed and represents the future state for the Charity.

As the expectations of papers are not clear there appears to be a default position where anything deemed to be relevant to the remit of a committee is ultimately reported for its attention, typically for information. This is exacerbated further by the conflation of assurance and management roles as noted previously.

Recommendations

3.10.1 Work already ongoing within the Charity to develop an integrated performance review at Divisional level, as opposed to reporting based on functional area, should be prioritised. The existing reporting arrangements appear to be a legacy of the IPU structure which have not been removed as part of the transformation. This is driving inefficiency in information flows from ward to Board, particularly when considered alongside issues previously referred to.

3.10.2 Where authority to manage, review and assure specific functional areas is delegated to executive sub-committees, elements of the IPR relevant to those areas should be reported in line with this, either on a consolidated or Divisional basis.

3.10.3 Minimum data-sets should be established for Board committees with a view to identifying what 'standard' information should be reported to committees as a standing item or at a given point in the year. The Board and Committee 'ways of working' as set out in 3.2 should also set our protocols for requests for additional information to the committee either within or outside the committee cycle.

3.10.4 A writing guide should be established to act as a guide to those drafting papers and reports for committees. This should set out principles and guidance on the purpose of reporting (assurance vs. management for example) along with examples of structures and formats to aid the development of concise and effective papers.

4. Governance and Committee Structure

4. Governance Structure and Recommendations

4.1 Proposed Structure

Whilst there is no single governance structure that is applicable to all charities and / or healthcare providers, the structure set out below represents one proposed option. The proposed structure aims to address the governance needs as they exist today and will require ongoing review and revision where appropriate. We have also articulated the structure in the context of the Five Lines of Assurance as set out in the Executive Summary and in appendix J. For the purpose of this structure the 4th line of assurance is internal audit which is not shown on the structure below.

The principle driver for the presentation of the structure as set out below is to clearly demarcate Board assurance structures from executive and management fora, as the current lack of clear distinction between the two is a driver for significant confusion / lack of clarity in the operation of the governance framework.

Overleaf we have set out the proposed (high-level) assurance and management committee information flows along with an overview of the purpose of each committee and management forum.

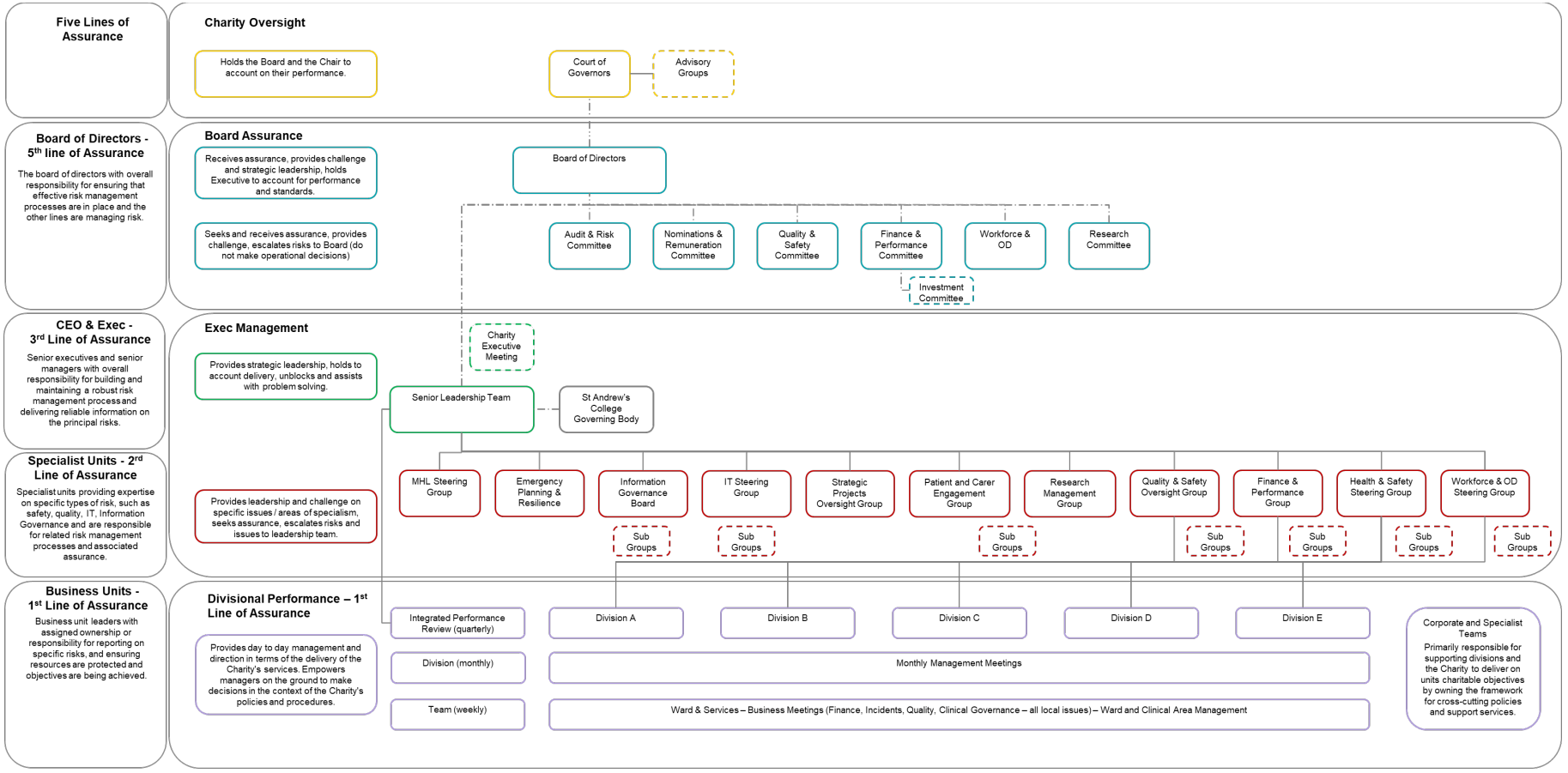


Figure B

4. Governance Structure and Recommendations

4.2 Information Flows and Reporting

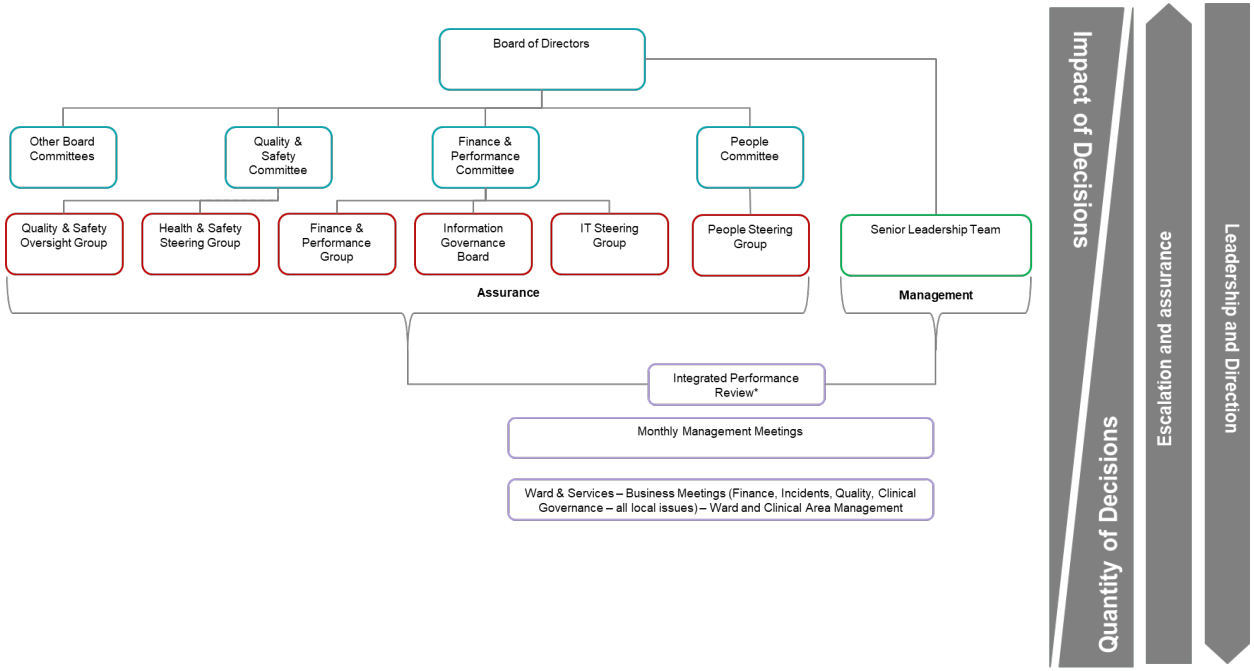
There are a number of key principles in terms of decision making, reporting and information flows which should be observed in terms of the volume and nature of reporting that is required across the governance framework.

1) **Management Reporting** – provides insights to inform managers on aspects of the Charity's activities delegated by the Board through the Executive, in order to help the Executive, leadership and managers throughout the Charity make better informed decisions.
2) **Assurance Reporting** – provides confidence to stakeholders in regards to the performance, systems and processes the Charity has in place, that strategies and objectives are being implemented as intended and that risks are being managed in line with expectation and established best practices.

The information being produced for the consumption of the Board and sub-committees should have a clear purpose. Information produced for the use of the SLT may have a dual purpose in terms of Board or sub-committee reporting. This should be encouraged where appropriate to avoid duplication of effort or re-work, however, in some cases may not be appropriate.

Information typically provided to Boards and Sub-Committees includes:

- Quantitative data, including metrics and trends, with narrative that interprets the data and draws on intelligence from operational activity;
- Succinct presentations, papers or reports which focus on specific issues or areas of risk or concern;
- Reports aligned to the delivery of specific strategic or business plan objectives, themes or outcomes relevant to the scope of the committee; and
- Ad-hoc papers regarding the review or approval of items for which delegated approval is within the purview of the committee – such as a policy, procedure, decision on financial expenditure or similar.



4. Governance Structure and Recommendations

4.3 Board Committees

Overview

The table below outlines the proposed future structure and purpose of each governance committee along with material changes (where applicable) of Board sub-committees going forward. These high-level overviews will require further definition and refinement as part of the early stages of the transformation programme.

Committee/Board	Proposed Future Purpose	Significant Changes to purpose
Audit & Risk Committee	The Audit Committee is responsible for providing assurance to the Board of Directors on the Charity's system of governance, risk and internal control by means of independent and objective review of financial, corporate governance and risk management arrangements, including systems to ensure compliance with laws, guidance, and relevant regulatory obligations. The Committee provides effective governance over: • The quality and integrity of the Charity's financial reporting; • The charity's systems for risk management, compliance and internal control; • The Charity's systems to ensure compliance with legal and regulatory requirements; and • The qualifications, performance and independence of the Charity's internal and external auditors.	1) Remove reference to 'effective governance over clinical governance' – this should be owned by the QSC.
Nomination & Remuneration Committee	The Nominations & Remunerations Committee is responsible for leading the process for Board, Director and Governor appointments, ensuring that the Board and Court of Governors are diverse and maintain an adequate balance of skills, experience, independence and knowledge of the Charity. The committee is also responsible for assessing and recommending the remuneration policy and to determine packages for the individual Executive Directors and senior managers, as established in the ToR.	No changes to scope are recommended in respect of the Nominations & Remuneration Committee.
Quality & Safety Committee	The Quality & Safety Committee is responsible for providing governance over all aspects of quality and clinical safety. The Quality Committee is responsible for providing the Board with assurance on the standards of quality and safety for clinical care and on clinical governance and risk management systems. The Committee is also responsible for providing assurance to the Board on the application of strategies and processes to ensure compliance with relevant Health & Safety requirements, including, where applicable, improvement plans.	1) As discussed at the Board away day on the 5th July 2021 - responsibility for oversight and assurance in respect of H&S at a Board level should be delegated to the QSC.
Investment Sub-Committee	The purpose of the Investment Committee is to advise the Board of Directors of St Andrew's Healthcare, through the Finance & Performance Committee, and the Directors of the St Andrew's Healthcare Pension Scheme on investment strategies.	The purpose of the Fundraising and Donations Group in respect of investment strategies should be clarified – this was not fully functioning at the time of our review, however, policy on investment of donations should not be managed at an Executive Committee level.

4. Governance Structure and Recommendations

4.3 Board Committees (continued)

Overview

Committee/Board	Proposed Future Purpose	Significant Changes to Scope
Finance & Performance Committee	The Committee is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues and for providing assurance that these are being managed safely. The Committee is also responsible for providing assurance to the Board of Directors on the delivery of the Charity's strategies in respect of key enabling functions including Information Management, Information Technology, Information Governance and Estates and Facilities strategies as well as assurance over the implementation of best practice in these areas.	We recommend the charity make significant changes to the purpose and scope of the Finance Committee. 1) Elevate the committee to be an assurance committee, removing tactical monitoring and 2nd LoD oversight functions including the monitoring of financial controls (to be retained within the scope of the ARC as far as is included presently). 2) The addition of a formal role in the monitoring of the Charity's performance in key areas of the IPR for which there is a direct financial impact, including occupancy and the use of agency staff. 3) The addition of a formal role to provide assurance to Board in respect of estates and facilities. 4) The role of the finance committee in terms of accounting policy should be clarified, this should remain the purview of the ARC. 5) As discussed at the board away day on the 5th July 2021 - receive assurance in respect of IT and Information Governance and be consulted on and recommend approval of the IT Strategy to the Board.
People Committee	The purpose of the Committee is to provide the Board with assurance that the Charity's 'People Strategy' and associated structures, systems and processes are in place and operating in line with best practice to support employees in the delivery of high quality and safe patient care. To assure the Board that processes are in place to ensure the Charity meets its legal and regulatory duties in relation to its employees. To assure the Board that processes are in place to support optimum employee performance to enable the delivery of the strategy.	We the scope and remit of the People Committee be revised to focus on the consideration of workforce and organisational development matters. Elements of the people Committee will be re-distributed with some elements being reported to Board as part of the CEO's report on the activity of the SLT.
Research Committee	Provide strategic leadership and direction to the Research Centre in support of the Charity's research strategy and provide the interface between research undertaken by the Research Centre and the Board of St Andrew's Healthcare. Coordination of the wider research activity undertaken by the Charity and 3rd parties for the benefit of the Charity, its patients and the broader research agenda; this may include for example coordination and alignment of higher education placements to the areas of research focus in the Strategy (when approved).	The Research Committee should act as an assurance committee to the Board with a management group established under the executive committee to manage operational and tactical delivery. The move towards this structure should be aligned to the development of the Charity's research activity and strategy.

4. Governance Structure and Recommendations

4.4 Executive Sub-Committees

Below we have set out in summary the purpose of the proposed (future state) executive management and associated sub-committees. The committees and groups included align to those outlined on page 38.

Senior Leadership Team (SLT) should act as the executive management decision-making body for the Charity, chaired by the Chief Executive with membership including the Charity's Executive Directors, Divisional and Clinical Directors and other key stakeholders including for example the Company Secretary.

The revised SLT should have a remit to:

- support the Board in setting and delivering the strategic direction for the Charity within the overall context of the Charity and its partners within the local health and social care system by contributing options for strategic direction, ensuring the integrated and effective delivery of the Charity's agreed Strategy and fulfilment of its duties, standards, targets and other obligations;
- oversee the Charity's management of risk in all aspects of the delivery of its services;
- ensure that there is always appropriate integration, connection and liaison between individual clinical services, between clinical and corporate functions and between strategic and operational matters: within the Charity and between all the Charity's partners;
- support individual directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;
- ensure the fullest clinical contribution to determining the strategic direction and operational delivery; and
- approve policies within the delegated authority from the Board of Directors.

SLT has sub-committees which report to it by means of a covering report and minutes.

Its sub-committees should support SLT to:

- Monitor compliance and implementation of best practice in respect of mental health law, as well as support around good governance over the use of mental health law, by the **Mental Health Law Steering Group**;
- Monitor and test arrangements for and preparedness for serious adverse incidents, by the **Emergency Planning & Resilience Group**;
- Monitor delivery of the Charity's service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Charity's objectives or other obligations, as advised by the **Finance & Performance Committee**;
- Monitor delivery of the Charity's information governance strategy, including the implementation of best practice, aligned to the delivery of patient outcomes, as advised by the **Information Governance Group**;
- Monitor the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensure that appropriate actions are taken, as advised by the **Quality and Safety Oversight Group**;
- Monitor the delivery of the Charity's information management and technology strategies and plans, as advised by the **IT Steering Group**;
- Monitor compliance with statutory obligations under the Health and Safety at Work etc. Act 1974, ensuring, so far as reasonably practicable, the health, safety and welfare of all employees and others not employed by St Andrews Healthcare, as advised by the **Health and Safety Steering Group;**
- Monitor delivery of high impact programmes and projects aligned to the Charity's strategy, including managing interdependencies of individual projects, ensuring the strategic portfolio of projects is delivered to agreed budgets and timescales, as advised by the **Strategic Projects Oversight Group**;
- Monitor the delivery of the Charity's People Strategy and plans, including training and development, as advised by the **People Steering Group**;
- Monitor the delivery of the Charity's strategy and plans around patient and carer engagement, ensuring that the view of the patient is considered in all strategic and operational decisions, via the **Patient Engagement Steering Group**; and
- Monitor and drive delivery of the Charity's research strategy at an operational level, via the **Research Management Group.**

5. Detailed Findings - Risk Management

5. Summary of Findings

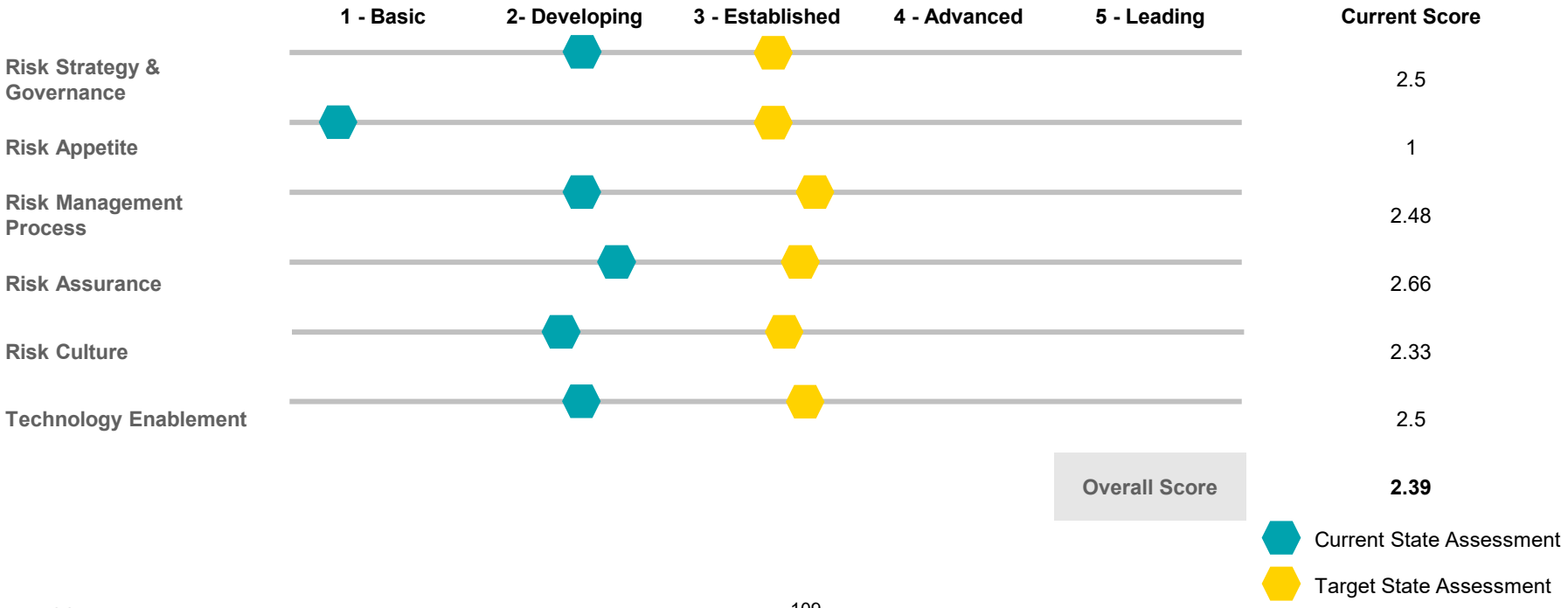
5 Risk Maturity Analysis

We have applied EY's risk maturity assessment tool to assess St Andrew's risk management framework. EY's proprietary assessment tool measures the entity's risk management framework against elements of good practice pulled from both practical experience and from risk management standards. The tool assesses the risk management framework across six 'pillars' on a score of 1-5 (see Appendix H for the scoring methodology and details of the six pillars).

We have assessed St Andrew's risk management framework as being at the second level of maturity - 'developing'. These scores reflect the average scores in each of the pillars, and the overall score reflects the average score of all scoring metrics This reflects positively on core structures in place with regards to risk management, particularly in the clinical space and demonstrates the initial steps taken to implement a process for risk management across all six pillars followed by subsequent developments and improvement activities. We acknowledge that St Andrew's are in the beginning stages of their risk management maturity journey, and that they have an ambition to make proportionate improvements over the next 12 - 18 months, including comprehensive updates on their risk strategy, policy and procedures and migration onto Datix. However, we have noted significant opportunities for improvement with regards to the organisation's risk appetite and the embeddedness of risk management into the organisational culture and decision making.

As well as assessing maturity now, we have aligned the findings and recommendations in our report to a 'target' score for the organisation. By delivering the recommended actions outlined in section 5 St Andrew's can move towards established and advanced practice across the organisation. This should be viewed as a recommendation relating both to continuous improvement and in the context of a specific transformation programme; developing a prioritised project plan with aligned resources to support the work would enable effective delivery.

Maturity Assessment



5. Detailed findings – Risk Management

Risk Strategy & Governance - Scoring | Risk Maturity Score: 2.5

Definition(s)	Description
Risk Strategy and Governance are defined as the overall objectives that the organisation is trying to achieve with respect to risk management, the lines of communication for reporting on risk management issues and events, and the oversight maintained by organisational leadership	Risk Strategy and Governance allow for a clear vision for how risk will be managed within the organisation, and the structures and accountabilities that will enable this.

Good Practice Principles	
Charity Governance Code, Section 4 (Decision Making, Risk & Control)	"4.2 The board has a sound decision-making and monitoring framework which helps the organisation deliver its charitable purposes. It is aware of the range of financial and non-financial risks it needs to monitor and manage."
Charity Commission for England and Wales Guidance – Charities and Risk Management (CC26)	" Charity trustees should regularly review and assess the risks faced by their charity in all areas of its work and plan for the management of those risks. Risk is an everyday part of charitable activity and managing it effectively is essential if the trustees are to achieve their key objectives and safeguard their charity's funds and assets."
Care Quality Commission Guidance KLOE's – Management of Risk	"There is a demonstrated commitment to best practice performance and risk management systems and processes."

Maturity Scoring

	Level 1 - Basic	Level 2 - Developing	Level 3 - Evolved	Level 4 -Advanced	Level 5 - Leading
Risk Vision		2			
Risk Strategy, Risk Policy and Risk Management Framework			3		
Linkages		2			
Risk Oversight and Accountabilities			3		
Risk Function		2.5			
Risk Resourcing			3		
OVERALL	2.5				

5. Detailed findings – Risk Management

5.1 Risk Strategy | Risk Maturity Score: 2.5

Observation

Desktop reviews and interviews identified that, although St Andrew's has a documented Risk Strategy in place (Risk Management Strategy 2019 to 2022), it has not been updated since 2019. Best practice requires an organisation's risk management arrangements, including its risk management strategy, to be formally reviewed and updated annually, or sooner following significant change to ensure that the vision and tone from the top is line with the organisation's position and current strategic objectives. Furthermore, although the Risk Strategy successfully outlines St Andrew's risk management priorities for the period 2019-22, it does not include many of the other key components of a sound risk strategy (including risk management vision / philosophy), such as:

- Risk management philosophy i.e. Vision or Mission Statement from Board, CEC, CEO and SRO for Risk articulating their commitment to risk
- Arrangements for embedding risk management
- Risk appetite and attitude to risk
- Benchmark tests for significance
- Specific risk statements/policies
- Risk assessment techniques

Having a robust Risk Strategy helps 'set the tone from the top' and outlines risk management objectives and expectations to employees, providing 'one view' on how risk is managed across the organisation. Our Leadership Forum Survey identified that 29/63 (46%) responded unfavourably to the following statement –

'*Risk management expectations are understood throughout the organisation*'.

What a Future State might look like – components of a sound risk strategy

We understand that as part of Project Pegasus, St Andrew's is reviewing and refreshing its Risk documentation; this is expected to include the Risk Strategy document. It is important for an organisation to have a clearly established strategy in relation to risk management. This can provide a framework from which the other aspects of Risk Management can effectively operate. For example, a well detailed risk strategy can help embed risk culture by clarifying expectations. The risk management strategy should include details of what the organisation is seeking to achieve with respect to risk management and set out the details of the level of risk maturity that is desired, together with the information on the level of contribution that is expected from risk management. In effect, risk management strategy will establish the way in which risk management activities are aligned with the other activities in the organisation and the contribution that is expected from risk management activities.

Recommendations

5.1.1 The Risk Strategy is amongst the risk documents anticipated to be updated as part of Project Pegasus. The Risk Strategy should include the above components as a priority, and should be clearly communicated throughout the organisation and revisited annually.

5. Detailed findings – Risk Management

5.2 Risk Governance – Oversight, Accountability | Risk Maturity Score: 2.5

Observation

Ineffective risk governance arrangements, such as those where is a lack of clear oversight and accountability for risk management activities may lead to an inability to identify, assess, monitor or mitigate risks in a timely or effective fashion due to poor information flows and/or an inability to act promptly and effectively on key risk information.

Through desktop review of 6 months' worth of Board, Audit Committee and CEC minutes, TORs and committee structure, and stakeholder interviews and surveys, we have identified that at the highest levels of the organisation, roles and responsibilities are well defined, particularly for key leadership groups such as the Board and Audit and Risk-Committee. However, below these, there is uncertainty with regards to who holds ownership and oversight for risk management within organisation leadership. With regards to clarity on roles, responsibilities and accountabilities, with 27/63 (43%) of respondents in the Leadership Forum Survey answered unfavourably to the following statement:

- **Between wards / departments and central functions and across our operating model there is sufficient clarity on roles, responsibilities and accountabilities to ensure we consistently manage risk effectively.**

Furthermore, 9/27 (33%) of Board and Governors responded unfavourably to the same question, providing further indication that across the wider organisation, management do not feel that there is consistent clarity as to accountability and the flow of information.

With regards to Executive ownership, we do note that there is a clearly identified SRO with regards to risk management, namely the Chief Nurse. The Chief Nurse is supported in the management of risk by the Risk function (see finding 5.3), and those members of the executive for whom risk-related activities form part of their brief, such as the Company Secretary. However, overall ownership for risk management at an executive level has shifted multiple times in the past year, which may blur the lines of accountability and reporting.

Furthermore, it was noted that there is blurring between different committee remits, most notably the Quality and People Committees, with the result that the flow of risk information from Ward to Board is disrupted. Furthermore, although ownership of different aspects of risk sits with different tiers of organisational leadership (e.g. Material Risk Register with CEC, BAF with the Board) and there are expected upwards reporting lines per the Charity's existing 4 lines of defence, it has been identified from interviews with stakeholders that the Non-Executives at times do not feel empowered to provide pushback and challenge to the inputs from the Executive regarding risk management activities. This can be demonstrated further in the responses in the Board, Executives and Governors Survey regarding the same statement above. Only one Non-Executive director responded favourably to that statement, whilst all others responded either 'Neither agree nor disagree' or 'Disagree'.

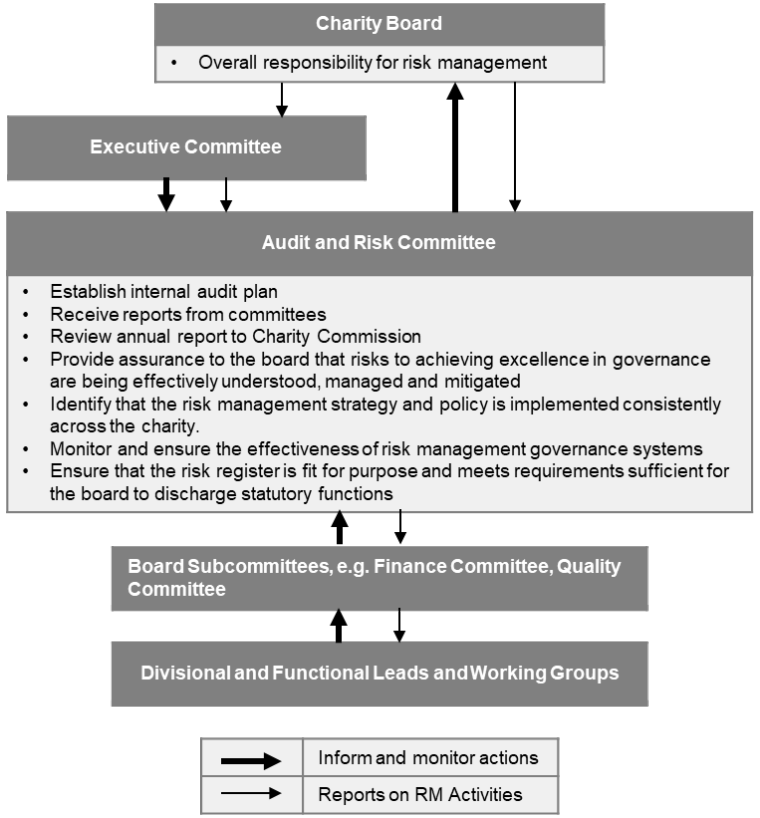
5.2 Risk Governance – Oversight, Accountability (Continued) | Risk Maturity Score: 2.5

Proposal for Future State

As outlined in Figure C, risk governance for charities is a high-profile issue, and in our experience, trustees of charities consider governance issues to be their primary concern. Good risk governance should typically include the following components:

1. **Risk management responsibilities:** In order that risk management can be fully embedded into the core processes and operations of an organisation, a clear statement of risk management responsibilities is required; including responsibility for:
   - development of risk strategy and standards;
   - implementation of the agreed standards and procedures;
   - auditing compliance with the agreed standards.
2. **Committee structure and terms of references:** identifying the committees with risk management responsibilities and the relationships between those committees should be explicit. Terms of references for the various committees should be in place and refreshed on a periodic basis; this should include details of the membership and responsibilities of the various committees, and where these responsibilities include risk management this should be clearly articulated.
3. **Lines of communication for reporting on risk management issues and events:** information on how risk information is communicated between the various committees should be explicit. The reporting structure should be proportionate to the level of risk and the complexity of the organisation. The reporting structure for the management of risk should be proportionate to the level of risk within the organisation and the size, complexity, nature and risk exposure of the organisation. It is vital that the risk governance/ architecture reinforces the fact that the responsibility for managing risks remains with the owner of that risk.

Figure C: Example risk governance for a charity, based on original by Paul Hopkin, 'Fundamentals of Risk Management'



Recommendations

5.2.1 As part of the broader review of governance and reporting structures, we recommend that the risk management responsibilities of each section of the organisation's leadership be clearly defined, with accompanying lines of communication and committee structures clearly articulated. This should be enshrined within terms of reference, where appropriate.

5. Detailed findings – Risk Management

5.3 Risk Governance – Risk Function Resourcing | Risk Maturity Score: 2.5

Observation

We note that there is a small corporate risk function comprising of 3 individuals, which in itself would be proportionate for an organisation of St Andrew's scale, size and complexity and generally in line with peers should these roles be FTE. However, none of these individuals have full time risk roles, with the result that at best the risk function at St Andrew's is 1.5 FTE.

A lack of sufficient risk management resourcing arrangements might increase the risk of single point of failure or 'key-person' risk, as well as hindering the ability to embed consistent risk management processes into the organisation's DNA.

Options for Future State

St Andrew's has a centralised model of risk management, where the majority of risk management activity is driven centrally. Although it is pivotal that the risk management team continues to provide value add support to the business as well as owning and developing the framework for risk management, the business should not be reliant on the team on a day-to-day basis.

In order to effectively embed risk management in business areas and to ensure that both accountability and responsibility for managing risk is understood and consistently delivered, we would suggest partially moving towards a more federated delivery model, where this resource is supported by additional individuals across the business.

A network of risk 'specialists' or risk 'champions' across the organisation through whom best practice is cascaded and supported on an informal basis could provide this required framework. These networks are often supported by a regular forum or network group through which changes to approach, best practice or other important information can be shared by the risk team.

Key benefits of this approach include:

- Enables agility and scale in risk management through embedding the knowledge and experience to support the framework across the organisation;
- Supports continuity in the event of changes in personnel within either the central team or within a specific business area, as the skills and knowledge required to support the framework are replicated across the organisation;
- Empowers local managers to manage and escalate risk within their own business areas; and
- Embeds strong risk management culture, acting as the 'glue' between the risk management team and the rest of the business, supporting implementation of risk management in business processes and procedures. This is particularly important in a setting where managing risk is fundamental to the delivery of the day-to-day activities of the organisation.

This approach will also allow the risk management team to focus on areas of greatest need, ensuring finite central resources are delivering the highest impact possible with their time through challenge, aggregation, analysis and reporting of risk information to support leadership and risk informed decision making.

Please see Appendix G for more details with regards to the establishment of a risk champions network.

Recommendations

5.3.1 Divisional / functional risk champions should be appointed to support the imbedding of risk at an operational level. This would also facilitate the embedding of risk within organisational culture. A Risk Champion network would consists of Risk Champions, one selected from each division or function, who interact with both the risk team and their respective organisation.

5. Detailed findings – Risk Management

Risk Appetite – Scoring | Risk Maturity Score: 1

Definition(s)	Description
Risk Appetite is defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take' (ISO 31000)	Risk Appetite allows an organisation to identify, balance and have a clear understanding of the extent to which they wish to take on risk in the organisation's activities. A clearly defined risk appetite will ensure that decision-making is in line with the overall strategic objectives of an organisation

Good Practice Principles	
Charity Governance Code, Section 4 (Decision Making, Risk & Control)	"4.3 The board promotes a culture of sound management of resources but also understands that being over-cautious and risk averse can itself be a risk and hinder innovation."
Government Finance Function 'Orange Book' - Risk Appetite Guidance 2020	"Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both risk appetite and risk tolerance, an organisation clearly sets out both an optimal and acceptable position in the pursuit of its strategic objectives."
HMT – Thinking about risk – Managing your risk appetite, 2006	"Risk appetite can provide consistency in the decision-making process. It enables people to take well calculated risks when opportunities arise that will improve delivery, and conversely, to also identify when a more cautious approach should be taken to mitigate a threat."

Maturity Scoring	Level 1 - Basic	Level 2 - Developing	Level 3 - Evolved	Level 4 -Advanced	Level 5 - Leading
Link to business strategy	1				
Approach/ methodology and risk appetite statements (RAS)	1				
Risk Appetite Measures (RAMs)	1				
Oversight, monitoring and reporting	1				
OVERALL	1				

5. Detailed findings – Risk Management

5.4 Risk Appetite | Risk Maturity Score: 1

Observation

We recognise that risk appetite is an advanced risk management topic, which relies on the quality of risk data and performance measures / indicators and on mature and consistent risk management capability in place across an organisation. Nonetheless, best practice enterprise risk management requires an explicit measurable risk appetite statement to help senior management articulate and control how much risk they will accept acting as a guide or necessary check and challenge to assess risks 'in the round'. Without clarifying the organisation's expectations regarding risk appetite and applying them in a consistent and documented manner, any changes to the charity's risk strategy cannot be effectively implemented and BAU Risk Management processes may not function in an effective or consistent manner. This could result in a number of issues both related to excessive risk exposure and missed opportunities to risk-adverse behaviours.

Although the charity's risk procedures (Risk Management Procedure v1, August 2019) include an outline of risk appetite requirements, including the key factors which might affect it, this has not been updated since 2019. Furthermore, both interviews and surveys identified that there is a lack of clarity at St Andrew's regarding risk appetite and tolerance, with no consistently agreed and defined Risk appetite, and an accompanying lack of understanding of the topic, throughout the organisation. Per interviews with stakeholders, it was identified that the principle consideration with regards to risk appetite was risk avoidance. Whilst being more risk-averse is not in itself an issue, it needs to form part of a clearly defined framework or approach across the organisation.

In the Leadership Forum Survey, 26/63 (41%) of respondents responded unfavourably to the following statements:

- Our risk appetite is clearly articulated and meaningfully cascaded throughout St Andrew's healthcare in our governance structures and control environment.
- Risk appetite is used to facilitate balanced trade off conversations (e.g. between quality of care and delivering value for money)/ is used to inform our capacity to take on more risk or an early warning indicator of where we may need to intervene early/ take proactive action to reduce or prevent risk from occurring.

In the Board and Governor's Survey, 12/27 (44%) of respondents similarly responded unfavourably.

Usage of Risk Appetite/Link to Strategy

There is no evidence within the available documentation that risk appetite is being actively used in either risk management processes or wider business processes. Furthermore, per our interviews with stakeholders it has been identified that there is limited understanding of the appetite for financial risk, which interviews identified is hindering discussions with regards to the charity's strategy for obtaining sufficient investment funds. Upon consultation with stakeholders, it was identified that where any form of risk appetite is identified on an ad hoc basis, this is done on an inconsistent basis by individual divisions, functions, or even line managers, with the result that these activities are ill-defined and inconsistent, as well as on a siloed basis.

Risk Appetite Statements, Framework & Methodology

Although as mentioned previously, there has been consideration of the criteria which should be factored in to any discussions of risk appetite within the Risk Management procedures, as well as a pro forma statement template, there are no documented risk appetite statements, frameworks or methodology which relevant stakeholders can consistently apply to identify, manage and monitor risk appetite. This may be a key reason why risk appetite has been performed principally on the ad hoc basis mentioned above. Furthermore, it is perceived that basis for these appetite considerations is highly subjective, which may be in part due to the lack of a consistent methodology

Risk Tolerance Limits and KRI's

Risk appetite limits and metrics, and the processes in place in the event of a breach of said limits, are not routinely developed and integrated into core processes, and risk reporting does not reflect the organisation's risk profile in the context of its appetite and tolerances. This may contribute further to the ad hoc and inconsistent risk appetite activities – there is a perception amongst stakeholders that too much weight is being placed on individuals' expertise due to the lack of objective KRI's to measure against.

Oversight and Reporting against Risk Appetite

In our inspection of Risk Reporting, such as that found in Board and Audit & Risk Committee, we found that there was no evidence of reporting against risk appetite. It was noted in these discussions however that the organisation needed to refresh its approach to risk appetite.

5.4 Risk Appetite (continued) | Risk Maturity Score: 1

Future State Expectations – articulating a practical risk appetite framework/ approach, statements and tolerances

Critical to the delivery of any meaningful improvements to Risk Management at St Andrews is the existence of a clearly defined and well-documented Risk Appetite Approach / Framework. Given the charity's clinical environment and the resultant variety of clinical and business risk outcomes, it is essential that these appetites be defined to prevent risk decisions being made on a subjective basis and in isolation.

Any Risk appetite framework / approach developed by St Andrew's should include explicitly-defined appetite statements, as well as plans for the monitoring of risks against appetite. These statements and monitoring plans should be underpinned by key risk indicators based on quantifiable metrics, and risk tolerances should be identified throughout. The KRI's will act as early warning indicators, whilst the tolerances can provide limits to identify breach points in terms of excessive risk. Where possible these risk appetites, tolerances and KRI's should also be linked to individual risks and included as part of risk registers where possible. Risk appetites, tolerances and KRI's should exist at all levels of risk management, and should be scaled accordingly. Once developed and finalised, the risk appetite, tolerances and KRI's should be clearly communicated to all levels of the organisation and included as part of risk management training.

We recommend that St Andrew's refer to Good Governance Institute's Risk Appetite Maturity Matrix for NHS organisations to support better risk sensitivity in decision-making: https://www.good-governance.org.uk/wp-content/uploads/2012/01/Risk-Appetite-Maturity-Matrix-3.pdf (see right):

With regards to Key Risk Indicators that the organisation could implement, these could include:

- People – Staff Turnover e.g. voluntary resignations of key persons (ie those in senior roles or identified as successors to those in senior roles)
- Technology – Number of IT events with material business impact (i.e. number of critical / high technology and data incidents reported per month)
- Clinical – Number of material self-harm incidents (i.e. number of serious / critical self-harm incidents reported per month)

Figure D: Good Governance Institute's Risk Appetite Maturity Matrix for NHS organisations

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

Recommendations

5.4.1 We would recommend the development of a clearly defined and well-documented Risk Appetite Approach / Framework. This could be a standalone document, or be embedded within the updated Risk Strategy. Examples are provided at appendix N.

5.4.2 Refreshed guidance on the use and application of risk appetite should be clearly communicated throughout the organisation.

5. Detailed findings – Risk Management

Risk Management Process - Scoring	Risk Maturity Score:	2.48

Definition(s)	Description
Risk Management Processes are defined as those processes relating to the identification, assessment and documentation of risks, as well as how these risks are managed, monitored and responded to.	Clearly and well-defined Risk Management Processes are important in order to have a clear understanding of the risks affecting the organisation, and to ensure that measures are in place to mitigate and respond to them in an effective and timely fashion.

Good Practice Principles	
Care Quality Commission Guidance KLOE's – Management of Risk	"The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks."
Charity Commission for England and Wales Guidance – Charities and Risk Management (CC26)	"…having a rigorous risk process and a clear risk management policy helps ensure that the identification, assessment and management of risk is linked to the achievement of the charity's objectives, all areas of risk are covered… a risk exposure profile can be created that reflects the trustees' views as to what levels of risk are acceptable, the principal results of risk identification, evaluation and management are reviewed and considered, and that risk management is ongoing and embedded in management and operational procedures"
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17	"…providers must have the systems and processes in place to assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others…"

Maturity Scoring

	Level 1 - Basic	Level 2 - Developing	Level 3 - Evolved	Level 4 -Advanced	Level 5 - Leading
Approach and Context		**2.5**			
Risk Identification		**2.5**			
Risk Assessment		**2.6**			
Risk Monitoring		**2.33**			
Risk Profile / Registers		**2.4**			
Risk Reporting		**2.66**			
Control Environment		**2**			
OVERALL	**2.48**				

5. Detailed findings – Risk Management

5.5 Risk Management Process – Risk Identification and Assessment | Risk Maturity Score: 2.48

Observation

We note that St Andrews has a documented risk management process (Risk Management Procedure v1.0, last reviewed August 2019) which outlines the process in place to identify, understand, monitor and address risks. This procedure includes key expected elements, such as consideration of inherent, residual and target risk assessment, and details expectations for frequency of review of risks and risk registers. However, this has not been updated since 2019 – we understand that it is due to be updated alongside the migration to Datix as part of Project Pegasus. The absence of an up-to-date effective and clearly documented risk management process may lead to the inability to identify, assess, monitor and mitigate risks in an effective and/or timely fashion. This may lead to an ineffective controls environment, or risk incidents due to unidentified risks.

We have identified the following areas that should be prioritised as requiring updating as part of this process:

Risk Identification

It should be noted that in our Leadership Forum Survey, 35/63 (56%) of respondents answered favourably when asked their thoughts on the following statement:

- Q35a. Our people and systems are appropriately configured to promptly identify risks and issues. People are encouraged to ask questions and speak up when they have concerns.

This indicates that stakeholders feel they have the resources to identify risks as they emerge. We observed that there are more than 500 risks across the 40 operational risk registers, which is not excessively high in and of itself, equating to approximately 12 risks per risk register. However it has been identified through interviews with stakeholders that there is a considerable amount of siloed working with regards to risk management, where individual divisions and functions are considering risks without communication and cross-working with the other functional units. In addition, where similar risks with variations of root cause have been identified, these are split out, rather than considered jointly.

Whilst there is a degree to which this is appropriate, for example, with regards to the specific risk profiles of different divisions, this may lead to a disjointed approach with regards to risk mitigation efforts, with different divisions or functions mitigating the same risk in different ways, rather than a coordinated approach. In addition, the granularity of risk identification with regards to similar risks may lead to these risks not being looked at as an aggregated whole, where the collective impact of these similar risks is not suitably identified and resultant mitigating efforts implemented.

In addition, although St Andrew's applies risk categorisation in the annual report, no categorisation of cause is applied to risks in the risk registers. Risks are assessed in terms of impact but not differentiated consistently by cause.

This may further hinder efforts to look at the collective impact of related or similar risks.

Use of Risk Standards and Scoring Criteria

We note that attempts have been made to tailor risk management arrangements to St Andrew's, and in some places this is done to a good standard, such as learning from clinical failures / linking risk management to a quality approach and learning from past events. We further note that the risk assessment procedures make reference to recognised standards including COSO, BCI and ISO. However, in places the use of these standards has resulted in standards and processes being corporate in nature, compared to what we might expect for an entity within the healthcare and/or charity sectors.

Furthermore, although the materiality threshold criteria outlined within the procedures do take into consideration a number of different factors driving the severity of a risk, the principal criteria used to score the impact of a risk for the 5x5 matrix are solely financial. Furthermore, the scale of these financial impact scores are not proportionate to the current financial position of the charity.

5.5 Risk Management Process – Risk Identification and Assessment (Continued) | Risk Maturity Score: 2.48

Future State – Risk Identification

We would suggest the use of a dual categorisation approach for an organisation of St Andrew's level of risk maturity. There are a number of advantages to the use of a dual categorisation approach:

- Dual categorisation often supports more effective risk analysis and evaluation as specific controls can be aligned to both cause and impact separately.
- It would allow for aggregation and thematic analysis of risks including analysing relationship between and differentiation of cause and consequence, whilst also allowing the risks to continue to be managed on a divisional level.
- Effective categorisation can also aid in the assessment of the most appropriate response to a risk as well as both tactical and organisation-wide mitigation planning.
- Dual categorisation can support effective top-down analysis and risk identification through analysis of relationship and grouping around both cause and consequence categories. This is an effective tool to support horizon scanning and consideration of strategic risk.

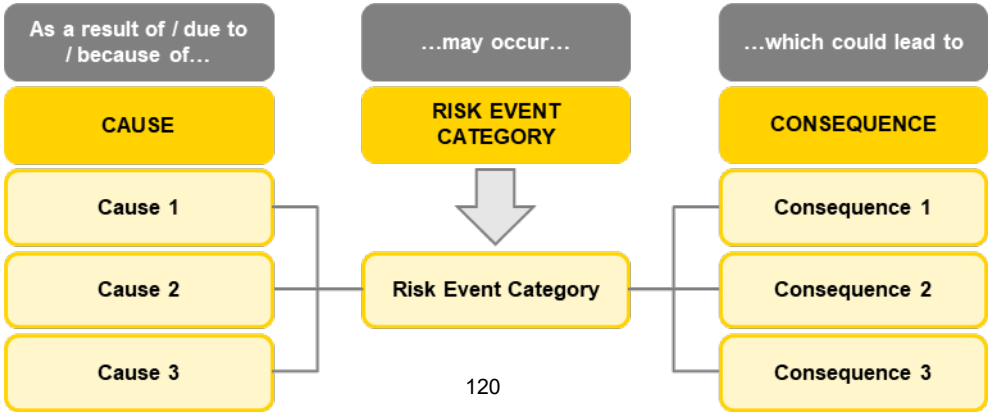
Cause categories would typically align to a set of categories outlined in St Andrew's risk register and/or risk management procedures and are allocated on a qualitative basis. Consequence categories can be a mix of both qualitative and quantitative criteria and typically align to areas such as service delivery, finance and reputation generally answering the 'so what' question.

It is often not practical to require this level of analysis for all risks down to an operational (ward / service) level. However, additional risk analysis is often undertaken as risks are escalated.

Conversely to the considerations regarding the aggregation of risk, for 'critical' or strategic risks it is also important that analysis and evaluation of risks or risk groupings is carried out in sufficient detail to understand all causes and consequences. It is therefore often helpful to have a more detailed record of these risks which allows for analysis against all aspects of the risk. This can then be summarised for the purposes of the risk register, for example with the highest scoring category applied.

A visual manner in which this categorisation could be articulated is as follows, through a bow-tie diagram. A bowtie is a visual tool to help articulate risk and is widely used in various high-risk sectors like health/ social care. It shows how a risk event category might have one or more causes that can trigger the risk event category, which can lead to one or more consequences/impacts.

Figure E: Example Bow Tie Diagram



5. Detailed findings – Risk Management

5.5 Risk Management Process – Risk Identification and Assessment | Risk Maturity Score: 2.48

Future State

Risk Assessment Criteria

In order to implement these recommendations, specifically with regards to assessing risks, we recommend that St Andrew's refers to the guidance provided by the Charity Commission (CC26). These provide a useful template for how other criteria can be matched to existing financial criteria (once these have been scaled to appropriate levels for the charity). The criteria used for the other categories could align to those for the Materiality Threshold assessment. See Appendix F for more details

Recommendations

5.5.1 Risk Registers should be reviewed to identify where common risks sitting across multiple risk registers should be aggregated and assessed on this aggregated basis. These aggregated risks in turn should be considered for inclusion on the Material Risk Register. This holistic review could be undertaken through Datix's functionality allowing all the organisation's risks to be cross compared.

5.5.2 As part of the risk identification process, non-clinical risks should be categorised into one of a number of categories (in line with the Charity Commission's guidance), which should be included as part of risk registers and embedded within the functionality of Datix. This will allow for similar risks to be compared and common trends identified and aggregated. Clinical risks should be categorised as such to allow for them to be managed and monitored in an appropriate manner.

5.5.3 Risk management standards should be aligned with those expected for the healthcare and/or charity sectors, such as the HM Treasury Orange Book, the Charity Commission's Charities and risk management (CC26), and the Charity Governance Code - 4. Decision making, risk and control — Charity Governance Code.

5.5.4 The Risk categories identified as part of the materiality threshold criteria should be reflected in risk documentation such as the Operational Risk Registers.

5.5.5 The 5x5 Impact criteria should be revised so that financial impacts are proportionate to St Andrew's financial position, and that additional criteria for non-financial impacts are included. A 5x5 matrix should be maintained as it is deemed best practice in terms of optimising the ability to differentiate between different levels of risk without providing excessive details.

5. Detailed findings – Risk Management

5.6 Risk Management Process – Risk Monitoring and Review | Risk Maturity Score: 2.48

Observation

We further noted the following with regards to the ongoing documentation, monitoring and review of risks and risk registers:

Mitigating Actions

Risk mitigation actions are not consistently documented for all risks, for example, of 20 risk registers sampled, 5 (Allied Professions, Soft FM, Essex FM, Estates Capital Project and Executive Medical Director) had multiple risks where the 'risk mitigation' field was not populated, whilst for one further register (Emergency Preparedness), the only detail in this field was that there was no mitigation. It should be noted that for some of these risks with missing 'risk mitigation', the 'mitigating action' field was populated. We understand that the Xactium system required the risk mitigation field to be populated to proceed with adding the risk to the risk register, which suggests that these risk registers were being maintained offline, which may lead to version control issues.

Where risk mitigation and or mitigating actions are detailed, there is insufficient detail with regards to specific action plans and mitigating controls, meaning that these plans may not be effectively implemented and or tailored to address the specific needs of the risk. In addition, the cost of mitigating actions were not detailed or discussed as part of the risk management process, despite this being included in the stated Risk Management Procedures.

Frequency of Risk Review

Furthermore, although we noted that sufficient structures were in place to allow for effective frequency of review of risks and risk registers (risk registers on a quarterly basis, no less than every sixth months for risk assessments), and that compliance with this review schedule was monitored by the Risk Function, these were not being complied with, resulting in two thirds of risks being overdue for a review as of the last available data. A failure to review risks in a timely fashion, particularly those with a high velocity, may lead to failure to detect worsening of a risk or deterioration of a control environment, resulting in a risk event or similar negative outcome for the organisation.

Future State

In order to facilitate the effective detailing of mitigating actions in place for risks, we recommend aligning with a methodology such as the 5 T's of Risk response:

- **Tolerate**
- **Transfer**
- **Take (Exploit)**
- **Treat**
- **Terminate**

The 5 Ts act as a helpful tool for agreement and recording of management decisions regarding risks, which can also act as a sense check prior to identifying and planning for treatment plans. They can also be used to direct and link to assurance sources, for example having a focus on treat / take / tolerate risks with finite assurance resource.

We believe that the existing frequency of review per policy is robust. However, greater compliance with this policy is necessary in order to achieve effective frequency of review of risks and risk registers. Automation functionality such as push notifications from Datix and/or dashboard reporting to highlight risk registers and risks in need of review could provide a possible solution to helping risk management stakeholders perform their activities in a timely manner. This should also be a key objective of the establishment of a risk champions framework, with risk champions driving the regular performance of these risk review activities. Regular ongoing review activities would also allow for larger time intervals between risk deep dives, which are currently identified by stakeholders as being excessively time-consuming on their current frequency.

Recommendations

5.6.1 Risk registers should be maintained online to ensure that the required fields for each risk are appropriately populated. Where possible, mitigating actions should outline specific controls in place to mitigate the risks. These controls should each carry a specific unique identifier and should be tested on a periodic basis, such as through part of the IA function's annual plan. Where possible, Mitigating Actions should follow an established methodology such as the 5 T Model.

5.6.2 We would recommend automated functionality such as push notifications and/or dashboard reporting to help flag and identify risks and/or risk registers in need of updating/reviewing.

5. Detailed findings – Risk Management

Risk Assurance - Scoring	Risk Maturity Score:	2.66

Definition(s)	Description
Risk Assurance is defined as the means by which an organisation receives reasonable assurance that the significant risks are being adequately controlled	Risk Assurance acts a set of checks and balances on the risk management system in place; without regular, and ideally independent reviews, these systems may become ineffective and/or non-compliant with regulatory requirements.

Good Practice Principles	
Care Quality Commission Guidance KLOE's – Management of Risk	"Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns."
UK Corporate Governance Code, Chapter 4, Section 25	"The main roles and responsibilities of organisational leadership should include…reviewing the organisation's internal financial controls and internal control and risk management systems"
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17	"Providers… must continually evaluate and seek to improve their governance and auditing practice."

Maturity Scoring					
	Level 1 - Basic	Level 2 - Developing	Level 3 - Evolved	Level 4 -Advanced	Level 5 - Leading
Assurance Strategy		**2**			
Assurance Sources / Tools - Internal			**3**		
Assurance Sources / Tools - External			**3**		
OVERALL	**2.66**				

5.7 Risk Assurance – Assurance Framework | Risk Maturity Score: 2.66

Observation

Should an organisation lack an appropriate assurance framework with which to document and provide assurance with regards to the organisation's principal and material risks, this may in turn lead to in inability to effectively monitor and mitigate these risks, as well as creating significant shortcomings in the provision effective management information to the Board and Executive to inform decision making.

The Charity has no single articulation of its assurance policy and/or strategy which provides an integrated view of assurance, including relationships between different elements of the assurance framework, to ensure that assurance priorities align across the organisation and to act as a marker of 'what good looks like'.

An updated Board Assurance Framework was prepared as of April 2021 to replace the previous Strategic Assurance Framework. However, it is our understanding that the BAF is undergoing further revisions following feedback from senior stakeholders., with work ongoing to restructure how it will be presented going forwards. As such we have been unable to review its effectiveness. As no BAF is in place, and no other clear and consistent articulation of assurance exists, there is no accessible means for Non-Executives and other Board members to understand where to look for assurance on specific issues or concerns. There is also no means through which continuous improvement in assurance provision can be implemented.

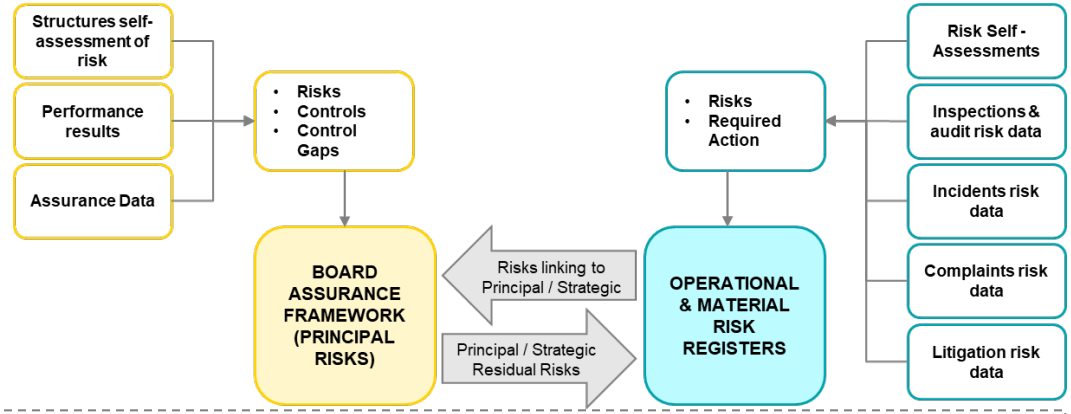
In addition, we note that ownership for the BAF does not sit with the Risk Management function, which may result in a disconnect with the rest of the organisation's wider risk management efforts. For example, there are uncertainties as to how information flows between the strategic risks maintained within the BAF, and the material and operational risk registers maintained by the risk function and across the business.

Future State

We have included a basic articulation of assurance flows under St Andrew's risk management model in figure F.

In this model, information flows from top-down and bottom-up, which allows for effective knowledge transfer throughout the organisation and greater transparency with regards to the charity's risk management environment (see Finding 5.10 for further details). This will also allow the BAF to map to the principal risks based on the upwards aggregated flow of information, combined with the insights at the top of the organisation.

Figure F – Example BAF information flow



Recommendations

5.7.1 We recommend that the BAF, upon the completion of the upcoming revisions by the relevant stakeholders, be fully communicated and its importance reinforced to stakeholders, to ensure that at its first quarterly review, it is sufficiently embedded and all quarterly updates appropriately made.

5.7.2 An accompanying Board assurance policy and strategy should be developed to clearly articulate key assurance activities and to ensure that they are aligned to the core business objectives and strategy of the charity. This policy and strategy should also clearly set out the expectations for how information would flow between the BAF and the other risk registers / elements of the assurance framework. The strategy should also include an articulation of annual / cyclical assurance provided to the Board. Example contents of an integrated assurance manual are included in appendix M.

5. Detailed findings – Risk Management

5.8 Risk Assurance – Assurance Model | Risk Maturity Score: 2.66

Observation

We note that St Andrew's has a 4 Lines of Defence assurance model (3 Lines of Defence plus external bodies) which is documented in the BAF Standard Operating Procedure. However, as a result of the lack of clarity regarding ownership and oversight of risk management (see finding 5.2) at an operational level below the senior leadership, there is uncertainty as to how the information flows through these lines from Ward to Board in practice.

Future State - 5 Lines of Assurance

Risk assurance is an important component of the overall risk management process. To improve communication between the board of directors, members of the executive and the business unit leaders; and to focus on providing consolidated assurance across the organisation, to enhance a risk-aware culture, St Andrew's may wish to enhance the effectiveness of their lines of defence model, with the five lines of assurance. This model is proposed by leading Risk Management professionals as an evolution of the 3 Lines of Defence model to elevate the role of the Board and other key executive stakeholders such as the CEO in risk governance.

The five lines of assurance model suggests the following sources of assurance:

- The board of directors with overall responsibility for ensuring that effective risk management processes are in place and the other lines are managing risk to
- Senior executives and senior managers with overall responsibility for building and maintaining a robust risk management process and delivering reliable information on the principal risks.
- Business unit leaders with assigned ownership or responsibility for reporting on specific risks, and ensuring s are protected and objectives are being achieved. resource
- Specialist units providing expertise on specific types of risk, such as treasury, safety, environment, legal and insurance with responsibility for related risk management processes.
- Internal audit activities, providing independent and timely information to the board on reliability of the risk management processes in the organisation and producing consolidated reports.

St Andrew's could consider implementing the 5 Lines of Defence Model as part of the realignment and clarification of reporting structures recommended elsewhere in this review (see section 4). Combined with the various external review bodies which current make up St Andrew's fourth line of defence, this would allow for a thorough holistic approach to assurance whilst ensuring that each aspect of the organisation has a clearly defined to role to play in the assurance framework. This tailored approach could then be communicated throughout the organisation so that all parties understand the expectations of their role to play.

Recommendations

5.8.1 St Andrew's reviews and clarifies its assurance structures as part of its broader governance structure realignment. This assurance model could be based around the 5 Lines of Defence as set out in Appendix J.

Note: Organisations are increasingly examining how assurance is structured and the different types or assurance which they require to satisfy both internal and external stakeholders. However, a helpful tool in assessing and mapping assurance requirements is the stratification of risks across 'risk type'. EY's NextGen ERM method identified three main types of risk and allows for the assessment of assurance requirements based on the nature of the risk. We have included an overview of this in Appendix J. This should be considered in terms of the articulation of the assurance policy and strategy as well as in terms of the flow of assurance through the five lines as outlined above.

5. Detailed findings – Risk Management

5.9 Risk Assurance - Additional Assurance Provision | Risk Maturity Score: 2.66

Observation

The charity has numerous sources of external assurance, including both audit and outputs from regulatory bodies such as CQC and Health & Safety Executive, we have observed that the outcomes of these reviews are reported throughout the governance framework. Through our interviews with stakeholders, it was identified that senior stakeholders were also engaged with these outputs.

The Charity also has an in-house Internal Audit team which provides assurance across the 4th line of assurance – please refer to 3.9 for findings related to the effectiveness and independence of IA.

5. Detailed findings – Risk Management

Risk Culture - Scoring	Risk Maturity Score:	2.33

Definition(s)	Description
Risk Culture is defined as the norms of behaviour for individuals and groups within an organisation that. determine the collective ability to identify and understand, openly discuss and act on the organisation's current and future risks.	Risk Culture is important because in order to implement fully effective risk management in an organisation and embed this into the minds, behaviours and activities of all staff, significant cultural change usually needs to take place.

Good Practice Principles	
Paul Hopkin – Fundamentals of Risk Management (Institute of Risk Management) – LILAC Model	An effective risk aware culture can be achieved through LILAC – Leadership, Involvement, Learning, Accountability and Communication
Care Quality Commission Guidance KLOE's – Management of Risk	The organisation reviews how they function and ensures that staff at all levels have the skills and knowledge to use those systems and processes effectively.
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12	"Providers must… make sure that staff have the qualifications, competence, skills and experience to keep people safe."

Maturity Scoring	Level 1 - Basic	Level 2 - Developing	Level 3 - Evolved	Level 4 -Advanced	Level 5 - Leading
Lessons Learned / Root Cause Discipline / Responding to Bad News			**3**		
Risk Culture Embeddedness - Rewarding appropriate risk taking		**2**			
Risk Resourcing – Training and Competence		**2**			
OVERALL	**2.33**				

5.10 Risk Culture | Risk Maturity Score: 2.33

Observation

Risk Culture Embeddedness

Best practice for the embeddedness of risk management into business practices is that risk forms part of the organisation's culture and DNA – all stakeholders should understand the organisation's approach to risk and risk appetite. Risk management should be integrated within performance management, business processes and the delivery of strategic objectives. Should risk management not effectively be embedded into the organisation's culture, this may lead to ineffective and / or disjointed risk management activities. We note that St Andrew's has a very strong foundation in terms of the embeddedness and understanding of clinical risk, which must be sustained whatever the outcomes of this review. This is embodied, for example in a strong cultural understanding of risk management relating to clinical incidents. In addition, St Andrew's has a documented and implemented approach to reflecting lessons learned from risk management within the organisation.

However, it is felt by a wide range of stakeholders that– risk is perceived to only be meaningfully thought about in a clinical sense, and not with regards to the business functions of the organisation or reputational considerations; outside of this clinical context, risk is not embedded into the DNA of the organisational culture of the charity. For example, risk assessment is not tied to its impact on strategic or operational objectives, and therefore there is a lack of understanding as to linkages between risks and business processes and activity. As such, Risk management is not viewed as strategic and value creating, which further hinders the ability to effectively identify, mitigate and monitor risks. Where individuals are required to perform risk management activities, these are largely perceived to be a tick box exercise with no material impact or consequences. This is in part due to a perception that the focus of individual's efforts should be delivering clinical care first and foremost. Despite this, it should be noted that it is perceived that there is a willingness to make improvements to risk management processes within the organisation, and there would be a strong 'buy in' to proposed changes to the process, provided that issues are addressed and ineffective mechanisms and processes are removed.

Risk Training and Competence

Underpinning and potentially worsening the issues with regards to embeddedness of risk within the organisational culture is a lack of formally documented and delivered training for both staff and board members with regards to risk management. We understand that there are plans in motion to develop training with regards to risk management at both a Board level and throughout the organisation, but these have not been implemented as of yet. Without a formally documented and delivered training programme for the organisation's employees, this may hinder efforts to embed understanding of the importance of risk management throughout the organisation. In addition, a lack of training may result in inconsistent or ineffective risk management efforts due to a lack of appropriate knowledge and understanding.

Future State – Communications Strategy

Creating a culture where effective risk management is an integral part of the way people work is a long-term aim for most organisations. When the Risk Documentation is updated as part of the planned refresh, St Andrew's may wish to consider launching a campaign to focus on the risks and the relevant controls. This communication should clearly set out the expectations with regards to Risk Management, as well as the importance and benefits of effective risk management in line with the updated documentation and its incorporation into BAU practices.

The campaign should use more than one means of communication if it is to be successful. The awareness campaign could include Leadership, Involvement, Learning, Accountability and Communication (referred to as the LILAC model) and may extend to:

- risk awareness training i.e., training in risk management procedures and learning from events.
- awareness poster campaigns;
- site inspections;
- arrangements for reporting defects;
- leaflets and brochures;
- setting risk management performance targets and ensuring that the commitment of senior management to the risk-aware culture is clear.

5.10 Risk Culture (Continued) | Risk Maturity Score: 2.33

Future State – Communications (Continued)

We understand that the importance of risk management is included as part of the proposed Communications Strategy and this must continue to be the case, and built upon and developed further. These expectations should be re-communicated on a periodic basis (e.g. annually) and/or whenever changes are made, and should be tailored to the different expectations of different ranks.

In addition the structures to communicate risk management outcomes, whether discussions at leadership level or operational updates from the wider organisation, should be organised to allow for an effective bottom up and top down transfer of knowledge in both directions. This would allow more effective implementation of mitigating actions and a greater 'buy-in' from more junior members of the organisation in terms of their involvement in the risk management process, whilst also improving leadership's visibility of risk management across the organisation.

Future State – Training

The implementation of a risk management training programme would be tailored to the needs of specific ranks and their accompanying responsibilities with regards to Risk Management, but nonetheless should seek to embed a culture of risk management at all levels of the organisation. This training should particularly focus on enabling clinical staff or those with a clinical background to have the knowledge and understanding to manage business and operational risks outside of the clinical environment. This training should extend upwards to the Board and form part of their development framework. Furthermore, refresher training should be organised on a periodic basis to ensure that all employees are up-to-date with the current risk management approach of the organisation.

Risk Champions and improved Risk Culture 'Buy In'

The recommended implementation of Risk Champions (See Finding 5.3) will also assist with the embedding of risk culture throughout the organisation by providing leadership and focal points for risk management within each business unit.

Recommendations

5.10.1 We recommend that a campaign be developed upon the update of Risk Documentation to communicate changes through the organisation and promote a culture of risk management.

5.10.2 We recommend that a communications strategy be implemented to periodically remind individuals of their risk management responsibilities and the importance of effective risk management, and that this be communicated to all new joiners.

5.10.3 We recommend that structures used to communicate risk management discussions be realigned to facilitate a top-down, bottom up transfer of knowledge and transparency regarding risk management throughout the organisation.

5.10.4 We recommend that a dedicated risk management training programme be implemented throughout the organisation, as well as for new joiners. This should be tailored to the needs of specific ranks, and specifically address the potential knowledge gap between those with clinical and operational backgrounds.

5. Detailed findings – Risk Management

Technology Enablement - Scoring	Risk Maturity Score:	2.5

Definition(s)	Description
Technology Enablement is defined as the leveraging of technologies and tools to facilitate and enhance the risk management process, such as through automation, dashboard reporting or data insights.	Technology Enablement allows for the streamlining and harmonising of risk management processes whilst also providing greater levels of qualitative and quantitative insights into the organisation's risk profile.

Good Practice Principles	
Care Quality Commission Guidance KLOE's – Information management	"Information technology systems are used effectively to monitor and improve the quality of care."
FCA Senior management arrangements, Systems and Controls (SYSC) 3.1.1 R, Principle 9	"Management should ensure the organisation has a sound technology infrastructure that... supports integrated and comprehensive risk management." "Management should make appropriate capital investment or otherwise provide for a robust infrastructure at all times"
FCA Senior management arrangements, Systems and Controls (SYSC) 3.1.1 R, Principle 2	"Organisations should design, build and maintain data architecture and IT infrastructure which fully supports its risk data aggregation capabilities and risk reporting practices not only in normal times but also during times of stress or crisis."

Maturity Scoring	Level 1 - Basic	Level 2 - Developing	Level 3 - Evolved	Level 4 -Advanced	Level 5 - Leading
Risk Management information System (RMIS) / ERM Tool		**2**			
Risk Data			**3**		
OVERALL	**2.5**				

5.11 Technology Enablement | Risk Maturity Score: 2.5

Observation

Risk Management Information Systems

We note that Risk Management Information is due to migrate from Xactium to Datix. With this migration, there is the possibility that the changes to risk assessment and documentation processes arising as a result of this review and from Project Pegasus may not be implemented into Datix' system build, resulting in a failure to embed these changes within the system/organisation. A lack of embedded changes within the system may lead to ineffective risk documentation and mitigation due to inconsistencies between the stated policy and what is contained within the system.

Risk Data

We note that there are concerns with the quality of risk data, such as with regards to the excessive number of risks on risk registers and the completeness of information regarding risks. There are concerns that Datix will not provide sufficient data-validation or checks on completeness of information in advance of risks being stored / submitted, allowing individuals to record risks without a complete set of supporting data; this has been common placed under Xactium. This is both a technical and cultural / behavioural point, we noted that data quality and completeness across the organisation (albeit not solely with regards to Risk management) has been identified as a material risk on the Material Risk Register.

In addition, there are concerns that there are limitations to the integration between Datix and other data-driven systems such as SAP-GRC, and RIO, meaning that the system will largely work on a standalone basis providing a snapshot of risks, rather than real-time updates (which is the ideal best practice for risk reporting).

Future State – Technology and Data

It is probable that the changes made to Risk Management Procedures will not be implemented prior to the migration to Datix. To offset this, a set of change management controls could be put in place to prevent legacy issues re-occurring in the new platform. Where changes are made after the migration, they should be reflected in Datix and reviewed to ensure full expected functionality is achieved. Any further changes and subsequent knock-on effects (such as system downtime) should also be clearly communicated to ensure that all relevant stakeholders are sighted, and any changes to the system should be reviewed and approved by an appropriate SRO.

With regards to data, St Andrew's could explore whether further integration with other data-driven systems such as SAP-GRC could be achieved, or failing that, that reporting driven from these applications could be used as the basis of updates made to Datix as a central repository.

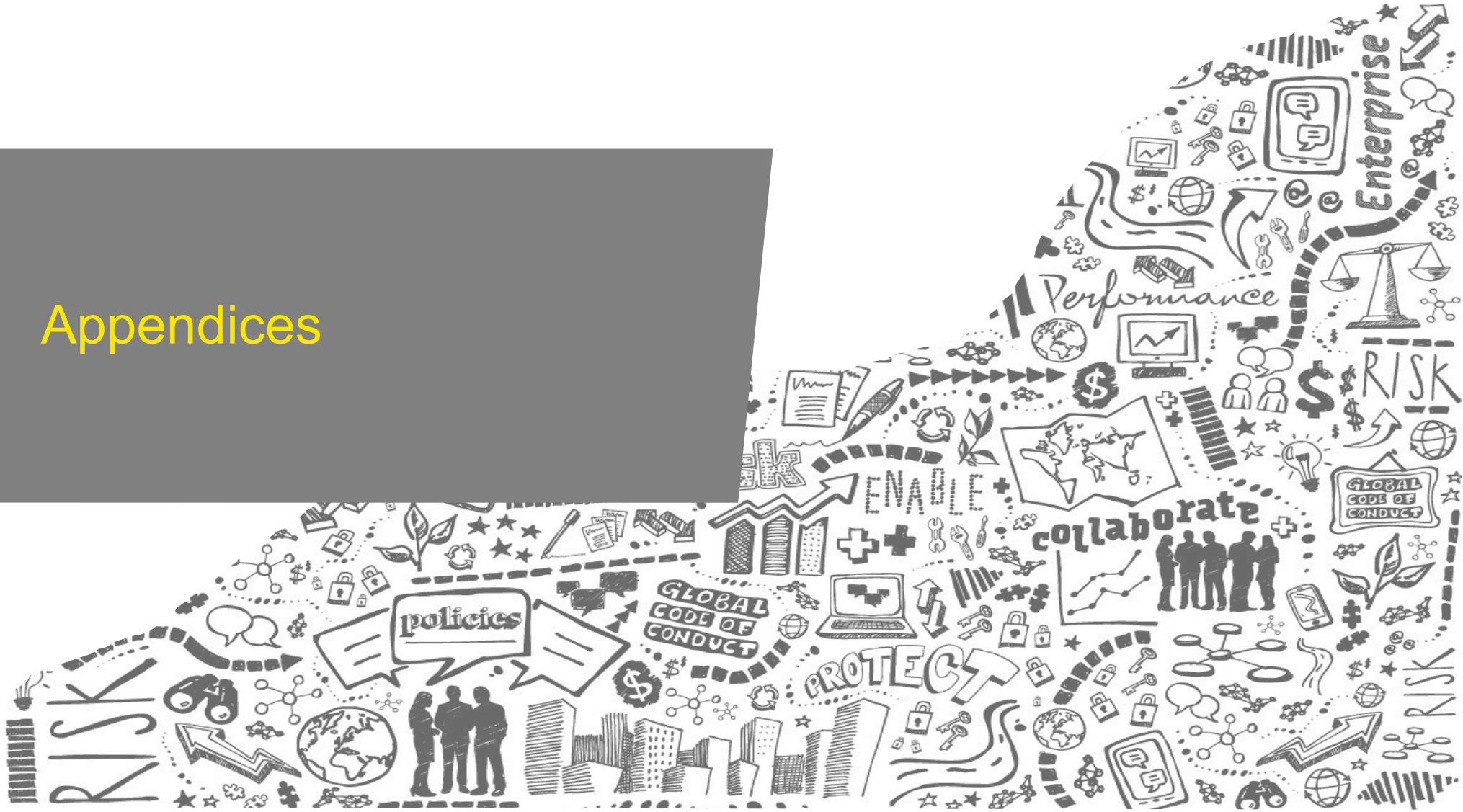
Recommendations

5.11.1 We recommend that any changes made to Risk Management Procedures as outlined in other findings (e.g. impact criteria and risk categorisation in finding 5.3) be reflected in the migration to Datix to prevent any legacy issues arising.

5.11.2 We recommend that a full review be undertaken to ensure that all key stakeholders have appropriate access to required risk registers

5.11.3 We recommend that all risk data due to be upload to Datix be refreshed and cleansed prior to upload to ensure its completeness and accuracy.

Appendices


Enterprise
Performance
RISK
ENABLE
collaborate
GLOBAL CODE OF CONDUCT
policies
GLOBAL CODE OF CONDUCT
PROTECT
RISK
RISK

Appendix A – Scope of Work

Our scope, methodology and approach were outlined in the contract and Statement of Work signed by the Deputy CEO on behalf of St Andrew's Healthcare on the 15th April 2021. We have summarised our deliverables, cross-referenced into our key findings, below.

1. Background and Objectives:

You are seeking to transform your governance arrangements through a series of recommendations, bringing both experience and leading practice insight.

2. Scope of Services:

EY was appointed to work with you to perform a review of your governance framework, including arrangements for risk management, and to make recommendations of improvement which will allow you to meet the needs of your stakeholders and deliver a leading class governance framework for the charity. Our scope of work included the following areas;

Scope of Services	Requirement	Report Reference(s)
An assessment and commentary of the Charity's existing governance framework, including arrangements for risk management. This will include assessment of governance and risk management against: • The Charity's regulatory requirements; and • In the context of the findings from the recent CQC review.	Assessment of the Charity's existing Governance framework.	Section 3
	Assessment of arrangements for risk management.	Section 5
	Assessment of governance and risk management against regulatory requirements.	Appendix E
	Assessment of governance and risk in the context of the CQC review.	Sections 2 to 5 – page 17
Benchmarking of the Charity's Board and Executive governance framework, including architecture, against industry practice and peers (three organisations to be agreed with you).	Benchmarking against leading practice risk management frameworks.	Section 5
	Benchmarking to support the articulation of governance architecture and improvements.	Appendix D
We will also undertake a desk top review of the legal form of three agreed organisations and provide commentary on the potential benefits of these if applied to the Charity.		outstanding
Definition of a set of underpinning principles of governance for the Charity from which a revised model of governance can be derived.		Section 2
Development of a governance architecture for the organisation alongside a broader set of recommendations for improvement of the governance and risk management frameworks. This will be supported by examples of industry practice in areas highlighted for improvement.	Development of a governance architecture.	Section 4
	Development of a broader set of recommendations for improvement of the governance and risk management frameworks.	Section 3
	Examples of industry practice in areas highlighted for improvement.	Various throughout – see appendix x, y, z
The development of a prioritised implementation plan for the Charity.		Section 2

Appendix B – Interviewee & Committee Attendance

Interviewee	Role
Paul Burstow	Chair
Stuart Richmond-Watson	NomRemCo Chair & Non-Executive Director
Professor David Sallah	Quality and Safety Committee Chair & Non-Executive Director
Professor Stanton Newman	Board Member & Non-Executive Director
Elena Lokteva	Audit & Risk Committee Chair & Non-Executive Director
Andrew Lee	Board Member & Non-Executive Director
Tansi Harper	Non-Executive Director (left in June 2021)
Katie Fisher	Chief Executive
Alex Owen	Chief Financial Officer
Dr Sanjith Kamath	Executive Medical Director
Martin Kersey	Executive HR Director
Jess Lievesley	Deputy Chief Executive Officer
Alastair Clegg	Chief Operating Officer
John Clarke	Chief Information Officer
Sajid Ali	Internal Audit & Risk Manager
Duncan Long	Company Secretary
Dr Ash Roychowdhury	Deputy Medical Director
Andy Brogan	Chief Nurse
Anna Williams	Director of Performance
Focus Group 1	Court of Governors (8 in total)
Focus Group 2	CEC Directors/Deputy Directors/Heads Of (7 in total)
Committee	**Date**
Audit and Risk Committee	27th April 2021
People Committee	13th May 2021
Charity Executive Committee	19th May 2021 and 26th May 2021
Board of Directors	27th May 2021
Quality and Safety Committee	8th June 2021

Appendix C – Document List

Document requested (Governance)	Provided (Y/N)
Current Board and Committee planner, Current meeting attendee list and register of members (governors)	Y
Full organisation structure	Y
Board member bio's	Y
Board committee structure and Terms of reference (ToR) for all Board committees, as well as for Board itself	Y
Executive committee structure and ToRs	Y
Public and private minutes and papers of meetings (last six months) – Board and sub committees, and Executive and divisional meetings and other committees as appropriate	Y
Internal Audit plans and annual reports for 2019/20, 2020/21, 2021/22	Y
External Audit report to those charged with governance (ISA 260) for the last available year	Y
Strategic Risk Register	Y
Communication strategy and example outputs	Y
Board away day(s) agenda and minutes	Y
Details of any Board development programme	N/A
Succession plans for Board members	N/A
Guidance/Policy on Board members appraisal process (including objective setting)	N/A
Report following most recent CQC inspection	Y
Any Scheme of Delegation that sets out the powers which the Board retains and the powers it has delegated internally and to whom.	Y
Articles of Association	Y
Matters Reserved for the Board	Y
Policies and Procedures (and management processes)	Y
CEC Performance Papers	Y
AGM Papers and Minutes	Y
Documentation outlining the role of the Court of Governors	Y
Finance and Performance Papers	Y

Document requested (Risk Management)	Provided (Y/N)
Copies of risk management framework documentation including: - Risk Management Strategy - Risk Management Policy - Risk Management Objectives - Risk appetite / tolerance policy	Y
Risk management processes and associated guidance	Y
Any guidance, handbook or tools associated with the above	Y
Assurance maps or integrated risk and assurance plan (or equivalent) – BAF and previous SAF	Y
Current risk registers including both strategic and operational risk registers	Y
Example of risk reports covering the last 12 months	Y
Details of key risk indicators / key performance indicators used by the risk function	N
Details of risk management training provided internally, including completion statistics and materials.	N
Details of externally facilitated training attended by key personnel	N
Communications plans for risk management activities	Y
Details of any tools or technology systems used to support the risk management framework (Datix Migration plan provided)	Y
Any reports following most recent risk management audits or equivalent	Y
Risk Improvement Plan	Y
Risk Project Implementation Plan (Project Pegasus)	Y

Appendix D – Benchmarking Overview

We perform the benchmarking exercise of the Charity's Board and Executive governance framework, including architecture, against industry practice and peers. This was based on publicly available information. The organisations against which benchmarking would be completed were agreed with the CEO and Chair, these included:

- Hertfordshire Partnership University NHS Foundation Trust
- Macmillan Cancer Support
- Turning Point

The table below aim to demonstrate the main differences of the Board structure between St Andrew's the three benchmarking organisations.

Information contained in this appendix is based on publicly available information at the time of review (May / June 2021). It is intended to provide only a general outline of the subjects covered. In isolation, it should not be regarded as comprehensive nor sufficient for making decisions.

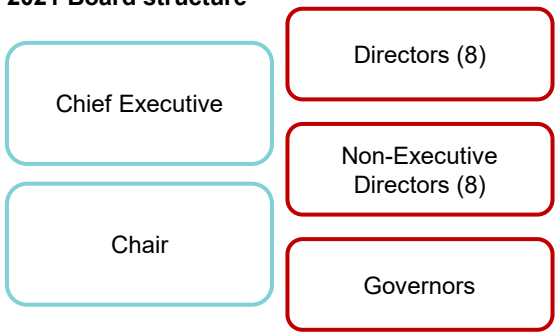
Organisation	St Andrew's	Hertfordshire	Macmillan Cancer Support	Turning Point
Number of NEDs (including Chair and Deputy Chair)	7 (54%)	9 (50%)	14 (100%)	6 (75%)
Number of Executive Directors (including Chief Executive)	6 (46%)	9 (50%)	8 (0%) – Not Trustees	2 (25%)
Total Board members	13	18	14	8
Number of Board committees	9 (including St Andrew's College Governing Body)	4	5	3
Board meetings frequency – number of meetings per year	6 (+4 strategy days)	11	6	7
Board committee meetings frequency – number of meetings per year	QSC, People Committee, Nomination and Remuneration Committee – 6 ARC, FinCom, Investment Committee – 4 CEC – Weekly	Nomination and Remuneration Committee – 9 Audit Committee, Integrated Governance - 5 Finance and Investment - 6	Charitable Expenditure Committee - 1 Finance and Audit Committee - 4 Fundraising, Marketing and Communications Committee - 4 Remuneration Committee - 2 Nominations Committee – 2	Audit Committee – 5 Remuneration Committee – 1 Nominations Committee – 1

Appendix D – Benchmarking

1) Hertfordshire Partnership University NHS Foundation trust

Hertfordshire Partnership University NHS Foundation Trust provides health and social care for over 400,000 people with mental ill health, physical ill health and learning disabilities across Hertfordshire, Buckinghamshire, Norfolk and North Essex. They employ nearly 3,000 staff who deliver these services within the community as well inpatient settings. They have operated as an NHS Foundation Trust since August 2007.

2021 Board structure



2021 Board Meetings

Date	Time	Room	Type
28 January	10:30 – 13:30pm	Da Vinci B	**Private**
25 February	10:30 – 13:30pm	Da Vinci B	**Private**
25 March	10:30 – 13:30pm	Da Vinci B	Public
29 April	10:30 – 13:30pm	Da Vinci B	Public
20 May	10:30 – 13:30pm	Da Vinci B	Public
24 June	10:30 – 13:30pm	Da Vinci B	**Private**
29 July	10:30 – 13:30pm	Da Vinci B	Public
30 September	10:30 – 13:30pm	Da Vinci B	Public
21 October	10:30 – 13:30pm	Da Vinci B	**Private**
25 November	10:30 – 13:30pm	Da Vinci B	Public
16 December	10:30 – 13:30pm	Da Vinci B	**Private**

Governors

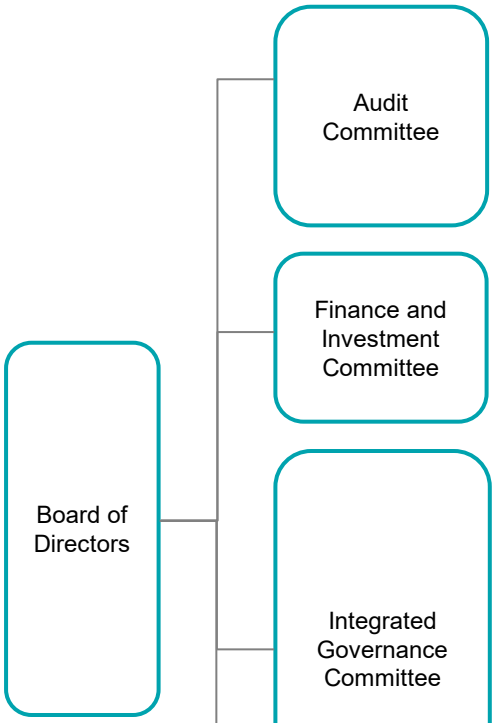
The Trust has up to 39 governors, appointed as follows: 21 Public Governors, elected by the Trust's membership, 5 Staff Governors, elected by the Trust's staff, and up to 13 Appointed Governors, nominated by the Trust's partner organisations.

Council of Governors Statutory Duties and Powers

- To appoint or and if appropriate remove the Chair or other Non-Executive Directors and the Trust's auditor
- To approve the appointment of the Chief Executive
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and other Non-Executive Directors
- At the AGM they receive the Trust's annual accounts reports and accounts, and report them to the auditor
- To hold the Non-Executive Directors to account for the Performance of the Board of Directors
- To represent the interests of members of the Trust and the interests of the public
- Approve significant transactions
- To approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose
- Approve amendments to the constitution
- Development and recruitment of a representative membership

Appendix D – Benchmarking

Board committees



- Oversees the probity and internal financial control of the Trust, working closely with external and internal auditors.
- Reviews governance
- Risk management and assurance
- Approves the external audit plan, the internal audit plan and accounting policies
- Reviews draft annual accounts before they are submitted to the Board.

Board members in Audit Committee:

- 2 Non-Executive Director

- Provides assurance to the Board that all Board members have an adequate understanding of key financial issues.
- In particular it reviews investment decisions and policy, financial plans, and reports and approves the development of financial reporting, strategy and financial policies, consistent with the foundation trust regime.

- Leads the development and monitoring of quality and risk systems within the Trust to ensure that quality, patient safety and risk management are at the heart of all Trust activities.
- The committee ensures that appropriate risk management processes are in place to assure the Board that risks are being identified and managed within the Trust.
- It also develops systems and processes to ensure that we are compliant with the registration requirements of the Care Quality Commission.
- The committee makes sure that the treatments and services that we provide are appropriate, reflect best practice, represent best value for money and are responsive meet people's needs.
- The committee also ensures that service users' views and experiences are reflected in the way our services are delivered.

Board members in Finance and Investment Committee, Integrated Governance Committee, and Nomination and Remuneration Committee:

- 2 Non-Executive Directors
- Interim Executive Director People and Organisational Development
- Deputy Chief Executive and Executive Director Finance
- Executive Director Strategy and Integration

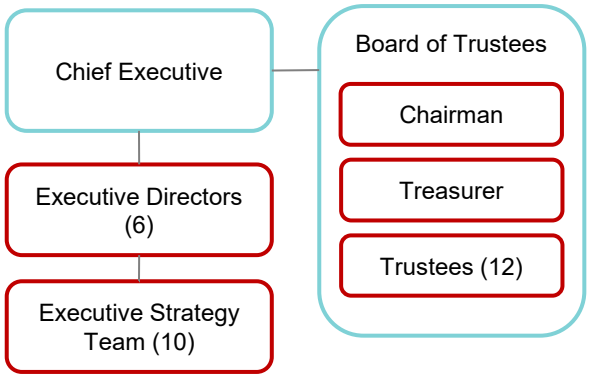
- Provides assurance to the Board that all Board members have an adequate understanding of key financial issues.
- In particular it reviews investment decisions and policy, financial plans, and reports and approves the development of financial reporting, strategy and financial policies, consistent with the foundation trust regime.

Appendix D – Benchmarking

2) Macmillan Cancer Support

Macmillan Cancer Support is one of the largest British charities and provides specialist health care, information and financial support to people affected by cancer. It also looks at the social, emotional and practical impact cancer can have, and campaigns for better cancer care. Macmillan Cancer Support's goal is to reach and improve the lives of everyone who has cancer in the UK.

Board structure



Board of Trustees – 6 Board meetings in 2019

- The Board and its committees meet regularly during the year, including at an annual away day, which helps trustees and the Executive Strategy team to focus in more depth on the Charity's strategic direction.
- The trustees are also directors under company law. They are appointed by the Board for a term of three years and normally serve a maximum of three terms.
- A framework of delegation is in place to set out matters delegated to committees of the Board, the Executive Strategy team or other staff. This is regularly reviewed and updated as necessary.
- In addition to receiving regular reports from the Chief Executive and Executive Directors, the Board is advised on clinical matters by the Expert Advisory Board, and is informed by the views of the Volunteer Forum, which consists of both national and regional groups, and whose Chairman reports to the Chairman of Macmillan's Board.
- The Board's Nominations Committee reviews the structure, size, composition (including the skills, knowledge and experience) of the Board, considers succession planning, and makes recommendations on appointments to the Board. The trustees all give their time to Macmillan on a voluntary basis and receive no remuneration. Out-of-pocket expenses may be reimbursed.

Statement of responsibilities of the Trustees

Company law requires the trustees to prepare accounts for each financial year that give a true and fair view of the state of affairs of the Charitable Company and the Group, and of the incoming resources and application of resources, including the income and expenditure of the Charitable Group for that period. In preparing these financial statements, the trustees are required to:

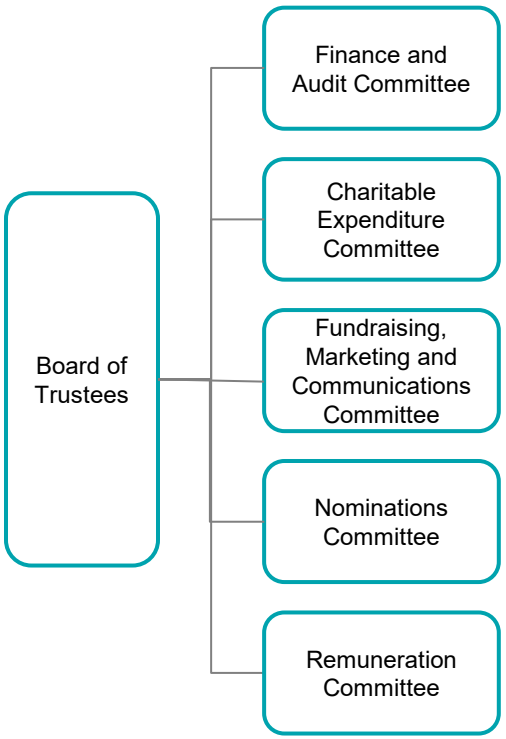
- select suitable accounting policies and then apply them consistently
- observe the methods and principles in the Charities Statement of Recommended Practice
- make judgements and estimates that are reasonable and prudent
- state whether applicable UK Accounting Standards have been followed, subject to any material departures being disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume the Charitable Company will continue in business.

The trustees are responsible for keeping proper accounting records that can disclose with reasonable accuracy the financial position of the Charitable Company at any time and provide financial statements. They are also responsible for safeguarding the assets of the Charitable Company and the Group, and taking reasonable steps for the prevention and detection of fraud and other irregularities. The trustees have overall responsibility for Macmillan's internal controls, while the Finance and Audit Committee reviews internal risks and monitors how well the trustees manage these risks.

The trustees are responsible for the maintenance and integrity of the corporate and financial information included on the Charitable Company's website.

Appendix D – Benchmarking

Board committees



- Monitors the financial performance of the Charity, the performance of Macmillan's investments and our investment strategies, financial reporting, planning and budgeting processes, compliance, corporate risk and our internal and external audit arrangements.
- The former Investment Committee merged with the Finance and Audit Committee in 2019.

- Reviews charitable expenditure and activities against strategic corporate priorities agreed by the Board.

- Oversees the Charity's fundraising, marketing and communications strategies and ensures that the Charity follows high standards of fundraising practice.

- Considers the membership of the Board and recommends potential new trustees for election. This committee also keeps under review succession planning in respect of honorary officers and the Chief Executive, and oversees Board effectiveness reviews and action plans resulting from such reviews.

- Determines and recommends to the Board the overall policy for the remuneration of the Charity's employees and keeps an oversight on people issues and related policies.

Board reviews

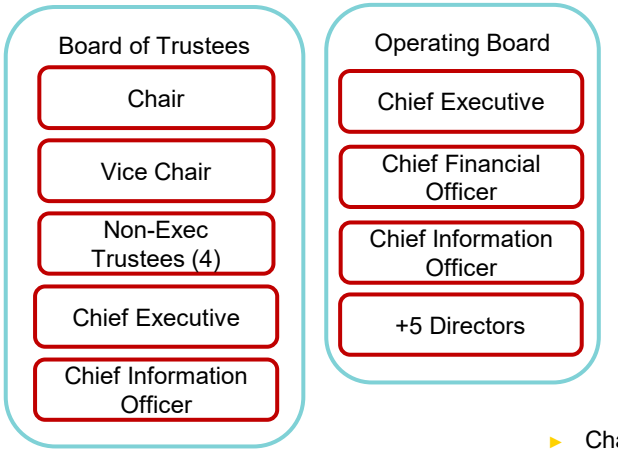
- The Board regularly undertakes a review of its effectiveness to identify any improvements to the Board's governance and ways of working or any training needs. The Board supports the principles of good governance set out in the Charity Governance Code and uses the Code to evaluate its effectiveness. The performance of individual trustees is assessed each year.
- An externally facilitated in-depth Board governance review was completed toward the end of 2018, with the actions and recommendations from this implemented during 2019. Actions included widening Executive Strategy team presence at Board meetings, reviewing Board agendas to ensure that strategic issues are covered in sufficient depth, reviewing and clarifying the remit of committees, and undergoing a detailed reputational risk scenario exercise to help identify any improvements we can make to our procedures.
- An in-house Board review will be undertaken in 2020 to evaluate the effectiveness of these actions and consider what further enhancements might be helpful.

Appendix D – Benchmarking

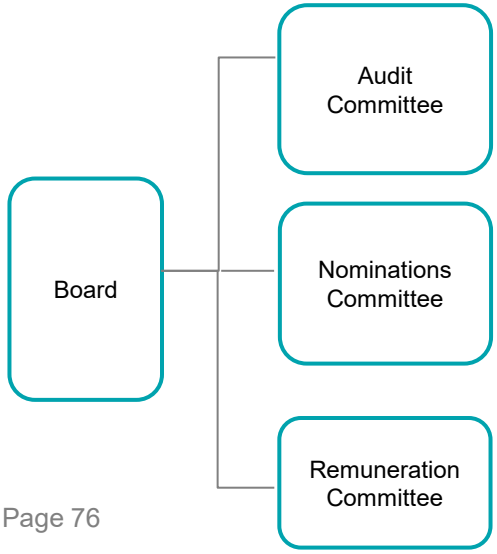
3) Turning Point

Turning Point is a social enterprise and registered charity that provides health and social care services in over 300 locations across England. The organisation provides services support for a range of people, including those with mental health issues, learning disabilities and/or substance-related disorders. Over 100,000 people are supported by Turning Point services around the country.

Board structure



Board committees



Board – 7 Board meetings in 2019/20

- Board Effectiveness – The Board conducts an externally facilitated full review of board effectiveness once every three years with a self-assessment of board effectiveness in the intervening years. During 2020 the Board engaged in a self-assessment of board effectiveness.
- Board appraisal – Each director, including the Chair and Chief Executive, had their performance reviewed and the board as a whole reviewed its effectiveness. As a result, the board is assured that the board and its members remain effective in their roles. The Audit Committee reviewed its effectiveness under the same criteria, with the participate of the internal and external auditors. The Chair of the Audit Committee reported to the board on the committees' effectiveness and its work over the course of the year. The board was assured that the committee is fulfilling its role and duties as described in the Governance Standing Orders.
- In addition, board members reviewed and updated the skills matrix. The skills matric is used as a basis for identifying future training and development needs as well as recruitment. Treasury management was made known as a development need.
- Chaired by the Vice Chair of the Board and attended by 3 NEDs in total. Oversees the internal and external audit processes, assessing the effectiveness of risk management and reviewing the company's overall financial performance.
- Commissions the internal audit function to scrutinise particular areas of concern as necessary though no such commissions were made during the year.
- Responsibility for review of internal controls is delegated to the Audit Committee.
- Makes recommendations to the board on recruitment, membership and succession planning.
- Other executive directors may join the committee as appropriate, but nonexecutive directors always remain in the majority. The chief executive may also be a member, except where this causes a conflict of interest. A non-executive director chairs the committee.
- Recruitment follows a reflection on the skills of the existing board and an analysis of any skills gaps that need to be filled to deliver the strategic objectives.
- When required, a committee is convened to review and set the remuneration of the executive directors.
- Other executive directors may join the committee as appropriate but non-executive directors always remain in the majority. The chief executive may also be a member, except where this causes a conflict of interest. A non-executive director chairs the committee.

Appendix E – Charities Governance Code Compliance Overview

Charities Governance Code Principle – Recommended Practice	Status	Report Reference(s)
Principle 1 – Organisational Purpose		
1.3 Determining organisational purpose	Improvement Required	3.2
1.4 Achieving the purpose	Improvement Required	3.2, 3.3, 3.5
1.5 Analysing the external environment and planning for sustainability	Improvement Required	3.2, 3.3
Principle 2 – Leadership		
2.4 Leading the charity	Improvement Required	3.1, 3.2, 3.6
2.5 Leading by example	Improvement Required	3.2
2.6 Commitment	Improvement Required	3.2, 3.6
Principle 3 – Integrity		
3.6 Upholding the charity's values	Aligned	
3.7 Ensuring the right to be safe	Aligned	
3.8 Identifying, dealing with and recording conflicts of interest/loyalty	Aligned	
Principle 4 – Decision making, risk and control		
4.5 Delegation and control	Not Aligned	3.2, 3.3, 3.7, 5
4.6 Managing and monitoring organisational performance	Improvement Required	3.10, 5
4.7 Actively managing risks	Improvement Required	3.4
4.8 Appointing auditors and audits	Aligned	
Principle 5 – Board effectiveness		
5.5 Working as an effective team	Improvement Required	3.1, 3.2, 3.9
5.6 Reviewing the board's composition	Improvement Required	3.1
5.7 Overseeing appointments	Improvement Required	3.1, 3.2
5.8 Developing the board	Not Aligned	3.2, 3.6
Principle 6 – Equality, diversity and inclusion		
6.4 Assessing understanding of systems and culture	Aligned	
6.5 Setting context-specific and realistic plans and targets	Aligned	
6.6 Taking action and monitoring performance	Aligned	
6.7 Publishing performance information and learning	Aligned	
Principle 7 – Openness and accountability		
7.5 Communicating and consulting effectively with stakeholders	Improvement Required	3.1, 3.2
7.6 Developing a culture of openness within the charity	Improvement Required	3.2
7.7 Member engagement	Improvement Required	3.1, 3.2

Appendix F – Charity Commission Recommendations for Risk Assessment Criteria

As noted in finding 5.5, at present the only scoring criteria used in the risk scoring matrix (as opposed to the materiality threshold criteria) for risk impact are those with regards to a risk's financial impact on the charity. As such it is recommended that the charity broaden its impact criteria, in line with the category of risk in question. The Charity Commission of England and Wales have prepared an indicative set of criteria for charitable organisations (CC26), detailed below. These could form the basis of a more detailed set of criteria for St Andrew's, which could also incorporate clinical outcomes and/or patient considerations.

Figure G a – Charity Commission Scoring Matrix

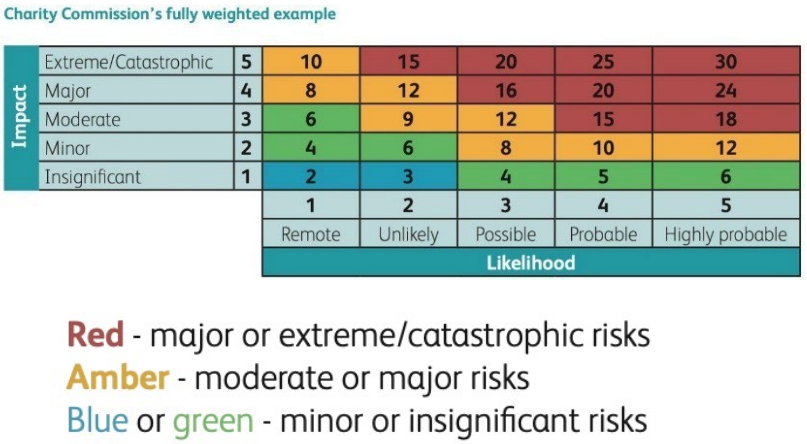


Figure G b – Charity Commission Example Scoring Criteria

Likelihood	Certainty	Number of instances	Time period
Highly probable / Very high (5)	Almost certain	1/10	Once in 3 months
Probable / High (4)	More likely than not	1/100	Once in a year
Possible / Medium (3)	Fairly likely	1/1,000	Once in 5 years
Unlikely / Low (2)	Unlikely	1/10,000	Once in 10 years
Remote / Very low (1)	Extremely unlikely	<1/10,000	Not in 50 years

Level of impact	Strategic	Operational	Financial	Reputational	Compliance
Very High	Would require a fundamental change in organisational strategic/ critical objectives.	Fundamental organisational changes would need to be implemented. Delay of 1 year + in delivery of project.	If the risk materialised the cost to the charity would be greater than £3 million.	Significant and irreparable damage to reputation. Sustained negative publicity resulting in loss of public/ professional/ political confidence in the charity.	Serious breach of governance regulations that would lead to status of the charity being reviewed.
High	Would require a significant shift from organisational strategy/critical objectives that would require BoT input.	A significant amount of work would need to be done at all levels to resolve the matter. Delay of 6-12 months delivery on the project.	If the risk materialised the cost to the charity would be between £1 milllion and £3 million.	Significant and irreperable damage to reputation. High negative impact on the charity's reputation. Could impact on charity's ability to influence public/ professionals/politicians. Generates significant numbe of complaints.	Significant breach of governance regulation requiring immediate notification of regulatory bodies.
Medium	Would impact on the organisational strategic/ critical objectives and would require management discussion.	A significant amount of work would be required by a team to repair operational systems. Delay of 3-6 months in delivery of project.	If the risk materialised the cost to the charity would be between £500k and £1million.	Minor damages but widespread. Significant localised low level negative impact on the charity's reputation/ generates limited complaints.	Breaches governance regulations and would require significant work to rectify.
Low	May have an impact on achieving organisational strategy but this could be resolved.	Low level processes would need to be revised but the matter could be resolved. Delay of 1-3 month's in the delivery of project.	If the risk materialised the cost to the charity would be between £100k and £500k.	Minor damages in a limited area. May have localised, low level negative impact on the charity's reputation/ generates low level of complaints.	May breach low level governance regulations but can be rectified.
Very Low	Little impact on the organisational stratergy.	Has no impact on the day to day operation of the charity. Less than 1 months delay in delivery of project	If the risk materialised the cost to the charity would be no more than £100k.	Has no negative impact on the charity's reputation/no media interest.	No impact on the charity's governance structures.

Appendix G – Risk Champions Network

What is a Risk Champions Network

The Risk Champion network consists of Risk Champions, one selected from each Division and/or Function, who interact with both the risk team and their respective organisation. A Risk Champion is a representative that has influence and is regarded as a subject matter lead for risk within their Division/Function. Risk Champions should have robust knowledge of business processes within their business are.

The Risk Champion is charged with leading and promoting risk management as well as building commitment and user adoption within the respective divisions and functions.

Risk Champions are not part of the risk team and would be expected to perform their role in addition to day-to-day role within their Division/Function. However, the role and time commitment required to perform the role should be formally recognised and reflected.

The following criteria should be used when selecting a risk champion:

- Viewed as a leader or role model
- Has sufficient influence over behaviour and outcomes
- Has excellent communication and presentation skills

Figure H: Example Future State Risk Network Structure

Risk Champion Role and Responsibilities

A Risk Champion will be recognised as the key contact to cascade risk management to their respective organisation, and escalate feedback from employees back to the risk management forum and risk team. Example Risk Champion responsibilities are stated below. These responsibilities should be customised for St Andrew's needs.

Primary Responsibilities:

- Participate in Risk Champion Forum meetings (cadence defined by the risk management)
- Facilitate communication forums to promote risk management awareness and understanding
- Cascade risk management messaging to the respective organisation
- Assist with risk management knowledge transfer and capture
- Support the deployment of the risk management process and subsequent changes
- Assist with solution adoption post deployment

Secondary Responsibilities – as needed:

- Assist with training facilitation
- Review and validate process and framework design
- Assist with testing of revisions

Time commitments of Risk Champions will vary depending on the point in the business cycle and the level of change / development in the framework. We typically see this role account for c.0.1 FTE per individual Risk Champion, although this is not uniformly distributed across a business year.

Appendix H – Risk Maturity Assessment Methodology

As part of our risk maturity assessment, we have assessed St Andrew's Healthcare against our six point maturity model, comprising the following pillars:

- Risk Strategy & Governance
- Risk Appetite
- Risk Management Processes
- Risk Assurance
- Risk Culture and Behaviour
- Technology Enablement

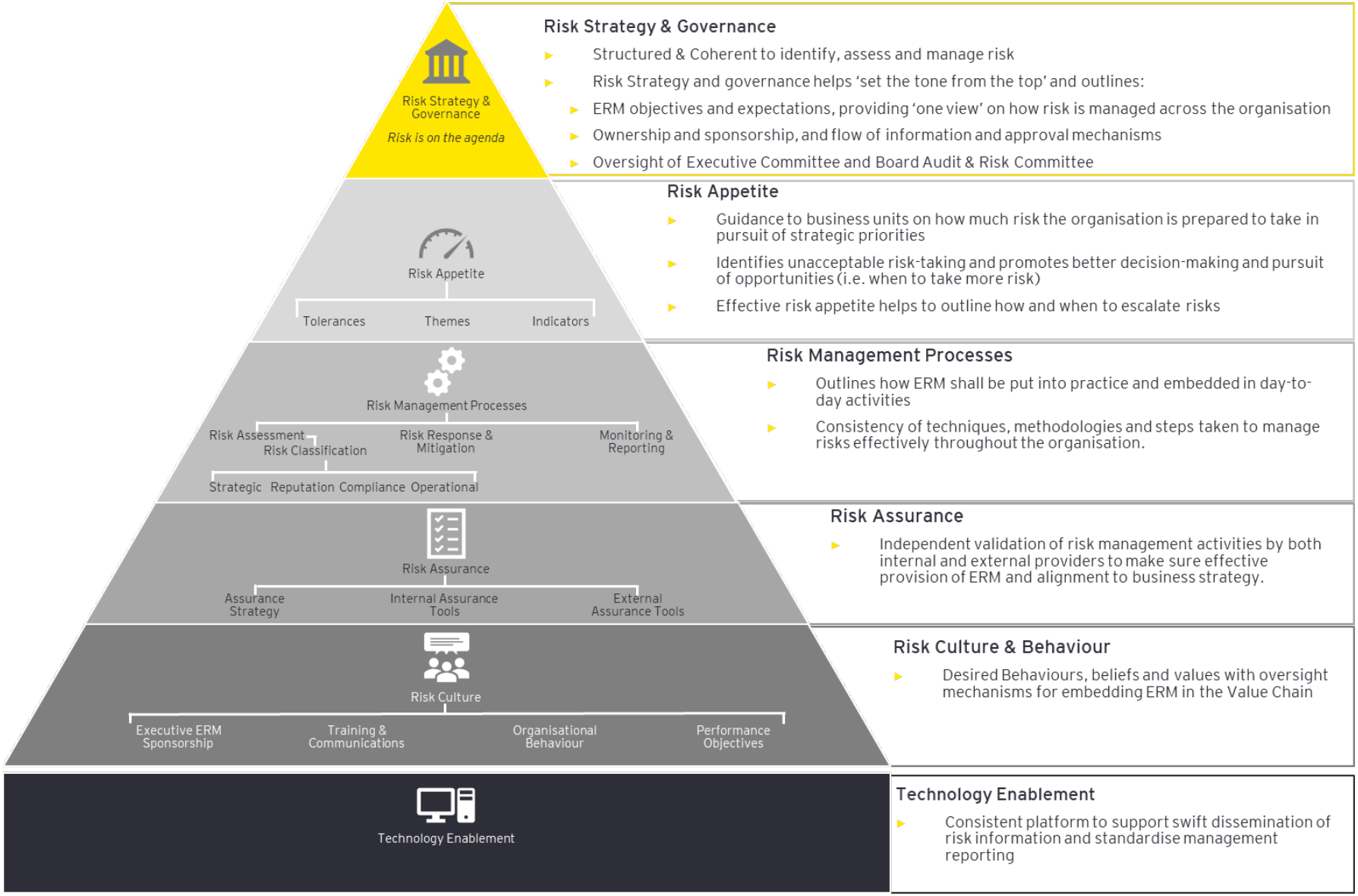
These six core competencies measure how well risk management is embraced by management and ingrained within the organisation. Please see overleaf on page 83 for further details of the 6 assessment criteria that comprise the maturity assessment.

In order to determine the maturity level for each of the six components, a score is calculated and aligned against one of 5 maturity levels (with diminishing maturity from Level 5 to level 1). To calculate this score, a number of sub-components are considered and individually assigned one of these maturity levels, with an accompanying score. The average of these scores is then take to determine the overall score for this component, in line with the table below. The overall score for the organisation is based on the average of all sub-components to allow for weighting of the more complex components where there are a larger number of aspects to be considered.

This score provides a quantitative basis with which to identify the overall maturity level of the organisation, as well as to compare the six components against one another.

Average Score	Maturity Level
1.99 or below	Basic
Between 2.00 and 2.99	Developing
Between 3.00 and 3.99	Evolved
Between 4.00 and 4.99	Advanced
5.00	Leading

Appendix H – Risk Maturity Assessment Methodology (Continued)



Risk Strategy & Governance

- Structured & Coherent to identify, assess and manage risk
- Risk Strategy and governance helps 'set the tone from the top' and outlines:
  - ERM objectives and expectations, providing 'one view' on how risk is managed across the organisation
  - Ownership and sponsorship, and flow of information and approval mechanisms
  - Oversight of Executive Committee and Board Audit & Risk Committee

Risk Appetite

- Guidance to business units on how much risk the organisation is prepared to take in pursuit of strategic priorities
- Identifies unacceptable risk-taking and promotes better decision-making and pursuit of opportunities (i.e. when to take more risk)
- Effective risk appetite helps to outline how and when to escalate risks

Risk Management Processes

- Outlines how ERM shall be put into practice and embedded in day-to-day activities
- Consistency of techniques, methodologies and steps taken to manage risks effectively throughout the organisation.

Risk Assurance

- Independent validation of risk management activities by both internal and external providers to make sure effective provision of ERM and alignment to business strategy.

Risk Culture & Behaviour

- Desired Behaviours, beliefs and values with oversight mechanisms for embedding ERM in the Value Chain

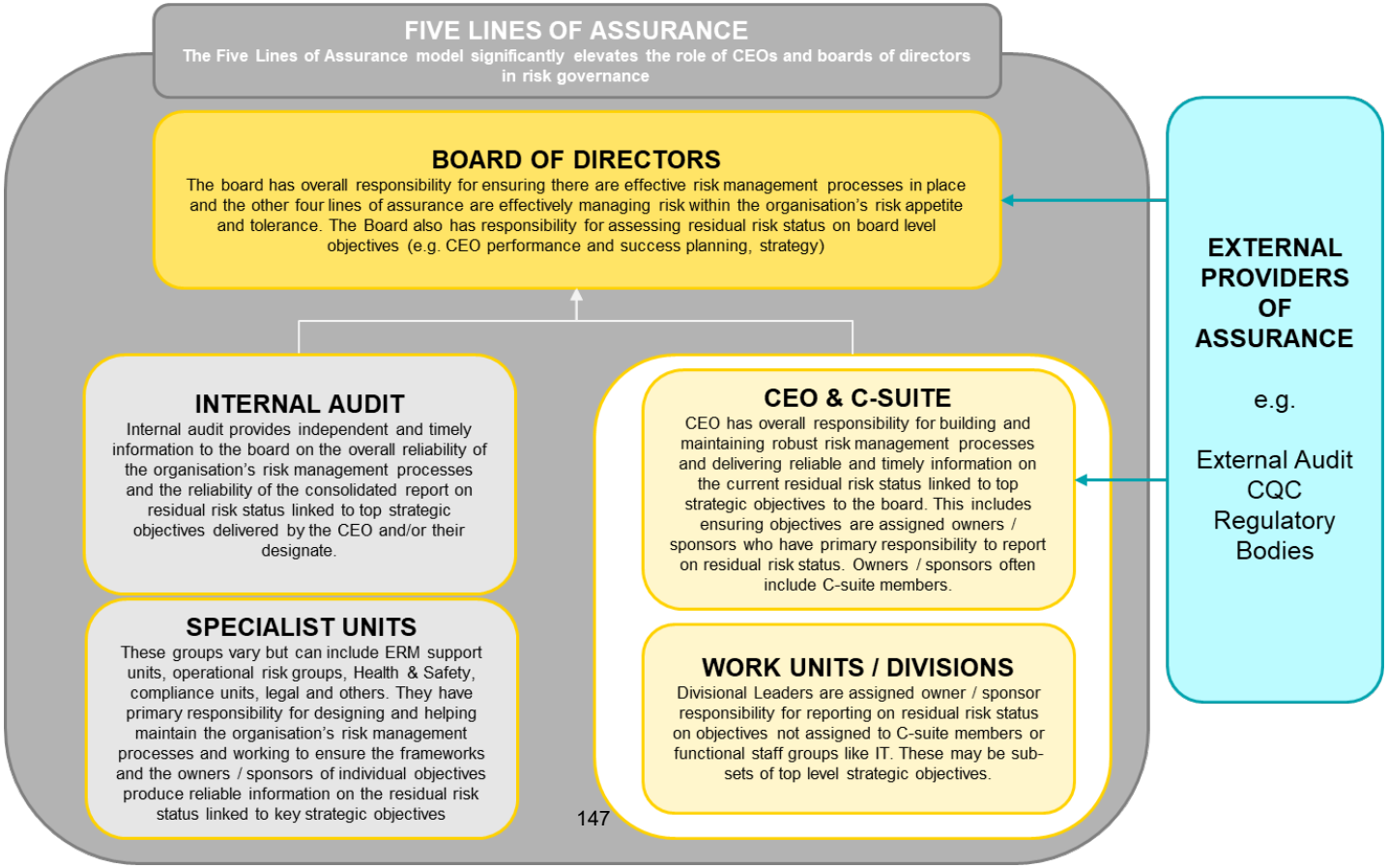
Technology Enablement

- Consistent platform to support swift dissemination of risk information and standardise management reporting

Appendix I – Five Lines of Assurance

Finding 5.8 noted that the Charity does not have a consistent and complete articulation of the assurance strategy and model for the charity. St Andrew's may wish to enhance the effectiveness of their lines of defence model, with the implantation five lines of assurance. This model is proposed by leading Risk Management professionals as an evolution of the 3 Lines of Defence model to elevate the role of the Board and other key executive stakeholders such as the CEO in risk governance. The structure is broken down as follows:

- 1st Line – Work Units / Divisions - Divisional leaders with assigned ownership or responsibility for reporting on specific risks, and ensuring resources are protected and objectives are being achieved.
- 2nd Line – Specialist Units - Specialist units providing expertise on specific types of risk, such as treasury, safety, environment, legal and insurance with responsibility for related risk management processes.
- 3rd Line – CEO / C-Suite - Senior executives and senior managers with overall responsibility for building and maintaining a robust risk management process and delivering reliable information on the principal risks.
- 4th Line - Internal audit activities, providing independent and timely information to the board on reliability of the risk management processes in the organisation and producing consolidated reports.
- 5th Line – Board of Directors -The board of directors with overall responsibility for ensuring that effective risk management processes are in place and the other lines are managing risk.



Appendix J – Risk Types (Example)

Risk Type - Upside, Outside and Downside Risk

Principles of Enterprise Risk Management help large organisations identify, plan, mitigate and manage macro risks or the combined / cumulative impact of material risks; including tactical planning to leverage upside risk.

Section 5.8 noted that the Charity has not effectively aligned the framework for the identification, response and assurance across risk management. EY's approach to risk categorization across 'outside', 'upside' and 'downside' aides effective management of exposure and planning of tactical response(s) as well as mapping of the different sources of assurance across an organisation's assurance framework.

This approach also aides with embedding risk management into strategic decision making, and developing digital capabilities to harness risk intelligence. Enabling better, digitally-led risk management that strengthens trust.

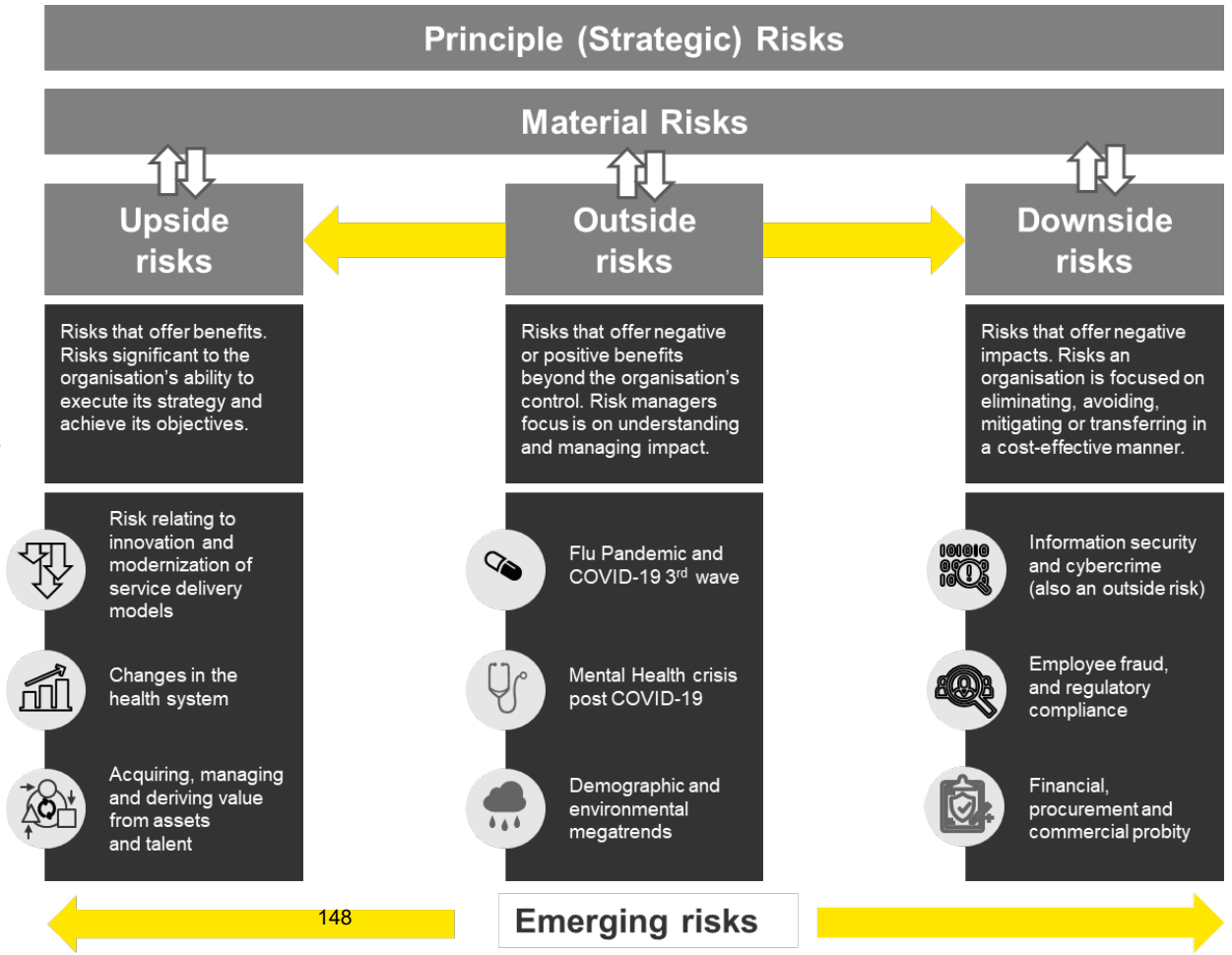
Articulation for St Andrew's Healthcare

St Andrew's Healthcare articulates three separate classes of risk at a Board level (although the risk management does not clearly distinguish between these as set out in section 5):

1) **Strategic Risks** – Significant changes to the external environmental context within which the Charity operates, materially influencing the strategic assumptions on which the Charity's strategy and objectives are based. These risks are relatively stable with a medium to long-term horizon.
2) **Material Risks** – A sub-set of operational risks which meet the materiality risk threshold as set out in the Risk Management Procedure; these are escalated and aggregated risks which typically have a short to medium term horizon.
3) **Operational Risks** – Risks to the delivery of the Charity's objectives which are identified and managed on a day to day basis.

The concept of 'strategic' and 'material' risks remains constant under this model, however, the identification of risks across upside, outside and downside at an operational and material risk level can be used to identify and direct assurance sources.

Typically for example downside risks are managed in the 1st and 2nd LoD with assurance typically being provided by IA or reporting on an exceptions basis.



Appendix K – Matters Reserved / Delegation (Examples)

Delegation

Delegation is the assignment of responsibility or authority from one individual or body to another to carry out specific activities. The person / body delegating responsibility remains accountable for the outcome of the given task(s). This can happen at various levels of an organisation and can be effective at a financial, operational, commercial, strategic level.

The example structures below aim to assist in providing clarity on the accountability, responsibility and requirements to consult in support of the execution of an organisations strategy and delivery of its business. We have also provided an example 'Governance Handbook' which provides a structure for conveying governance and delegation as a whole

Matters Reserved for the Board (example structure)

Accountability / Duty	Extent of delegation / Delegated to – responsibility of CEO (through structures as outlined in section 4)	Key / Core Assurance Deliverable(s)
Governance & Strategy		
EXAMPLE - Determining the overall strategic direction of the Charity. Consideration and approval of the Charity's strategic plan. Consideration and approval of formal strategic partnerships with other organisations.	EXAMPLE - Preparation of the Charity's strategic plan for consideration and approval by the Board, ensuring early consultation with the Board. Recommendations to the Board for formal strategic partnerships with other organisations.	EXAMPLE – - 1/2 yearly reports on progress towards delivery of strategic outcomes - 1/4rly reports on the delivery of strategic projects / initiatives - Regular updates on delivery against annual delivery plans

Delegation / RACI Matrix

The following table sets out the roles and responsibilities within the Charity across the Charity's core corporate processes. It aims to enhance performance and the timeliness of decision making by providing greater clarity on specific areas of accountability, responsibility and required consultation(s). These should be clear in most cases but the demarcations below may not correspond exactly with the reality of every decision.

In many cases projects / programmes require contributions from many different disciplines / functions and good management in order to be successful. These should be clearly set out at the outset of any such work along with a clear RACI for the delegation of decision making within the project or programme.

Definitions applicable to the RACI are as follows:

R – Responsible: The person(s) who does the work to achieve the task or objective. They have responsibility for getting the work done or decision made.

A – Accountable: The person who is accountable for the correct and thorough completion of the task. This is the role that responsible is accountable to and in some circumstances may approve their work.

C – Consulted: The people who provide information for the task and with whom there is two-way communication.

I – Informed: The people kept informed of progress and with whom there is one-way communication. These are people that are affected by the outcome of the tasks, so need to be kept up-to-date.

				Direction			Execution															
							Executive Team								Other							
	Key Process	Key Documentation	Decision / Approval	Reserved for Board	Accountable	Legal	CEO	CFO	CMO	COO					Director of	Director of	Director of	Director of	Director of	Director of	Director of	Head of
	Strategy and Planning																					
Examples	Strategic Planning and Development	Strategic Plan	Board	Y	CEO	I	A	C	C	R	C	C	C	C	C	C	C	C	C	I	I	I
	Budget Setting	Annual Budget	Board	Y	CFO		R	A / R	R	R	R	R	R	R	C	C	C	C	C	C	C	C

Appendix L – Terms of Reference Control (example)

Terms of Reference Control

Fining 3.3 (recommendation 3.3.10) noted that there are a number of templates in circulation and use for ToRs across the sub-committee structure. We also noted that there is no document control page used to inform review and governance around changes to ToRs.

The outline structure on the right is a template document control page for ToRs which will aid in adding clarity to the governance and ownership of the sub-committee ToRs. This example is taken from a UK Government Agency which has recently undergone a governance transformation.

Document Control

Document Description

Document Title	SAMPLE Committee ToR
Issuance/ Revision	1.0
Date	
Owner	
Author	

The Board of Directors (hereinafter referred to as the "Board") may recommend changes to this SAMPLE (hereinafter referred to as the "Committee") Terms of Reference (hereinafter referred to as the "ToR") for approval from the Board, provided that any such modification does not violate any applicable laws, rules, regulations or the Charity's Articles of Association and further provided that any such modification is appropriately disclosed to concerned parties.

- The changes to this document shall be consecutively numbered and dated.
- The following log shall be used and signed off for all updates.

Approvals

Name	Role	Date
SAMPLE Committee	Review	
SAMPLE Committee Chair	Recommend	
Board of Directors	Approve	

Document Change History

Date	Issuance/ Revision	Author	Description of Changes

Distribution

[to be completed as appropriate]

Appendix M – Assurance Strategy / Policy

Assurance Strategy and Policy

An assurance strategy outlines the vision in relation to assurance, explaining what this means, detailing the system and processes in place and highlighting roles and responsibilities. This should act as a reference point for the Board, Committees and Management in terms of the roles and responsibilities for the provision of assurance as well as how assurance flows from ward to Board across the various assurance processes in operation.

We have provided an example of contents of an assurance strategy taken from a NHS Foundation Trust for reference.

Contents:

1) Introduction
2) Policy Statement
3) Aim
4) Assurance Vision
5) Assurance System
6) Benefits
7) Links to Strategies, Policies and Guidance
8) Implementation of the Strategy
9) Types, Sources and Levels of Assurance
10) Assurance Values
11) Assurance Reporting / Use of information
12) Assurance Tools
13) Training
14) Monitoring compliance

Appendix N – Risk Appetite Examples

Risk Appetite

We have included two examples of structured risk appetite statements. The first (1) is from a healthcare setting, the second (2) is from a corporate setting but aligns to a key risk area for the Charity.

1.

1 Averse	2 Cautious	3 Balanced	4 Opportunist	5 Embracing
Preference for **ultra-safe** strategic options that have a **minimal degree of net risk** but only have a potential for limited reward	Prepared to consider a range of options known to result in a **low level of net risk** but mitigating controls are expected to **limit the potential for reward**	Willing to consider all potential options and choose the one that is most likely to result in successful delivery while also providing an **acceptable level of reward and value for money**	Eager to be innovative and to choose options offering potentially **higher business rewards but presenting greater net risks**	Actively seeks new and innovative opportunities with **no track record**, and a **high risk/high return profile**

People and Talent Risk Appetite Statement	Key Risk Indicator (KRI)
We rely on honest and highly skilled employees. We prioritise health and safety, training, and honesty. Unethical behaviour will not be tolerated. To ensure our workforce remains agile, skilled and sustainable, we will consider accepting, in some circumstances, managed moderate levels of risk where necessary to deliver required change. In the pursuit of its objectives, we: Will not accept risks which may lead to a breach of its code of conduct, its ethics, or purpose, values and behaviours. No deviation is tolerated. Acknowledges that some attrition is inevitable, as whilst the company aims to provide high quality careers, not all aspirations can be met. We will therefore accept moderate risk relating to regrettable staff turnover levels. Will strive to be the employer of choice in our industry and maintain a high level of employee satisfaction. Will strive to establish and maintain a talented workforce, especially through the professional development and retention of high-potential employees.	Total Headcount 5 – 10% variance headcount vs target Employee satisfaction (i.e., annual survey of employee satisfaction) >90% Talent Management/retention rate of high-potential employees >90% Code of conduct breach 0

Key ▼ Current position ▼ Target risk appetite ▬ Acceptable Tolerance Range → Direction of travel

Appendix N – Risk Appetite Examples

Risk Appetite

We have included two examples of structured risk appetite statements. The first (1) is not from a healthcare setting, the second (2) is from a healthcare setting.

2.

Integrated Risk Assessment	We acknowledge that risks are not mutually exclusive/no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of all our stakeholders – our people, patients/ service users, suppliers and partners, investors, and society. Our approach to risk appetite therefore involves assessing risks 'in the round' and having risk trade-off conversations; giving us a flexible framework within which we can try new things and make agile decisions with a reasonable risk-versus- return mindset. We use it to facilitate a forward-looking view of risk, adaptable to local circumstances to help drive management action and facilitate informed decisions. Our Board expects all departments to manage their operations within these boundaries and set their own appetites/tolerances where appropriate.

#	Risk Category	Trust Risk Appetite	Good Governance Institute (GGI) Risk Level
1	**Performance and service sustainability** We have a LOW- MODERATE appetite for risks which may affect our performance and service sustainability, and are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient safety and quality improvements as long as patient safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19) which may result in lower performance levels and unsustainable service delivery for a short period of time.	Low - Moderate	**MINIMAL** (ALARP - as little as reasonably possible) **- CAUTIOUS**
2	**Financial sustainability** We are entrusted with public funds and must remain financially viable while safeguarding the public purse. The Trust has no appetite for accepting or pursuing risks that would leave the organisation open to fraud or breaches of Standing Financial Instruction (SFI's). We strive to deliver our services within budget/ our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.	Low - Moderate	**MINIMAL** (ALARP - as little as reasonably possible) **- CAUTIOUS**
3	**Workforce** We are committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. We have a MODERATE risk appetite for decisions taken in relation to workforce but given the recognised workforce shortages we may tolerate a HIGH level of risk on some occasions to support patients. N.B., We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.	Moderate - High	**CAUTIOUS - OPEN**

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Paper for Board of Directors	
Topic	EPRR Standards Annual Assurance 2021 - 2022
Date of Meeting	Thursday, 30 September 2021
Agenda Item	**10**
Author	Claire Jones – Head of Emergency Preparedness, Resilience and Response (EPRR)
Responsible Executive	Jess Lievesley – Deputy Chief Executive and Accountable Emergency Officer
Discussed at Previous Board Meeting	Not previously discussed by Board
Patient and Carer Involvement	Patients and carers have not been involved in this self-assessment as it is an assessment of our organisational response to EPRR incidents
Staff Involvement	Subject matter experts across the Charity are involved in the EPRR Programme and provide assurance in their areas for compliance against specific standards.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☒
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	This report will be presented retrospectively to the Audit and Risk Committee. It has not been presented to any Committee prior to submission due to an unforeseen late change in the process for submission this year, which has resulted in a submission date that is earlier than the next Audit and Risk Committee.

Report Summary and Key Points to Note

Introduction / background

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own, the NHS in England and providers of NHS funded services readiness to respond to emergencies. In order to do this, NHS England asks providers (NHS services and providers of NHS funded care) to complete an EPRR assurance process.

For St Andrew's this process has 2 main stages:

1. Organisational self-assessment against NHS Core Standards for EPRR
2. Submission to Head of EPRR and System Resilience for Northamptonshire Clinical Commissioning Groups to confirm and challenge on behalf of NHS England.

The Civil Contingencies Act 2004 and the Health and Social Care Act 2012, underpin EPRR and the standards to which we follow. Additionally, the NHS Standards Contract Service Conditions require providers of NHS funded services to comply with NHSE EPRR Guidance and the NHS Core Standards for EPRR. These are the minimum requirements organisations must meet and therefore assure against.

This year NHSE/I have requested assurance on compliance against a reduced number of EPRR Core Standards in recognition of the demands over the last 18 months and have advised the full set of standards are currently under review as per the extract from the letter from Stephen Groves – National Direct for EPRR, NHS England and NHS Improvement – on 22nd July 2021 outlining this years' assurance process.

"The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. We have, therefore, removed a small number of standards to accommodate this year's assurance process, until we undertake a full review."

Purpose

The purpose of the Amended Core Standards for 2021-22 are to:

1. Enable NHS services and providers of NHS funded care to share a common approach to EPRR
2. Provide a consistent and cohesive framework for EPRR activities
3. Inform the organisation's EPRR Annual Plan.

Standards and Deep Dive

The NHS England Core Standards for EPRR are split into 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and Control
5. Training and Exercise (not contained in this year's submission)
6. Response
7. Warning and informing
8. Cooperation
9. Business Continuity
10. *CBRN – Chemical, biological, radiological and nuclear incidents (not applicable to St Andrew's Healthcare)*

Not all of the domains and standards are applicable to St Andrew's Healthcare and are decided by the organisations function and statutory requirement. The standards that are applicable to St Andrew's Healthcare are detailed in the EPRR Core Standards Assurance document (appendix 1)

Each year, as well as assurance against each standard, there is a 'deep-dive' required in a specific focus-area. The deep dive for the 2021-22 EPRR annual assurance focusses on 'Oxygen Supply' and is aimed at acute Trusts and is not applicable to St Andrew's Healthcare - whilst as an organisation we have Oxygen use, this deep-dive is in relation to piped oxygen on wards – which we do not use.

Process
In summary the organisation is asked to:

- Undertake a self-assessment against the individual NHS EPRR Amended Core Standards; these individual ratings will then inform the overall organisational rating of compliance and preparedness.

- Present the above outcomes to the St Andrew's Board. (To note – the outcomes would usually be submitted to the Charity's Audit and Risk Committee (ARC) prior to submission to the Board, but due to the timing of the ARC meetings and the unforeseen change to submission date to the CCG – it has been agreed with the Chair that the outcomes and statement of compliance will be presented to the Board first and then ARC retrospectively.

Compliance
Following a complete review of the standards, the organisation has identified full compliance with 30/32, and partially complaint with 2/32 applicable standards.

St Andrew's Healthcare is therefore providing a response of **Substantially Compliant.**

Recommendations
The Board is asked to:

1. Note the self-assessment, detailed in appendix 1 – Core Standards Assurance 2021 - 2022
2. Approve the proposed actions for the 2 partially compliant standards as detailed against standards Ref 1 and Ref 42 in appendix 1 - Core Standards Assurance 2021 – 2022 document.
3. Approve the proposed statement of compliance – attached (appendix 2)

Appendices

1.1 Appendix 1 – Proposed EPRR Core Standards self-assessment including the proposed actions for the two 'Partially Compliant' Standards

1.2 Appendix 2 – Proposed Statement of Compliance

Ref	Domain	Standard	Detail	Other NHS funded organisations	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance										
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	The Accountable Emergency Officer (AEO) for St Andrew's Healthcare is Jess Lievesley - Deputy Chief Executive, and is supported in the role by the Head of EPRR. There was a Non Executive Director in place as the formal Board Member supporting the AEO until earlier this year when they stepped down from their role. The organisation is currently nominating a replacement to this role.	Partially compliant	Non-executive director to replace Paul Parsons as support to the AEO.	Jess Lievesley	Dec-21	Paul Parsons, who was the NED representing EPRR at Board level stepped down and a replacement is being discussed by the Board.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	The EPRR Policy and Procedures replaced our "Business Continuity Policy" and were published in January 2021, are fully version controlled and reviewed annually. The organisation has a number of Business Continuity Plans and Practice Guidance Notes in place to support the delivery of this policy. Our EPRR Policy is further supported by our Risk Management, Procurement, Incident Management and Health and Safety procedures.	Fully compliant				
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	The EPRR Programme is reported to the Charity Executive Committee (CEC) Audit and Risk Committee (ARC) and to the Board at intervals throughout the year. The results of the 2021 annual assurance process for EPRR has been presented to the Public Board on the 30th September 2021 and will be published thereafter. The next report for EPRR is due to be presented to the Board early 2022 and will provide a detailed update on our progress against our annual plan, training activity, overview of incidents, review of any major or critical incidents and lessons learned, exercises undertaken and to formally agree the EPRR Annual Plan for 2022/23.	Fully compliant				
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	The Charity has a full time Head of EPRR responsible for the design and delivery of the Business Continuity Management System (BCMS) and the EPRR Annual Plan - with the support of the EPRR Committee formed of subject matter experts in their fields across the Charity. The EPRR Committee is a sub-committee of the Audit and Risk Committee.	Fully compliant				
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	All business interruption incidents (including near misses) are captured via the organisations incident reporting system. These are investigated where required by a subject matter expert and the results are discussed in the EPRR Committee. Any learning is shared to relevant individuals and where appropriate on the EPRR internal site. Following any Major or Critical Incident a full debrief will be undertaken as per our Incident Management procedures and learning from this will be shared and action plans put in place if required. The organisation actively participates in exercises run by the Emergency Services (we have our next planned for later this year) alongside our own internal testing and exercising. Lessons learned from these tests and exercises help inform our training needs, documentation changes and process improvements.	Fully compliant				
Domain 2 - Duty to risk assess										
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	EPRR Risks are identified in a number of ways within the organisation: Identified risks from completing Business Impact Analysis Identified as part of the learning from incidents or near misses Identified within the NHSE EPRR Standards Identified pas part of learning from external incidents Identified via the (Local Health Resilience Partnership (LHRP) or Local Resilience Forum (LRF). These risks are recorded within the organisations EPRR Risk Registers, and if necessary form part of the organisations Material Risk Register. Consideration is taken in regards to the community risk register as part of our participation in the LHRP and LRF.	Fully compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	EPRR has a designated Risk Register that recognises the risks associated with EPRR Planning and Business Continuity. The EPRR Risk register is reviewed during the EPRR Committee meeting and has a robust system for review and escalation. Reviews also occur outside of the EPRR Committee meeting by the Head of EPRR. In addition to a designated EPRR Risk Register we also have Business Continuity Risks detailed in other risk registers such as COVID-19, EU Transition, HR, IT, Finance, Operations etc. which are reviewed periodically by the Head of EPRR. The organisation has a risk management team who oversee the reporting of risks and provide support to risk owners in establishing the risks, mitigations and further actions required.	Fully compliant				
Domain 3 - Duty to maintain plans										

Ref	Domain	Standard	Detail	Other NHS funded organisations	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	The Charity applies the Incident Command arrangements to address both 'critical' and 'major' incidents, applying risk assessment to determine the requirements for response, and reference to JESIP principles where the Charity's response requires joint working with other agencies. Incident Command applies to GOLD, SILVER and BRONZE roles for strategic, tactical and operational roles in an Incident Command activation, and is supported by the 'Incident Command Manual' which is reviewed annually.	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	The Charity applies the Incident Command arrangements to address both 'critical' and 'major' incidents, applying risk assessment to determine the requirements for response, and reference to JESIP principles where the Charity's response requires joint working with other agencies. Incident Command applies to GOLD, SILVER and BRONZE roles for strategic, tactical and operational roles in an Incident Command activation, and is supported by the 'Incident Command Manual' which is reviewed annually.	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	The Charity has a Heatwave Plan that is current and is reviewed annually. Awareness sessions are delivered via open sessions to allow staff to ask questions about the plan. Following the closure of the annual plan each year, a review is undertaken with key internal stakeholders to make recommendations for changes to the following years plan.	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	The Charity has a Cold Weather Plan that is current and is reviewed annually. Awareness sessions are delivered via open sessions to allow staff to ask questions about the plan. Following the closure of the annual plan each year, a review is undertaken with key internal stakeholders to make recommendations for changes to the following years plan.	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	The Charity is not an acute hospital - however we have made available the 'Concepts of Operation' documentation and will liaise with local Trusts, LHRP and LRF to support where appropriate.	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	The organisations overarching EPRR Policy, Procedures and Guidance Notes support our response in this respect. The shelter and evacuation of staff and patients and visitors is also supported by the organisations Health and Safety and Fire Policies.	Fully compliant				
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	The organisations overarching EPRR Policy, Procedures and Guidance Notes support our response in this respect. The shelter and evacuation of staff and patients and visitors is also supported by the organisations Health and Safety and Fire Policies. A number of the buildings on our sites are secure buildings and are accessed via an airlock - access via these are further supported via our Security Policies.	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Information governance and confidentiality protocols strictly enforced regarding patient identities and information. The key posts, Caldecott Guardian, Senior Information Risk Owner (SIRO)and Data Protection Officer (DPO) are all in place with executive director appointed to oversee use and control of patient information responsible for approving and signing off procedures and investigations, supported by Information Governance function.	Fully compliant				
Domain 4 - Command and control										
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	On Call arrangements ensure there is 24 hour access to Incident Command, as the designated senior manager on-call with assume Silver Command in the event of an incident being declared. There is a rota in place for Gold Command who are available at all times. Contact can be made directly through switchboard to all staff on call or on the Gold Command rota so this mitigates the need for local directory lists to be kept. There is also alternative access to Silver and Gold Commander contact details should switchboard be unavailable.	Fully compliant				
Domain 5 - Training and exercising										
Domain 6 - Response										

Ref	Domain	Standard	Detail	Other NHS funded organisations	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	The organisation has a dedicated ICC for Silver Command and a separate room for Gold Command, In the event that these facilities cannot be used due to the location of the incident, then alternative facilities are available. There is also the ability to host Silver and Gold Command centres virtually should the need arise.	Fully compliant				
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	The organisation has a range of business continuity plans and guidance notes in place in line with the EPRR Framework. Additionally, following any major or critical incident (or a significant business interruption) a BCP specific to that event will be produced if there is a risk of reoccurrence in the future.	Fully compliant				
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Incident Command documents include 'Status Report Forms, (SRFs)' i.e. 'SitRep' reports, to document updates to business continuity teams and Incident Command teams respectively. The use of the SRFs is practiced during Incident Command and Business Continuity exercises.	Fully compliant				
Domain 7 - Warning and informing										
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	The organisation has a communications plan in place to support communication with patients, staff, families and key external stakeholders in the event of a Major or Critical incident. A member of the communications team with form part of the Silver Command Incident Team should a major or critical incident be declared. The organisation has a member of the communications team available 24 hours a day to respond to any emergency communication needs.	Fully compliant				
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	The organisation has a communications plan in place to support communication with patients, staff, families and key external stakeholders in the event of a Major or Critical incident. A member of the communications team with form part of the Silver Command Incident Team should a major or critical incident be declared and a specific communications plan will be delivered in response tailored to the situation. The organisation has a member of the communications team available 24 hours a day to respond to any emergency communication needs.	Fully compliant				
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	The organisation has a specific policy in place which details the protocols for responding to contact from the media and the use of Social Media by staff.	Fully compliant				
Domain 8 - Cooperation										
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	There are a number of informal mutual aid agreements in place with other services and providers, and we are part of the Local Health Resilience Partnership and the Local Resilience Forum in Northamptonshire due to the size of the Northampton Hospital site. Formal mutual aid agreements with our partners in each area are currently being finalised. These will document the process for requesting, receiving and managing mutual aid requests.	Partially compliant	Formal mutual aid agreements to be finalised with partner agencies	Claire Jones	Dec-21	
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Y	Any response required by our organisation to an incident affecting 2 or more LHRP's would be co-ordinated through our Gold Commander and Incident Command Team The LRF has the out of hours contact details of the organisations Head of EPRR and is able to contact the organisations Gold Commander on call via switchboard should a major or critical incident outside of the organisation require our assistance.	Fully compliant				
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	Information governance and confidentiality protocols strictly enforced regarding patient identities and information. The Caldecott Guardian, Senior Information Risk Owner (SIRO)and Data Protection Officer (DPO) are in place and would oversee the sharing of information with stakeholders in conjunction with the communications team and the Silver Commander during an activated Incident Command.	Fully compliant				
Domain 9 - Business Continuity										
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	The organisations EPRR Policy explicitly states "It is the Charity's policy to have documented procedures to manage the effects of unplanned disruptive events and situations. The documented procedures should be consistent with ISO22301." These procedures include: Incident Management Business Continuity Plans Disaster Recovery Plans Risk Assessment and Business Impact Analysis	Fully compliant				

Ref	Domain	Standard	Detail	Other NHS funded organisations	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	The Emergency Preparedness, Resilience and Response Policy and Procedures define the scope and objectives for the Charity's business continuity and emergency planning process, and is additionally supported by an EPRR specific risk register. Risks are reviewed frequently by the Head of EPRR, and are also reviewed as a standing agenda item at each EPRR Committee meeting (quarterly). The organisation also has an Internal Audit and Risk Manager who reports on the current status of the organisational risks to the Charity Executive Committee and to the Audit and Risk Committee. The EPRR Annual Plan is reviewed and updated each year to set out the priorities and plans for the organisations EPRR Programme for the coming 12 months. This is approved by the EPRR Committee and submitted to the Audit & Risk Committee prior to submission to the Board for approval.	Fully compliant				
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Board of Directors signed off a "Standards met" noting that action continues to be taken through the IGG, to review, monitor and ensure continual improvement in Information Governance within the organisation.	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	The Charity's Business Continuity Plan (BCP) format addresses disruption effects on people, IT, premises, key suppliers / contractors, IT services and other key dependencies identified through the business impact analyses. The BCPs have been developed to interface with the Incident Command process to escalate for the provision of support and contingency actions should the disruption incident effects be likely to breach incident command thresholds.	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	EPRR (including the Business Continuity element) forms part of the Internal Audit schedule and the results are published in line with organisations audit procedures and included in the EPRR Board report closest to when they are completed. The next audit is due to be completed in 2022.	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	There is an EPRR Committee in place for continuous review of the BCMS to ensure that we are on target to meet actions and also to review incidents, lessons learned, best practice and to identity any future actions required to ensure our BCMS is meeting the required standards	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	The organisations procurement team work closely with suppliers to ensure continuity of supply, and where there is anticipated or possible risk of interruption the risk is added to the appropriate risk register and business continuity plans are requested from suppliers to provide assurance. The frequency of monitoring and reporting of supply levels in particular instances is increased during times of heightened risk of disruption.	Fully compliant				
Domain 10: CBRN										

St Andrew's Healthcare Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021 – 2022

Statement of Compliance

St Andrew's Healthcare has undertaken a self-assessment against required areas of the EPRR Amended Core Standards self-assessment tool v1.0

Following self-assessment, the organisation has assigned an EPRR assurance rating of '**Substantial**' (from the four options in the table below) against the applicable core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed with the organisation's Board along with agreed action plan.

Signed by St Andrew's Healthcare Accountable Emergency Officer

30th September 2021

Date of Board meeting: 30th September 2021 | Date presented at Public Board 30th September 2021

Sub Committee Updates

People Committee
Paul Burstow

Quality & Safety Committee
David Sallah

Committee Update Report to the Board of Directors

Name of Committee:

People Committee

Date of Meeting:

14 September 2021

Chair of Meeting:

Paul Burstow

Significant Risks/Issues for Escalation:

- The staffing concerns in Northampton were discussed including an update to the Staffing Action Plan to mitigate the key challenges

Key issues/matters discussed:

- The Head of Health and Safety provided an overview of the lagging and leading indicators, including:
  - The number of RIDDORs is down
  - Violent injury count is down
  - Completion of low level accident investigations
- The correlation between supervision and incidents was discussed and the development of a heat map was proposed to triangulate the various sources of information to assist the Committee
- The operations staffing status was discussed including progress on the overall Staffing Action Plan, previously reviewed by the Board in August. The committee update included the addition of a new action, the establishing of a 24/7 Operational Hub to oversee the operational requirements. (Appendix 1 for information)
- HCA recruitment update (any actions being taken will be incorporated into the overall staffing action plan)
- Review of risk register deep dive for retention of key skills (915) and recruiting required capabilities (914)
- The draft Diversity and Inclusion annual report was discussed and further analysis of the reasons for the overrepresentation of black staff in the grievance and disciplinary processes was requested
- Your Voice update including progress against the action plan and changes to the questions within the 2021 survey ensuring more close alignment to the NHS
- People KPIs including turnover, absence, nurse fill rate, agency spend and mandatory training
- Updates were provided from the following reporting groups:

  - BENNs Group – improving attendance was discussed
  - Carers Group
  - Employee Forum
  - Learning & Development Group
  - Inclusion Steering Committee

Decisions made by the Committee:

- Draft Diversity and Inclusion annual report reviewed and approved for submission to the September Board of Directors (Appendix 2)
- Risk Register deep dive retention of key skills (915) and recruiting required capabilities (914) agreed

Implications for the Charity Risk Register or Board Assurance Framework:

- There continues to be staffing shortages within the Northampton site and this is a key priority for the Charity
- Health and Safety is identified as an area for ongoing monitoring including the time taken to complete accident investigations
- Mandatory training is 93% overall and training is below 90% (ILS, BLS and Safeguarding level 3) is showing improvement with an increase of up to 4% in July
- Sickness absence increased to 8% in July (data shows an increase in short term absence in July and August)

Issues/Items for referral to other Committees:

- For QSC to assess the relationship between care hours and outcomes as the MHOST project develops and to benchmark this with other comparator Trusts
- For QSC to consider the role of therapeutic risk in the development of clinical practice and models of care and provide an update at a future Board meeting

Issues Escalated to the Board of Directors for Decision:

- Draft Diversity and Inclusion Annual Report

Appendices:

- Appendix 1 – Staffing Action Plan – People Committee update as presented at the 14th September committee meeting
- Appendix 2 – Diversity and Inclusion Annual Report
- Appendix 3 – People Strategy - committee previously approved the strategy for submission to the Board at the May 2021 People Committee Meeting
- Appendix 4 – Diversity and Inclusion Strategy – committee previously approved the strategy for submission to the Board at the August 2021 People Committee Meeting

People Committee

Appendix 1

Staffing Action Plan

Staffing Action Plan

v0.4 - Sept 21

Objective: to improve the supply of suitable skilled nursing staff (Registered Nurses and Healthcare Assistants) available to work on our wards

Ref	Action	Overview (Aug 21)	Sept Progress Update
1	Maximise the availability of our permanent nursing workforce by improving the way we manage staff absence through improved data and rigorous adherence to absence policies		
1.1	Improve our management of short-term sickness absence by improving the availability, accuracy and timeliness of data relating to sickness.	19.08.21: On track	Periods of sickness 555 in August compared to 866 in July showing a reduction in short term sickness partly due to the number of staff that had to self isolate in July from the NHS app notification.
1.2	Improve our management of short-term sickness absence by ensuring compliance with Absence policy (all staff calling in and speaking to a manager when unwell, managers following up on sickness absences, return to work interviews etc.)	19.08.21: Despite this being an area of focus, and despite support from HR Business Partners, high Covid absence rates make it difficult for managers to stay on top of all short-term sickness absence. All employees contact the Central Absence Team to report absences, this allows for one central point for data to be collected, the CAT notify managers of the absence. The CAT team review short and long term sickness daily and place people back on shifts via KRONOS if they have clocked in. The CAT team attend daily Gold command calls to update on absence data, this provides an accurate and consistent approach to managing all staff absences linking with payroll and mangers in a timely manner.	Ongoing HRBPs working closely with managers to review individual sickness cases and ensuring return to work meetings are happening. Review of the CAT team integration currently taking place.
1.3	Improve our management of long-term sickness by ensuring compliance with the Absence policy (as detailed in 1.2, above).	19.08.21: With support from HR Business Partners, management of long-term sickness (LTS) is robust and LTS is currently below 2%. Occupational Health review all long term sick absence cases and support individuals to return to work where possible. Compassion focussed training is being rolled out across the Charity to support individuals well being and this will positively impact absence levels further. The Employee Relations (ER) team continue to focus on LTS cases and manage ill health capability cases to their conclusion.	300 staff trained on compassionate focused staff support and roll out plan being reviewed.
1.4	Improve our management of other absences by reducing the categories on kronos of available absence codes	19.08.21: Task complete Special paid leave provision per annum moved in line with annual leave year so there is transparency across both reporting periods. Closer links to HR procedures to manage absence further and transparency for individuals on pay arrangements. Reduction in KRONOS codes within the system.	Closed.
1.5	Improve our management of other absences by ensuring nurse managers are aware of the policy and instituting regular audits of take-up	19.08.21: Currently on track but multiple competing priorities for nurse managers might mean it takes time to embed a new approach to managing other absences. As point above, procedures are now linked to manage absence rates and to further support managers in discussions with individuals. Plans to review the recording of special paid leave so that managers are aware of levels within their teams. Currently the cut off for pay is 5 days, awareness has been communicated to line managers. This is in line with current SAP provisions and it reflects the current HR procedure.	1-1 coaching and training for managers on policy and application underway.
1.6	Improve the availability of staff on wards by improving our management of staff who are considered "non-patient-facing" or who cannot undertake MAPA training	Increased visibility of individuals to the OH team for review, where needed focus on support to return to work or manage in line with the ill health capability procedure. Review of recruitment process to ensure that physical elements are covered off during the recruitment phase and people are able to manage the MAPA provisions of the role.	OH briefed by training team around specific MAPA requirements to support assessments and recommendations. Any individuals exempt currently re-referred to OH for updated review.
2	Maximise the availability of nursing staff by adopting a flexible approach to staffing		
2.1	Offer flexible shift working to nursing staff	19.08.21: Approach has been agreed by CEC and the plan is now in development. MHOST and Allocate roll out in progress including weekly steering group. Career breaks launched in April 21 to further support flexible offer.	Care hours assessment for MHOST being reviewed for each ward by nursing team. Programme Director (internal) appointed for MHOST/Allocate project with updates bi-weekly to SPOG.
2.2	Introduce alternative contracts such as term time working and annualised hours	05.08.21: Adverts updated to highlight flexible working options. Recruitment started for a new permanent flexible HCA team to cover required shifts across all divisions. New contract options in development.	Flexible HCA recruitment currently at interview stage and plan to recruit 40 during 21/22.
2.3	Return to practice, study support and extended research and/or secondment opportunities	19.08.21: In progress to support previously qualified nurses to complete their return to practice course while working with us part time. A number of blended/split roles have been advertised/offered providing broader opportunities for research/secondments.	Number of blended posts already advertised and overall flexible working project being developed.
3	Improve the availability of workchoice staff, by improving our understanding of what drives take-up of shifts, and improving support		
3.1	Undertake a consultation exercise with workchoice staff to improve our understanding of shift take-up	19.08.21: Consultation is scheduled to begin in mid-September	Consultation with staff complete and key theme of feedback is confidence that shifts can be completed where originally booked. Targeted incentives for specific wards being reviewed to securely staff challenging wards and minimise need for movement from other wards.
3.2	Ensure all workchoice staff have clear line management arrangements and receive regular supervision	19.08.21: This is a complex piece of work, aligning workchoice staff to wards and avoiding overloading the line-management responsibilities of senior nurses. We have therefore deliberately set a longer-deadline. Preliminary work is underway.	Initial scoping being undertaken.
4	Improve the supply of Agency staff by ensuring rates are appropriate and that St Andrew's is a destination of choice		
4.1	Undertake a review of agency rates and implement new rates as appropriate	19.08.21: Temporary increase to agency rates for Nurses and HCAs to match internal incentive scheme.	Materialisation of CAMHS Agency workforce has not materialised to promised levels.
4.2	Establish regular meetings with Agencies to review take-up of shifts and identify barriers to increased shift take-up	19.08.21: Task **complete.** A first round of meetings was held with all Agencies in June and July. Barriers to be addressed include the amount of notice provided for STAH shifts, the support offered for staff new to wards, the availability of long-term block booked shifts. All of these are being addressed. Follow-up meetings have been scheduled with all Agencies.	As above- focus on greater commitment from agencies to deliver to plan
5	Improve workforce planning so there is a better understanding of the staffing requirement and recruitment needs		
5.1	Review current approach to setting establishment numbers and report on whether it is meeting the charity's needs	19.08.21: **Complete.** Review concluded that the establishment levels we recruit to are inadequate, as they do not take account of non-patient facing staff (including maternity leave), and they assume all enhanced support will be covered by overtime and bureau and agency staff. This creates an artificially low recruitment target.	Complete.
5.2	Reset recruitment and operational staffing targets and KPIs in line with revised approach to establishment levels	19.08.21: On track.	Nursing Fill staff rate KPI updated to link to latest establishment – the roles counted within the KPI calculation as 'nursing' or available to work currently being assessed. Reviewing establishment figures to accurately include enhanced support.
5.3	Growing our own' Nursing Career Family	19.08.21: Ongoing investment in the ASPIRE Graduate Nursing Programme (150 people on/completed the programme). Increased volume of places on Cert in Mental Health (25%), Increasing places on our Nursing Associate during 2022. First cohort of Advanced Clinical Practitioners complete in September 21. Introduction of a new Apprenticeship for experienced HCA's to mentor others to aid retention. The ASCEND Programme, which aims to grow non medical AC's will be an attractive career path for senior Nurses.	Trainee Nursing Associate cohort to be recruited for March start. Deputy Director of Workforce Planning working with Chief Nurse and finance to look at 3 year plan for the roles incorporating into the wider nursing workforce planning.
5.4	Growing Healthcare professionals of the Future in a range of professions.	19.08.21: Over 100 people are on range of Apprenticeship programmes, offering linear and multi faceted career development. Programmes include Degrees in AHP's such as Social Work and Occupational Therapy. On average 14% of our workforce is promoted each year.	On-going.
6	Improve retention of staff		

Ref	Action	Overview (Aug 21)	Sept Progress Update
6.1	Engagement / Wellbeing: Roll out of the Recovery & Restoration Framework which includes I) Compassion Focused Staff Support roll out ii) launch of the new strategy iii) Monthly Round Up MS Teams Q&A + Cascade iv) Your Voice Live Q&A sessions at each site v) CEC Ward visits vi) introduced career breaks and an upgraded Long Service Model	19.08.21: On track	Feedback obtained from Employee Forum on Recovery & Restoration Framework, number of items actioned or in progress. Your Voice live session held in Essex and Birmingham and started in Northampton - now ward visits due to Covid. Long service celebration event to be held 16 September. New strategy shared on 9 September Round Up.
6.2	Staffing: Engagement in new Engagement in new MHOST staffing model and new rostering system.	19.08.21: In progress. Weekly steering project group in place	Charitywide communication sent and an engagement team including key ward based staff is being established to develop an engagement programme.
6.3	Reward: 21/22 Pay Award to match NHS backdated to April	19.08.21. Awaiting confirmation of NHS contribution and Board approval in August	Board approved 3% pay review. Currently being rolled out for payment in September with communication circulated.
6.4	Wellbeing: Increased investment in Occupational Health / Health & Wellness resource	Complete	Complete
6.5	Learning & Development: A range of programmes to ensure people have the specialist skills needed to deliver care.	Specialist Training Action plans in place for LD/ASD, and other divisions in progress following a pause due to Covid and course prioritisation.	In progress.
6.6	Recognition: Ongoing implementation of CARE Awards, introduction of COVID Outstanding Contribution Awards at this year's Annual Awards Event	Awards Event scheduled for 10th Sept. 21/22 CARE Awards launched and monthly and Q1 winners announced.	Annual award held in Northampton 10 September. Birmingham held 14 Sept and Essex TBC.
	Targetted ward incentive program	7 wards identified whre additional incentive payments are required to support the effective deployment and allocation staff to match clinical and acuity needs	Plans being drafted and intended to run from October to January 2022
6.7	Induction and reflective practice for New members of the Nurse Family	Preceptorship programme for Newly Qualified Nurses, Extended Induction programme for HCA's, called the Care Certificate, updated Clinical Supervision Training to aid reflective practice and lessons learnt.	In progress.
7	Address staffing 'hotspots' (particular wards or times of year) with targeted interventions		
7.1	Implement a pay incentive scheme to mitigate against the impact of the school summer holidays, and the potential for reduced overtime and bank shifts	18.08.21: Complete. Scheme implemented with additional payments for overtime and (the fourth and above) bank shifts for Workchoice. Began 24 July and ends 6 September subject to review. Evidence is that an anticipated significant decline in staffing over August has been mitigated.	Incentive scheme concluded 6 September, review of targeted approach detailed in 7.1.
7.2	Produce a proposal for an incentive scheme targeting specific wards in Northampton where staffing is a particular challenge	19.08.21: On track. Wards identified and incentive scheme developed (based on a scheme which has proved successful on other wards). Costings being worked up.	Review taking place ensuring a targeted approach for 6/7 wards to provisionally launch mid- end of September.
7.3	Short term redeployment of Enabling Functions to wards where required	19.08.21: Staff trained and inducted to support ward working requirements. Prioritised those with a clinical background such as within education, college and L&D team.	On-going support being provided from Enabling Functions.
7.4	CAMHS carried out listening sessions with day and night staff	An action plan is being developed to move forward ideas and suggestions obtained from listening groups.	Discussion to take place with recruitment, Ops and HR to finalise action plan.
8	Transform the Charity's approach to setting staffing establishments and rostering staff by adopting best practice from across the Mental Health sector		
8.1	Ensure staffing levels for each ward are safe, appropriate and in line with national practice by implementing the MHOST staffing model across all Northampton wards	19.08.21: This is a large and complex project in its own right, and is being managed separately. It is included here as it is a major element of our attempts to improve our staffing position. Steering group meeting weekly.	Communication sent to all staff on 6/9 raising awareness of MHOST project.
8.2	Introduce an eRostering solution	19.08.21: This is a large and complex project in its own right, and is being managed separately. It is included here as it is a major element of our attempts to improve our staffing position. Steering group meeting weekly.	In progress with project group. Reviewing the 1st division where this will be rolled out.
9	Ensure the Charity's recruitment activity and processes delivers the right numbers of staff more quickly to post		
9.1	Reduce the time to hire by implementing DocuSign technology for the electronic issuing of our employment offers and management of our pre-employment checking process	On track: DocuSign went live on 16.08.21 for the issuing of offer letters and employment contracts. Reference checking process being testes from 31.08.21. We will also be using the technology to provide accurate and timely internal confirmation of internal processes including internal moves and promotions which will be live by 31.12.21.	The issuing of contracts and offer letters via DocuSign is live. Testing for references currently taking place.
9.2	Focus on how we can further reduce our time to hire for all posts	On track: COVID increased our time to hire due to the need to safely manage our induction numbers within government guidelines and at lower levels than we managed pre-pandemic. Our current plan is to return to pre-pandemic levels by the end of the year and then further improve through 2022.	Full action plan on how to reduce time to hire being produced with close working with recruitment, HR Services, L&D.
9.3	Nurse pay progression to support the recruitment and retention of experienced nurses and Clinical Nurse Leads	On track: First of three staggered increases went live in October 2020, the final increase goes live in April 2022 with the pay progression path communicated to all nurses.	Letters to be sent to all Nurses in September explaining the pay review increase and progression path.
9.4	Ongoing recruitment activity for Nurses and HCAs. Adjust targets according to establishment levels	On track: Physical Careers Fairs restart post-COVID in September 2021. University careers events due to restart post-COVID from October 2021. We are also restarting onsite assessment centres. We have extended our experienced nurse refer-a-friend scheme to include Nurse Manager posts.	HCA recruitment plan being reviewed at Sept People Committee. 40 HCAs starting in September with 55 more new HCAs in pipeline. 21 Staff Nurses and SSNs starting in September (and an additional 13 ASPIRE nurses) with an additional 7 confirmed for Oct/Nov start and 17 to start before end of January. Physical career RCN fair attended in London 9/10 September.
10	Establish a 24/7 Operatinal Hub to oversee the Operational requirements of the nothampton site, with arms length support to regional hospitals	Plan drafted and being developed by the DCEO with an expectation that this can be operational by the end of October 2021, providing a full range of operational oversight and supporting the effective allocation of staff. The Hub will also provide a central escalation point- introducing a duty senior manager on site role and improve the organisational response to incidents and event	Plans drafted and due to be considered by CEC w/c 27 September

People Committee

Appendix 2

Diversity & Inclusion Annual Report

Paper for Board of Directors	
Topic	Diversity and Inclusion annual report
Date of Meeting	Thursday, 30 September 2021
Agenda Item	**11**
Author	Story authors, Cheryl Nyabezi, Bobbie Kelly, Lara Conway
Responsible Executive	Martin Kersey
Discussed at Previous Board Meeting	Not previously discussed
Patient and Carer Involvement	Input on patient and carer stories
Staff Involvement	Feedback from various groups including Inclusion Committee and Network Group Chairs
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Charity Executive Committee – 8 September 2021 People Committee – 14 September 2021

Report Summary and Key Points to Note

- The Diversity and Inclusion report is produced annually covering a range of articles written by either staff, patients or carers as well as key data analysis. This year the stories include covid support, patient involvement, Peer Support Workers, Research and Innovation, mentoring and learning and development.

- As with previous years the report includes and assesses the relevant D&I data for the 2020-21 period (pages 20-23).

- Feedback on this report has been obtained from the CEC, People Committee, Inclusion Committee and Network Chairs.

- Once feedback has been obtained from the Board of Directors the report will be updated and submitted to the NHS in October.

Appendices: None

Inclusive HEALTHCARE

DIVERSITY & INCLUSION REPORT

2020-21

Transforming lives together

Contents

Please note, some of the photos in this report were taken before the current social distancing measures came into force.

"Equality is important to me. It always has been because everyone deserves to be listened to."

– BT, Patient

Welcome from Katie Fisher,

Chief Executive Officer

Welcome to our latest Diversity and Inclusion report.

Twelve months ago, none of us could have anticipated what an unpredictable and emotional year it was going to be.

The Coronavirus pandemic has given us numerous challenges, and our staff have been on the frontline throughout, working around the clock to care for our patients. Many of our staff have worked longer hours, taken up additional shifts and also volunteered to best support our patients. I will be forever thankful that they found the energy to push through their own fears, anxieties and tiredness to put our patients first.

Supporting our most vulnerable staff has been a priority throughout the pandemic; this includes those with underlying health conditions who were required, by the Government, to shield and stay at home, as well as our colleagues from ethnic minority communities who were disproportionally impacted by Covid-19. For the latter, we provided Risk Assessments, wellbeing advice and Occupational Health support, as well as increased support from our line managers. We also prioritised our ethnic minority staff for Covid testing.

Showing our commitment to transparency and being an inclusive organisation is important to us. I am particularly passionate about understanding - and working towards removing - the barriers that stop women and ethnic minority staff achieving senior leadership positions. On a personal note, I am part of the Reverse Mentoring programme and regularly meet with my mentor, Emmanuel Mutyavaviri, who is a Senior Staff Nurse at our Birmingham hospital. I particularly value the relationship I have with Emmanuel, as he has helped me to think differently about the struggles our ethnic minority staff may have faced during their career. He has also given me insights into what it means to be a truly inclusive organisation.

While this report is an important reflection of our commitment to Inclusive Healthcare and how we are growing our people and culture, I know we have work to do. I hope you enjoy reading about our journey so far.

Katie

Public Sector Equality duty

Equality is a core value within our organisation and lies at the heart of how we deliver high quality compassionate services. It is also part of our wider Constitutional Values and our organisational culture. We are committed to promoting equality and diversity, and protecting human rights. We actively seek to explore and understand the needs of our diverse staff, service users, carers and the wider community.

We ensure we meet the aims of the Public Sector Equality Duty by:

- Eliminating unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act
- Advancing equality of opportunity between people who share a protected characteristic and people who do not share it
- Fostering good relations between people who share a protected characteristic and people who do not share it.

Introduction

Martin Kersey,
Executive HR Director

Welcome to this year's Diversity and Inclusion report, which I hope you find enjoyable and informative.

At St Andrew's, we know that diversity is one of our greatest strengths, contributing positively to our success and, most importantly, to the care we provide for our patients.

I am exceptionally proud that the Charity has one of the most diverse boards in healthcare. Our Charity Executive Committee, which oversees the day to day management of our hospitals, is also incredibly varied, with fantastic representation from both women and individuals from ethnic minority backgrounds. We strive to treat everyone as equal, and I am proud of our recent Ethnicity Pay Gap and Gender Pay Gap results, which you can read more about in this report.

I see this report as an opportunity for us to share the experiences of our staff and the people in our care, and I hope that together we can create better understanding of the benefits a diverse mix of staff can bring.

Martin

Cheryl Nyabezi,
Diversity and Inclusion Manager

Over the last year we have made significant strides towards that inclusivity goal.

Whilst Covid has taken a toll on families and communities, it has also magnified issues around race and gender imbalances. While Trans and non-binary communities continue on their journey to become more visible and to raise awareness, many inequalities have come to light. The pressures and frustrations brought about by Covid have increased mental health awareness as well as concerns, and as an organisation we are rising to the challenge to be a part of much needed change.

Our reflections have yielded results and I am excited that we have set several plans in motion to help us address any gaps that we might have within our service, both for our staff and for patients. We also acknowledged and celebrate the good practice that we have worked so hard to attain, such as our gender and ethnicity pay gaps, our senior leadership representation and our overall adherence to core principles of diversity and inclusion.

The St Andrew's family is one I am proud to be a part of and I continue to be excited to see what else we can do together.

Cheryl

2020-2021 Diversity Summary

Ethnicity

OVER **22%** of staff are from ethnic minority backgrounds

22% of our **senior leadership** are from **ethnic minority backgrounds**

15% **of our Board** are from an ethnic minority background

FEMALE representation has increased year on year:

64% **of staff are female**

50% **of our leaders are female**

35% **of our Charity Executive Committee are female**

Gender Pay Gap

0% compared to the national pay gap of **15.5%**

Our Gender Pay Gap ratio is 0% - a figure we have maintained for the last 3 years. This means that our median male and female hourly rates of pay are exactly the same

Age

There is balanced distribution across the age bands (see page 20). This is favourable when compared to the NHS where there is an ageing workforce amongst Nurses

20%

of senior leaders have declared a disability, significantly above the 10% external benchmark

8%

of senior leaders and leaders have declared their sexual orientation as LGBTQ+. This has increased by 5% and is favourable to the UK population demographic of 2.7%

Diversity and inclusion at St Andrew's

About St Andrew's

St Andrew's Healthcare is a charity that provides specialist mental healthcare for people with complex mental health needs. As a charity we exist to promote **wellbeing**, give **hope** and enable **recovery** through **innovation**.

The people who use our services come from different backgrounds and places, and have various mental and physical health needs. Some individuals need short–term, intensive support following a mental health crisis or breakdown, and some people stay with us for longer periods; for these individuals we can provide not just medical interventions, but therapy and support to help them get their lives back on track. Some patients come to St Andrew's towards the end of their life, and our expert staff care for them in as comfortable an environment as possible.

We provide care across a number of services, including Men's Mental Health, Women's Mental Health, Child and Adolescent Mental Health Services (CAMHS), Neuropsychiatry, Autistic Spectrum Disorder and Learning Disability. Our headquarters and largest site is in Northampton, but we also have facilities in Birmingham, Essex and Nottinghamshire (Winslow and Broom Cottage) which provide specialist locally-focused mental healthcare.

Across our hospitals, we provide treatment and care for over 570 inpatients who face challenges of mental illnesses, developmental disorders, brain injuries and neurological conditions. In addition we offer treatment and support for individuals within community settings and as outpatients, to different groups including former members of the Armed Forces and people within the Criminal Justice System. We also work with other services to support individuals as they leave hospital care.

Inclusive patient care

We take an equally inclusive approach to patient care and work hard to ensure our services and therapies are co-produced. Our Peer Support Worker programme is bringing people with lived experience of mental health recovery onto our wards, and our REDS Academy (Recovery and Every Day Skills) is going from strength to strength (see pages 12-15).

Our people

To meet our patients' needs and support their journey towards achieving hope and purpose in their lives, St Andrew's has a positive, welcoming, diverse and inclusive workforce made up of over 4,000 staff, 3,621 of which are permanent employees.

We employ more women than men, and have a higher ethnic minority population than the national average. We also have broad age distribution across our colleagues.

Charity Executive Committee

Our Charity Executive Committee oversee the day-to-day management of our hospitals. The Committee meets weekly and its 20 members come from a diverse mix of backgrounds, including both operational and clinical staff. The different experiences of the members ensures we have broad and inclusive decision-making processes, involving key clinical, operational and functional leaders.

Staff and Carer Governors

As a charity, St Andrew's is supported by up to 40 governors, whose role is both to help the charity achieve its goals and hold its leaders to account. The Board seeks governors' views on important decisions, and governor approval on the appointment of Executive Director roles.

Governors also have the option to become more involved with the charity through visiting wards, volunteering and mentoring staff. Our governors come from a wide range of backgrounds and represent different viewpoints.

The Board of Directors

We are proud of our diverse Board representation and progress we have made in this area, in 2018 our ethnic minority representation at Board was 0%. Now 15% of the Board are from ethnic minority backgrounds vs the UK average of 1.5%. Additionally, 38% of the Board are female vs the external benchmark of 33%.

"I felt I wanted to drive change. I had seen a potential problem in my ward that should not be ignored. Everyone in the Inclusion Steering Committee (ISC) has their reasons for coming together, and that creates a great energy for positive change. I'm already surprised about how much I feel will be done."

– Sam, ISC member

Inclusion Strategy and Steering Committee

Our strategy

Our inclusion strategy is focussed on achieving Inclusive Healthcare. This means creating patient outcomes and employment opportunities that embrace diversity and promote equality of opportunity. It also means not tolerating discrimination for any reason.

Our goal is to ensure that Inclusive Healthcare is reinforced by our culture, and is embedded in our day-to-day working practices.

Our strategic aims are to:

1. Fix the basics
2. Improve ethnic minority and female representation
3. Focus on mental health in the workplace

"I joined the ISC to understand the impact that I can have as a leader on championing inclusion within the Charity. Growing up I was taught the importance of having role models that you can relate to, and it is essential that we are an inclusive organisation at all levels. The ISC has developed dramatically, and each meeting has had items for discussion that are both thought provoking and inspiring. The agenda is wide ranging, and has taught me to think about inclusion in areas that you wouldn't think consideration was needed. I would recommend everyone to ask the inclusion question in every area of their work."

– Catherine Vichare, Clinical Director for Community Partnerships

The Inclusion Steering Committee

Our inclusion strategy is steered by our Inclusion Steering Committee (ISC). Chaired by our CEO, Katie Fisher, the committee was formed three years ago and meets every quarter. The ISC has 15 members, with representatives from all role levels and teams across the charity, including patients.

Our current focus is on:

1. Post-Covid recovery and restoration
2. Mental Health in the workplace – including Compassion Focussed Staff Trauma support
3. Supporting staff through changes at St Andrew's
4. Anti-Racism campaign

There is more information on each of these topics throughout this report.

"The ISC brings together an inclusive group from all corners of the Charity, to shine a light and take action on the things that truly matter, enabling our wonderfully rich tapestry of staff to thrive and in doing so enhance the experience of those in our care. The Committee gives a voice to those who may not feel they have previously been heard and understood."

– Sue Fairbrother, Learning and Development Manager

Covid-19 support

Protecting the health, safety and wellbeing of our staff has been critical throughout the Coronavirus pandemic. At the start we implemented health, safety and wellbeing measures, and undertook regular risk assessments, where required, to support and protect our people. We have also regularly reminded staff to ensure they follow guidance for social distancing and the use of PPE.

Staff who were considered to be clinically extremely vulnerable were advised to shield in order to minimise social contact. For these staff, where possible, we supported them to work from home. For some people this has meant an entirely different set of working tasks, but our line managers have ensured they check in regularly in order to provide support and guidance.

Supporting our BAME staff

During the height of the Covid-19 pandemic, data from Public Health England showed more people from BAME groups (Black, Asian and minority ethnic) were dying from coronavirus than those from white ethnic groups. Once the Covid-19 vaccination programme began, the statistics also showed that this at-risk group had a hesitancy towards vaccinations.

At St Andrew's we have worked hard to ensure that our BAME community – both staff and patients – have had additional support and guidance during this worrying and confusing time. To encourage take-up of the vaccination, we have worked with our local and national NHS partners to share targeted communications.

Also, we have:

- Held virtual TEAMS events where our ethnic minority staff can find out more about the vaccine and ask our clinical teams specific questions
- Took part in awareness-raising events with Northamptonshire Health and Care Partnership
- Prioritised our BAME staff for Covid-19 testing
- Prioritised our BAME staff for Occupational Health Support
- Offered advice on Vitamin D, including supplements and diets
- Provided a risk assessment for all BAME staff
- Increased levels of support from line managers and our BAME network
- Communicated access to our Employee Assistance Service, a 24/7 support line for all staff.

Dr Annette Greenwood
Supporting our staff after traumatic events

Due to the complex nature of our patients' mental health, our staff are sometimes victims of physical, racial or verbal abuse. At St Andrew's we have a Trauma Response team, who play a vital role in offering support to help staff process the trauma they have experienced and return to work.

Dr Annette Greenwood is our Trauma Response Lead. She explained: "Over the past year, I have helped a large number of staff from across our Charity, including people from BAME communities - and in particular colleagues from the African British and Caribbean community. When English is not your first language, it can sometimes be difficult to understand what support is available to you. From my perspective, at St Andrew's there's lots on offer - but it's hard to ensure that everyone knows what is available and how to access it.

"Last year I supported staff after a racist incident on one of our wards. I helped the individuals affected to access more than just psychological support; I also helped with practical things such as arranging medical treatment and helping staff to access support from the hardship funds.

"I see my role as quite humanitarian. If a member of staff from an BAME community is injured at work, it is often more difficult for them. For example, an injury may mean a period of not being able to work - this can have a knock on effect; what if that staff member usually sends money home? Does it mean their families aren't able to eat, or educate their children? There can be a massive impact on a large number of people from this one incident. Although we have a zero tolerance approach to racism at St Andrew's, due to the severity of our patients' conditions, incidents do sometimes occur. Staff do not always want to mention if an incident is racially charged, as they do not want to cause problems – we work hard to reassure our staff that by speaking out they are not causing a problems, but instead taking an important step forward in fixing the problems they experience.

"We work tirelessly to ensure everyone feels they can have a voice, and help us to make changes. At St Andrew's we are like a family. If you work for us, you can ask us for help as a member of our family."

Patient involvement

At the heart of Inclusive Healthcare is our patients. Our approach is to build a holistic package of care around each individual, in order to deliver the best possible outcomes for them. Co-production is a fundamental part of this: we seek to involve every patient – and where appropriate their carers – in designing their care.

"You have given me the most important gift that I could ask for. You have made me realise that I am a person first and a psychiatric patient second, which nobody else along this journey has ever done. You have made me feel proud again, and I am proud to have been a student at the Reds Recovery College."

– Patient, women's division

REDS Academy

All of our patients, carers and staff have access to our Recovery and Every Day Skills (REDS) Academy, which was launched in June 2018. REDS Academy offers courses designed to help people better manage their mental health and prepare them for life outside of our care. Since the Academy was launched, over 700 students have undertaken courses, including 30 people who are carers.

All of the REDS Academy courses are designed and delivered in partnership with patients and people with personal experience of mental health challenges. This co-production is vitally important to the success of the programme.

There are currently 67 courses available in the prospectus, offering a wide range of learning opportunities from understanding mental health to meditation, drama and dance. There are also courses on topics such as budgeting and how to best manage money. Due to Covid-19, REDS now deliver courses online as well as face to face, via their REDS Live programme.

All REDS Academy students (staff, patients and carers) are classed as equals, which harnesses the benefits of collaborative learning. All students at the REDS Academy receive certificates of achievement for completing courses, and all attendees are presented with red 'student' wristbands to wear.

"Having REDS in the hospital has been a real asset. The courses that have been on offer have given hope, helped set goals and shown the differences between clinical and personal recovery for both patients and staff."

– Staff member

700 students

have undertaken REDS Academy courses

Over 300

patients have studied with the Academy

67 courses

are currently available

Peer Support Workers

While Peer Support as an idea has been around for many years now, the concept of having Peer Support Workers as active staff members is a fairly new one.

"I think that the Peer Support Worker has helped one patient immensely. The patient is much calmer and really looks forward to his time with the Peer Support Worker. The patient seems to have lost that hopeless feeling that was prevalent when he first came to our ward. I'm sure that the Peer Support Worker has played a part in this."

– Staff member

Here at St Andrew's we began recruiting Peer Support Workers in 2019, and now we have 9 Peer Support Workers who support our patients on the wards. These are individuals who have been specifically hired and trained in order to use their personal experience of recovery from mental ill health to support the recovery of others. They have all, at one time, been a service user themselves, and as they have lived through mental ill health they are living proof to our patients that recovery is possible. They offer guidance, support and most importantly, hope.

Peer Support Workers are part of the multi-disciplinary team, and they work on the ward to support the recovery of patients. They are trained to specifically use their lived experience, which brings a new area of expertise to the team.

Working with the nursing team, peer support workers can help patients to identify their own recovery goals and aspirations. They are able to spend time talking with the patients, socialising, running group activities and providing emotional support. They also have knowledge of being a Service User in the community, so they can also offer lots of practical information and signpost patients to useful resources.

Being a Peer Support Worker can be a really positive experience, and some of our Peer Support Workers have gone on to permanent jobs in Healthcare, including as a Healthcare Assistant and in Social Work.

"We come from a variety of backgrounds and levels of experience. Our main purpose is to try and provide hope on the wards, and let patients know that while it is rarely possible to be entirely free from poor mental health, you can have a meaningful and satisfying life by learning to live with it."

– Peer Support Worker

Bryn's story

Bryn is a Peer Support Worker at St Andrew's. He has been with the charity for five months, and works on Rose Ward.

Here's his story.

"I have had difficulties with my mental health for most of my life, which has been very challenging - and still is at times - but this has not held me back from being a Peer Support Worker. In fact, it has made me stronger and allowed me to grow with my role.

"With my lived experience and the skills to use this appropriately, I am able to see things from the patient's perspective while supporting them and bring hope by working on the ward.

"This job gives me the drive I needed to believe in myself, and now I've learnt the value of what I can bring - not only to the patients but the whole ward.

It just goes to show that with the right help and support you can achieve anything, even with mental health problems. My time as a Peer Support Worker has taught me that there is an ever-growing light at the end of the tunnel, and it is not the oncoming train I used to believe it was. The hope I bring with me each day is getting bigger".

Race and Ethnicity

Over 22% of staff at St Andrew's are from ethnic minority backgrounds which is in line with the NHS and significantly higher than the national average at 12.5%.

At a senior level, our BAME representation is 22%, one of the highest in the country.

Ethnicity Pay Gap reporting

We value the importance that difference can bring to the workplace, and we're working hard to show our commitment to transparency.

As part of our commitment to inclusion we have reviewed the relationship between ethnicity and pay in our charity. Our 2020 Ethnicity Pay Gap results highlight the difference in average hourly pay between our ethnic minority colleagues and non-ethnic minority colleagues.

When organisations publish pay gap data the median is the main measure assessed. It is calculated by listing all rates of pay for Minority Ethnic colleagues and other colleagues, identifying the ones in the middle and then identifying any pay difference.

Our median ethnicity pay gap at April 2020 was -3.9% (based on disclosed ethnicity). This compares to -2.8% last year. The calculation considers total remuneration, which means payments such as enhancements for working unsocial hours are included. The figure of -3.9% means that overall our ethnic minority employees received a higher hourly rate of pay in comparison to our non-ethnic minority colleagues when taking into account enhancement payments.

Our BAME network

Our active BAME network offers peer support and networking opportunities. The network is open to individuals who identify as BAME, but also allies and people interested in raising awareness of the issues that BAME people face. The network has a calendar of events throughout the year, tailored to the needs and tastes of members of our BAME community.

Our ethnicity pay gap is

-3.9%

Akim Bande, Nurse Manager and Co–Chair, BAME Network

"The death of George Floyd and the impact of Covid 19 on members of the BAME community have prompted many to think about what we doing to tackle racism and discrimination, and how do we promote equality and diversity?

"It is important that we, and by we I mean everyone, not just members of the BAME community, need to focus on championing an environment where people can speak up and be reassured that their concerns are heard and understood. We need to be working with external organisations and community groups to ensure that we are ALL aware of what constitutes racism, discrimination hate crimes and how to tackle these issues. There is need to support and assist people who have witnessed or been subject to racism.

"We all have a right to expect a fair and inclusive working environment. It is important for members of our organisation, our service users and their friends and family to be aware that we do not indulge racial injustice or discrimination of any kind.

"We need to be having frank discussions. We need to be sharing our experiences. We need to be looking after each other. We need to keep learning and recognise the need for change. We need to recognise the whole human race as one."

"Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

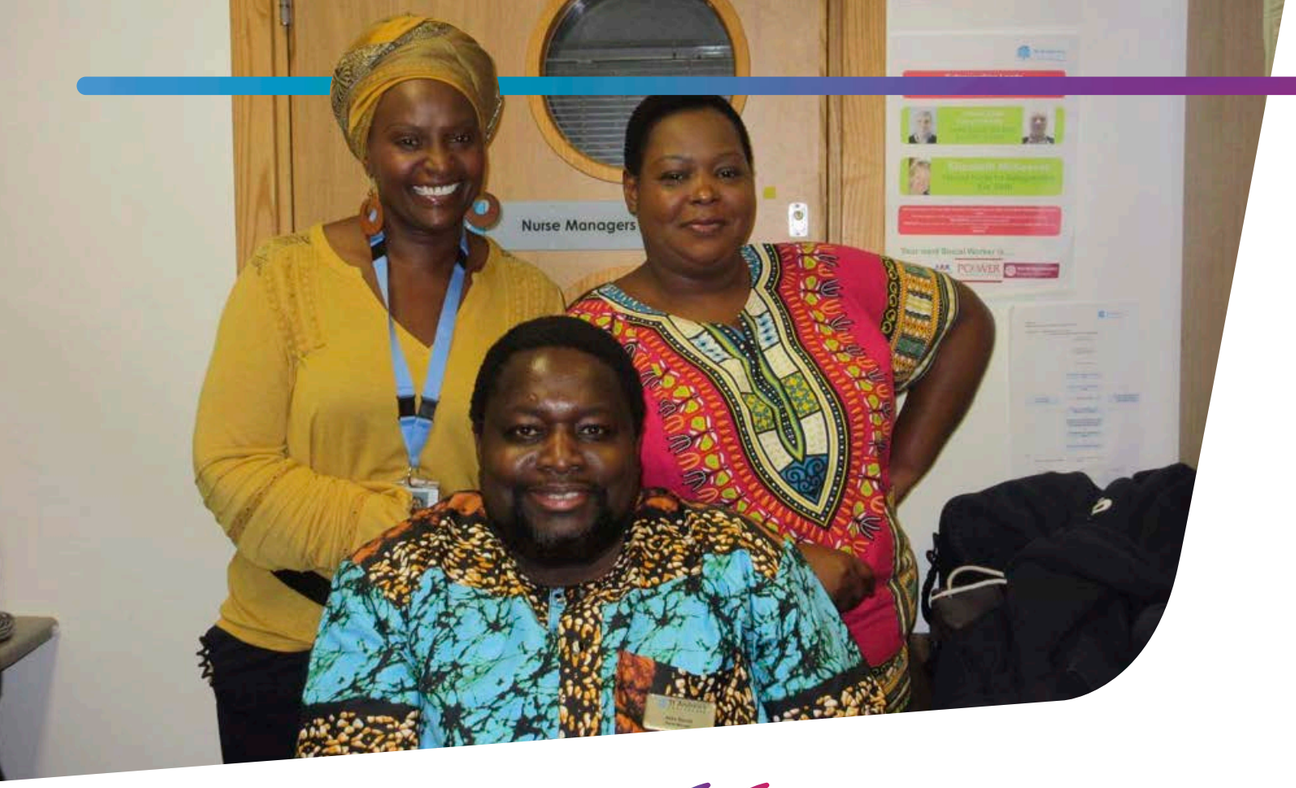
– Martin Luther King Jnr — Letter from Birmingham Jail, April 16 1963

Juliet Muzawazi, Specialist Nurse and Co-Chair, Bame Network

"Moving to the UK several decades ago helped me view certain aspects of life from a different perspective. I had never thought barriers to progress could be linked to race. I however saw the impact of these barriers in my community and I was resolved that I would never want to be discouraged by such for my own career.

"When the opportunity to volunteer as co-chair of the St Andrew's BAME Network came along, I saw a chance to reach-out and encourage more people from BAME communities to reach for the sky. I believe in grabbing opportunities and having a tenacious attitude. 'Never give up trying, discouragement is not an option'.

I hope my support for BAME staff will motivate them to be the best they can be. I believe that an inclusive environment is a place where everyone thrives, achieves more and delivers the best quality of care. It is exciting to see that this is what St Andrew's is aiming to achieve through the different staff networks."



Black History Month

In November 2020 we celebrated Black History Month across our hospitals and community settings with the theme Empowering and Celebrating Achievements. There was cultural dress, dance, food, events and music.

One of the special events was a virtual conference, held on Microsoft Teams, which featured updates from staff across the charity - including CEO Katie Fisher, Non-Executive Director Professor David Sallah, Sanjith Kamath, Executive Medical Director and Exec Sponsor of the BAME group and Birmingham Lead Chaplain, Kartar Singh Bring. There was an opportunity to ask questions and network with speakers including the host Richard Grant Poet (AKA Dreadlock Alien), Rob Neil OBE, and Wendy Irwin (Royal College of Nursing Equalities Lead). There was an opportunity to ask questions and network. The event was attended by around 100 people from across the charity, many of whom wore cultural dress.

"This was such an inspirational day with some very thought provoking and powerful speakers. The conference led me to buy and read some of the books that were recommended throughout the day, and also inspired me to give much more thought about how we can influence change and develop understanding through education days in our College. Some highlights of the day were Dreadlock Alien's incredible poems throughout the day, the Jerusalem dance and our very own Akim Bande's amazing DJ talents! I thoroughly enjoyed it and felt so grateful to be included in such an important and inspirational event."

– Cheryl Smith, Head Teacher, St Andrew's College

"I really enjoyed attending the conference in November. As a relatively new member of staff, I found it extremely interesting and especially loved the atmosphere on the call, which was inclusive and supportive. It really showed the challenges and the changes of our history, that have made a pathway to the present, although there is still work to be done, we have a solid foundation to build on."

– Laura Slater, Finance Assistant, Birmingham

SERVICE USER STORY:

Public Enemy: Why they matter!

Before Public Enemy, black youth were not well recognised in popular white culture. Black experiences and issues affecting young black people were not mentioned in music lyrics or many movies. These lived experiences related to suffering racism and prejudice. During the 1980s black people started to find their voice and there was no stronger voice than Public Enemy.

For me as a young black person experiencing racism from police and being divided away from other white communities it was really positive to know that these groups were out there and available for different races. They pulled no punches in their lyrics and let people know what it was like being young and black in a divided society.

Public Enemy were underground but had a strong following. I felt strong when I heard the lyrics. I felt powerful when I heard the bass and rhythm. I felt proud when they spoke about issues relating to me.

Their band brand was a cool target that influenced Stone Island clothing. They wore black monkey boots and military clobber. They were like black cobras moving on the stage.

With the Black Lives Matter campaign, their music, fashion and lyrics reach out to many black people. There are lots of black rappers and performers but they were the pioneers. They were the first rap artists to talk about black politics. Public Enemy are more relevant than ever.

They could easily headline a Black Lives Matter concert or festival, if ever there was one organised. My life matters.

By CF, Hawksley ward.

Organisational diversity and overall representation

Career level numbers:

- **E - Senior Leaders** - 21 total
- **D - Leaders** - 26 total
- **C - Manager/Expert** - 251 total
- **B - First line manager/Professional** - 882 total
- **A - Team Leader/Core Contributor** - 2,058 total

Patient demographics

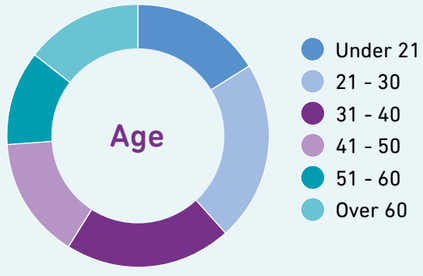
Gender

71% ♂

29% ♀

Ethnicity

- 21% BAME
- 70% White
- 9% Not Stated / Prefer not to say



Employee demographics

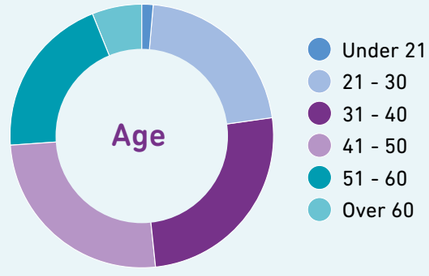
Gender

36% ♂

64% ♀

Ethnicity

- 22% BAME
- 47% White
- 31% Not Stated / Prefer not to say

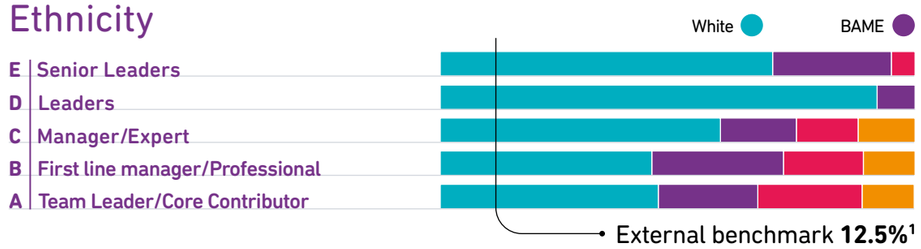


The below does not include people recruited to Workchoice, our internal staff bank for workers on flexible, zero hours contracts.

Prefer not to say ● Not Stated ●

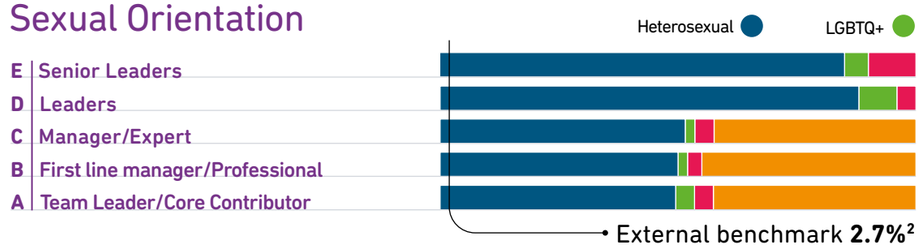
Total number of permenant employees **3,261**

Ethnicity



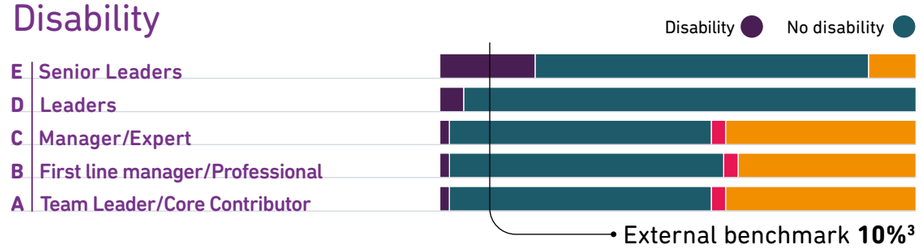
A quarter of senior leaders at St Andrew's are from a BAME background; a very favourable level against the national average of 12.5%.

Sexual Orientation



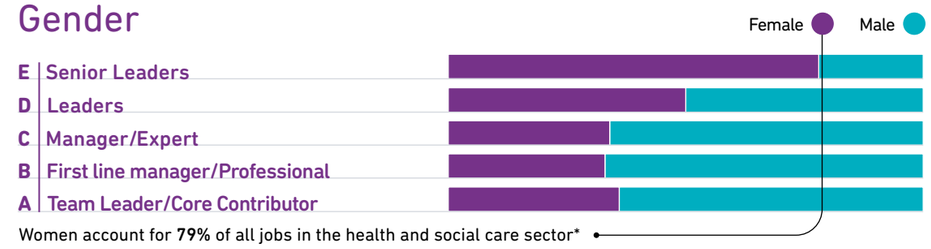
8% of senior leaders have declared their sexual orientation as LGBTQ+. This was 0% in 2020.

Disability



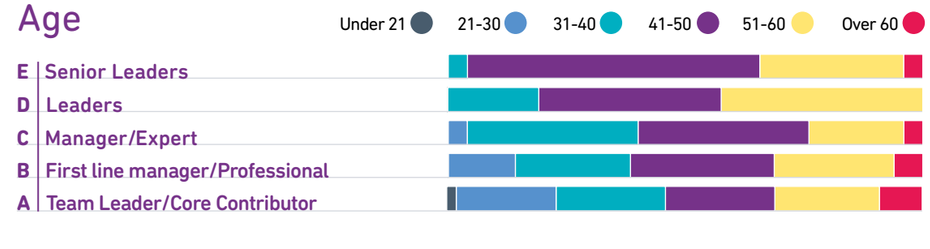
20% of our senior leaders have declared a disability, above the external benchmark of 10%. We aim to increase disclosure rates further and ensure staff are supported through our various resources including an in-house Occupational Health service and our ABLE Network Group.

Gender



There has been no significant change in gender representation. The proportion of females in senior manager roles has increased and St Andrew's continues to have a female CEO appointed in June 2018.

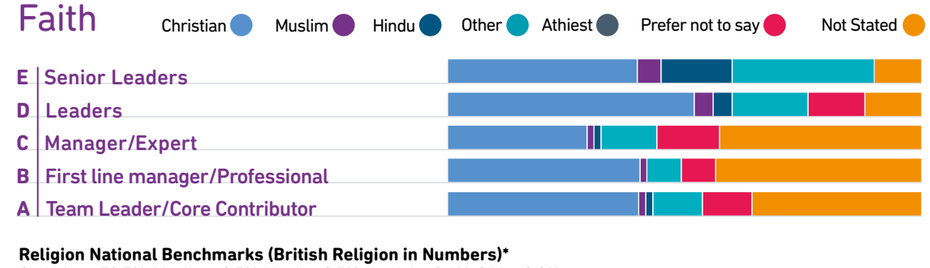
Age



Average age of the UK worker is over 41.

There is a balanced distribution across the age ranges. This is favourable when compared to the NHS which has an aging workforce among nurses.

Faith



Our faith disclosure levels remain similar to last year. An in-house chaplaincy team provide spiritual support to both patients and staff.

Religion National Benchmarks (British Religion in Numbers)*
Christian - 50.7%, Muslim - 2.5%, Hindu - 0.7%, Jewish - 0.6%, Sikh - 0.3%, Buddhist - 0.6%, Other non-Christian - 1.5%, No religion - 41.5%, Not answered – 1%

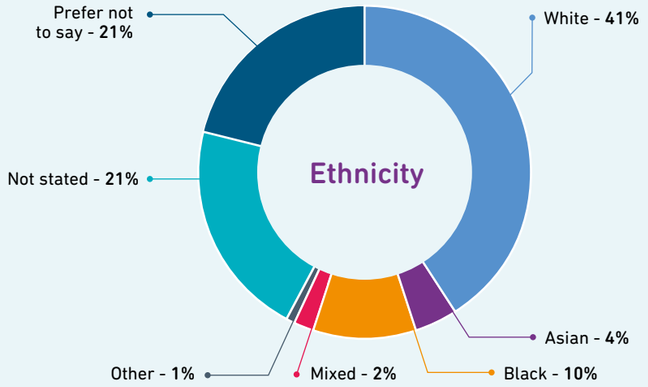
[1] NHS benchmark of 22%. [2] Office for National Statistics [3] UK Gov. Disability Stats

* ONS/Gov. Labour Market Stats.

Employee lifecycle

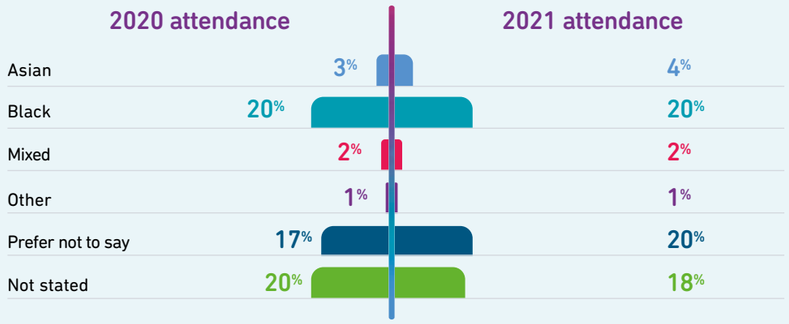
Leavers 2020/21

Following a challenging year in 2020/21 there was a small increase in overall turnover, which is also reflected in the number of BAME staff who left the charity compared to the previous year, although this is below the BAME workforce demographic.



Internal training

During 2020-21 the way training was delivered adapted to align with COVID requirements with over 23,000 hours of training undertaken. The number of BAME staff attending training remained at 26% and there was a 2% decrease for white staff attending training.



Training levels for black staff have increased from 11% in 2018, 15% in 2019 to 19% in 2021

* The ethnicity breakdown is provided as a percentage of total leavers and the figures exclude any leavers related to the Mansfield site closure in 2020.

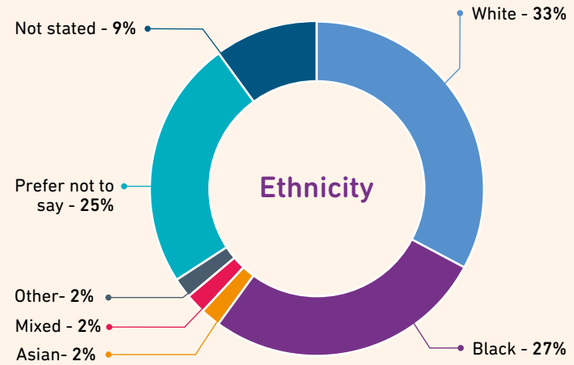
Employee relations*

During 2020 the charity set up a dedicated internal Employee Relations specialist team to support all disciplinary and grievance cases ensuring consistency in case management and accurate reporting of case numbers.

Disciplinary cases

There has been an increase in the number of overall disciplinary cases (including appeals) compared to the previous year.

The data shows there was a higher proportion of black staff involved in disciplinary cases during 2020/21 comparable to the workforce ethnicity demographic (black staff represent a minimum of 14% of the total workforce). This data continues to be tracked and is reviewed on a quarterly basis in conjunction with the Diversity and Inclusion team.

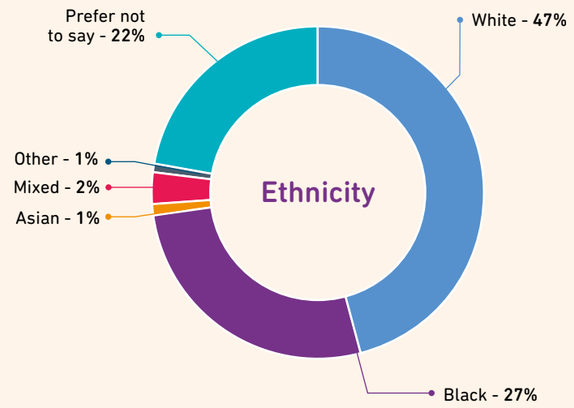


This data is regularly tracked and reviewed by the Senior HR team assessing the trends and actions that need to be taken. This year saw an increase in disciplinary cases relating to staff that work nights, where there is a higher proportion of black staff than the workforce demographic. An action plan has been developed to ensure a fair and consistent approach in employee relations. For example, on our Birmingham site hearing panels now include someone from an ethnic minority background.

* This data applies to permanent and WorkChoice staff (our temporary staffing bank) and count an investigation, hearing and appeal as a separate case. The grievance ethnicity data refers to the person who has raised the concern.

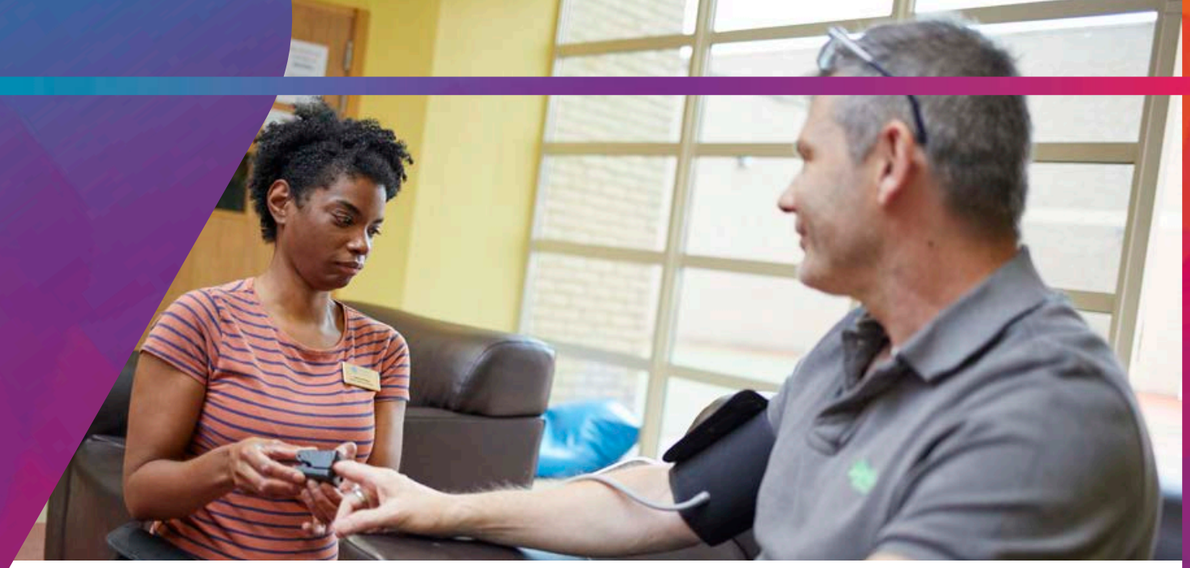
Grievance cases

There has been an increase in the number of overall grievance cases (including appeals) compared to the previous year. The data shows a higher proportion of grievances being raised from black staff compared to the wider workforce ethnicity demographic.



Disability

At St Andrew's we are committed to supporting everyone's mental and physical wellbeing, with various events and support channels open to both our staff and our patients.



Our ABLE employee network group is focussed on promoting equality of opportunity, and positive attitudes towards people with disabilities. Its overarching purpose is to enable positive physical and mental wellbeing in the workplace. This group is open to all staff interested in disability equality.

Corinne's story

"Having single sided deafness and experiencing problems in other workplaces in the past, I was very worried about joining St Andrew's and not being able to cope with the noise levels in an office environment.

My line manager from day one alleviated all these fears. She made sure that the team were aware of how it would affect me and what they could do to support me. Without prompting, the team around me made sure that they always spoke to me on my hearing side – something my own family struggle to remember! I wear noise cancelling earphones to help deal with noise levels and in the past I have been made to feel uncomfortable doing so. Again, the team completely accepted this and made sure that they included me in conversations and made me really feel part of the team.

My manager also ensured that I had a quiet space in the building if the noise got too much, and allowed me to work from home on Fridays when I told her that that was the day I most struggled with fatigue from being in noisy environments."

Corinne Hughes,
HR Services Assistant

Marlon Nyakuwanikwa,
Nurse Manager, Birmingham and Co-Chair ABLE Network

"I am honoured to be co-Chair of the ABLE Network. I believe the Charity takes the network seriously, evidenced by the support from senior management. The priority for me is to highlight the profile of the group and increase its membership. I am looking forward to work with colleagues in increasing awareness of the group and sign posting staff where they are able to get some support.

"The ABLE Network aims to promote opportunity and positive attitudes towards others with disabilities. The Network are planning various events to highlight World mental Health Day in October, International Day of Persons with disabilities on 3 December."

CASE STUDY: Katrina

"I was told I would never walk again and now I'm able to stand on my own"

37-year-old Katrina, a person in our care, was delivered the devastating news eight years ago that she would never walk again. She'd lost the power in her legs and was wheelchair bound following an incident in 2011 where she tried to take her own life.

"The branch broke and I fell about 20 foot," she recalls. "I fractured my T12 and damaged my spinal cord."

Due to the trauma experienced from the suicide attempt and her losing function in her legs, Katrina's mental health continued to decline. By 2017 she experienced further weakness and paralysis and then lost movement in her arms, rendering her unable to feed herself.

She was eventually diagnosed with Functional Neurological Disorder (FND) a psychological condition which means that the brain stops sending messages to the body. The depression, suicide attempts and FND were all brought on by problems she encountered when she was younger.

"They say it was brought on by trauma... stuff that happened to me in my childhood that I didn't speak about. My brain, more or less, couldn't take anymore," she explains.

Katrina was admitted to St Andrew's at the end of 2018 and spent months working with her physiotherapist Jyothi Kraleti, and the mental healthcare team to improve her mobility and function.

She has now regained complete movement in her arms and is able to walk using a frame, and is working towards walking completely unaided.

"I was told I was never going to be able to stand, let alone walk again, and now I'm able to stand on my own. It feels fantastic, it's just great. The physios of St Andrew's have been absolutely fantastic. If it wasn't for them I wouldn't be where I am today," she says.

Katrina is still working on improving her mental health to reduce her feelings of depression and anxiety, but she says she is determined to get better so she can teach football to young players. Her advice to others suffering from mental health problems is to keep going and believe that you will get better.

PRIDE

St Andrew's is committed to building a more inclusive working environment for everyone, where **everyone** has equal opportunities to **progress** and **grow**.

Our PRIDE network – formerly known as the LGBTQ+ (lesbian, gay, bisexual, transgender, queer and others) network - was set up in YEAR for employees who identify as lesbian, gay, bisexual or transgender, and allies.

The Network is open to everyone, including people who don't identify as LGBTQ+ who want to show their support for the community and get involved in our activities. The network aims to increase the visibility of employees who identify as LGBTQ+, while promoting equality across the Charity by supporting personal and career development. PRIDE works to ensure people feel they can 'bring their whole self to work', because we know that people who feel they must hide their identity in the workplace often suffer in terms of both wellbeing and performance. PRIDE also aims to help us improve the quality of care we offer our patients, especially those who identify as LGBTQ+.

PRIDE's three main aims are:

- To raise awareness about the issues that people identifying as LGBTQ+ face
- To support and give LGBTQ+ staff a voice at St Andrew's
- To engage 'allies' and help them to support their LGBTQ+ colleagues.

To spread awareness and promote inclusivity, PRIDE meet regularly and embrace key events in the calendar such as Pride, IDAHOT day – also known as the International Day Against Homophobia, Transphobia and Biphobia - and LTBT History month. The network share regular blogs and run mentoring and support sessions for staff, too.

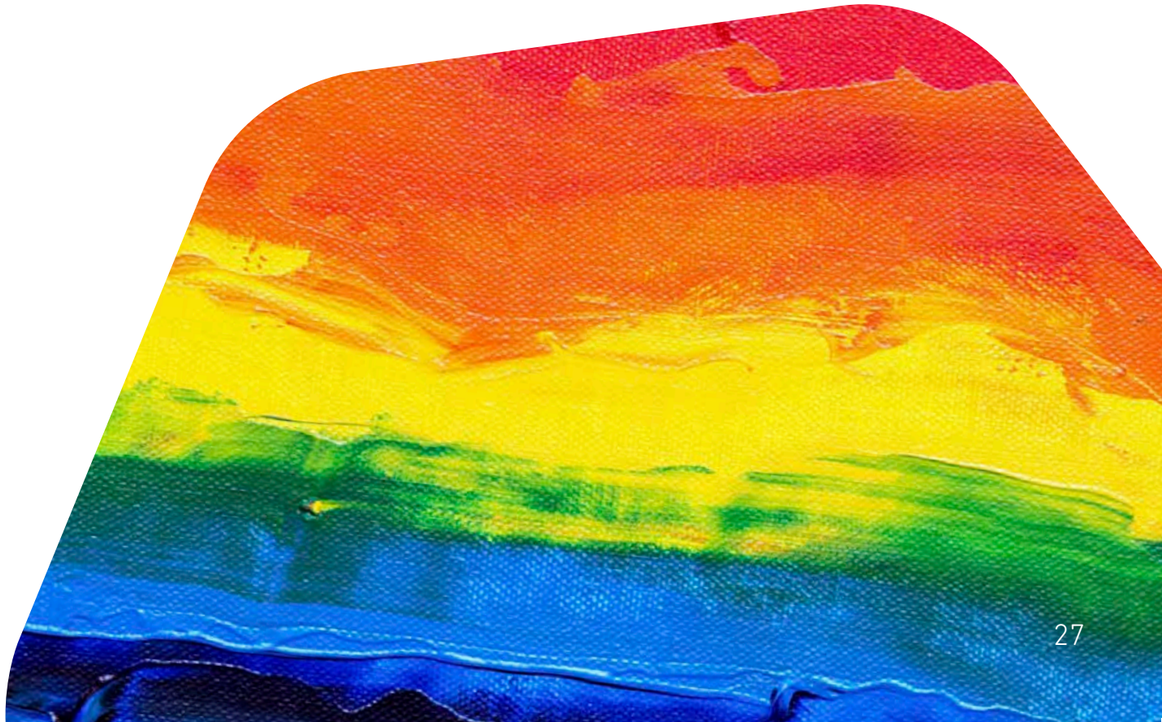
Sarah Ward-Greef, Co-Chair of PRIDE Leadership Development Facilitator

"Being fully accepted and feeling included in society and your environment is essential for people's emotional and mental wellbeing. The St Andrew's PRIDE network aims to celebrate an inclusive culture, honour the history and contribution of LGBT+ people, educate and be a source of support anyone who identifies, or wishes to be an ally to, LGBT+ people. I have worked within the charity for 12 years and feel more supported than ever to be truly out at work, and I hope that others feel supported in doing this should they choose to. The PRIDE network celebrates a diverse range of identities and connections and can be a great source of information and strength to those who need it."

Jessica Davies, Co-Chair of PRIDE Assistant Psychologist

"I was motivated to volunteer for this network because I want to make sure that LGBTQ+ staff at St Andrew's feel supported whilst at work. I think it is so important for staff of all gender identities and sexual orientations to feel included, accepted, and that they have a voice here. I hope that the PRIDE network will make a difference in validating issues that LGBTQ+ staff and patients may face and spread awareness of these difficulties without judgement.

"I hope to be able to support staff through my involvement in the network by continuing to write monthly informative blogs about the history of LGBTQ+ community, as well as light hearted pieces around LGBTQ+ pop culture, as a way for staff to learn more about the community in their own time. I would love to see the PRIDE network grow and develop, and we will also support members by organising events for the network, staff and patients to be involved in."



Faith and Spirituality

"We develop innovative ways to help our patients to recover, creating a personalised package of care designed around each individual, which focuses on their physical and spiritual wellbeing as well as mental health."

This is our clear commitment to inclusive holistic care – seeing each person as an integrated whole. We are each one of us much more than a physical body with a mind; we are spiritual people, with a deep, inner, personal being. We might articulate it in different words – the 'heart' of me, what makes me 'tick', my 'spirit', or 'soul'. Hard to express, but we know, deep down, that we are 'something more'. Patients and staff have this in common.

We all recognise that we may be physically or mentally unwell, but that does not mean that the real 'me' is diminished. Indeed it is often in challenging times we see the beauty, resilience and deep positive heart of a person shining through and gleaming even more brightly.

Our challenge is how to care for this deep, precious, hard to articulate essence of each person in an environment which separates care into different professions looking at physical and mental health matters. Care plans and care reviews are typically split into a whole range of separate health areas – but how can spirituality be included and indeed integrated into 'whole person' care? Furthermore how can the positive mental health impact that comes from our spiritual inner being be recognised, fostered, and contribute to recovery and wellbeing?

In May 2020, the Chaplaincy completed a pilot study of 24 patients (from ASD, LD and mental health wards) inviting them to make their own judgments of the impact that their spirituality or faith had on a range of mental health outcomes (those outcomes identified by patients themselves). An assessment tool, the 'Spirituality and Faith Outcomes Measure' (SAFOM) was developed for this. Each patient made at least two assessments, six months or so apart, and this made it possible to measure in a quantifiable way the substantive contribution to health made by spirituality and faith.

The results were crystal clear, showing that spirituality and faith have a quantifiable impact on mental health – just as one might measure the impact of medication or therapy – and of course at significant added value relative to cost.

The Chaplaincy's innovative work caught the attention of the Royal College of Psychiatrists, and in December 2020 Lead Chaplain Philip Evans was invited to give a presentation to a conference held by the College's Spirituality Special Interest Group. He did this in partnership with Dr Paul Wallang, Associate Medical Director, through the medium of a ten-minute video which can be viewed online here:

https://youtu.be/--THhlXVlm0

One of the patients who is quoted in the presentation spoke at a recent review meeting of how he saw his faith as an important part of his treatment. When completing his latest assessment he commented:

"Bringing faith and psychotherapy together is like putting on a light switch into the past, which gives you insight, understanding of where we have gone wrong, and healing."

A striking feature of this patient's assessment is that in two outcomes (Becoming/Identity and Compassion/Caring) the patient saw himself over the period as moving 'backwards'. But he commented that his later judgment was more realistic and grounded, and his faith had helped him gain this perspective. He said:

"Psychology is helping me think and be more thoughtful. My relationship with Jesus is making me more aware of my problems and what needs to be done to deal with them. This is a more realistic and honest judgment. By relying on the Holy Spirit and allowing him in, we can increase our understanding of who we are – the Holy Spirit gives a mirror into my life."

Spirituality is an inclusive concept. Many express it in terms of faith (and faiths of all type and tradition), but some do not use that language or express their spirituality in such a way. But we need to recognise that nonetheless the deep expression and recognition of self, beyond the physical and mental expression, still plays a significant part in recovery and wellbeing.

Another patient, who described himself as not religious, and who was included in last year's pilot project, has completed his assessment five times over a total period of two and a half years. He originally asked for chaplaincy sessions to explore issues of compassion, empathy, and guilt, which he saw as related to spirituality. His assessment shows steady positive progress in all outcome areas over time.

Respect for spirituality and faith, and support in particular of patients' exploration and expression of these areas, are at the heart of our approach to diversity and inclusion, especially given the demonstration of positive impact on health.

St Andrew's is at the leading edge of work in this area, and in February 2021 Paul and Philip were invited to speak at an international webinar of some 250 participants, hosted by the Value Institute for Health and Care, at Dell Medical School in the University of Texas at Austin.

Our pilot study has now been extended to include 50 patients across a wide range of clinical areas. Patients of all backgrounds continue to find their assessments to be positive and affirming. They enable them to explore and give value to aspects of their care which they regard as deep and important, but which can sometimes be overlooked, or not included as contributors to health.

Our continuing challenge is to ensure that spirituality, faith, and spiritual care are fully integrated into the overall care of our patients, into care planning and review, and including end of life care and discharge planning. Not as another separate segment or category of provision or outcomes, but fully reflecting the homogeneity of each whole person.

Paul Wallang

Gender

St Andrew's has a diverse workforce, where we employ more women than men. Our CEO, Katie Fisher, is the first female CEO in our Charity's history, and our Charity Executive Committee features seven women within its ranks (35%).

In 2019 we launched the WiSH (Women in St Andrew's Healthcare) network, which is fully inclusive and open to all staff, not just females. The network aims to ensure all members feel they have a voice, and can be a part of positive change. The network hold events throughout the year, including celebrating International Women's Day on March 8. This year the theme for IWD was #ChoosetoChallenge. Staff and patients across the charity took part by holding their hand high to show their commitment to choose to challenge, and call out equality.

"We can all choose to challenge and call out gender bias and inequality. We can all choose to seek out and celebrate women's achievements. Collectively, we can all choose to help create an inclusive world."

The WiSH network are planning to launch WiSH Wednesdays in the near future, a bi-weekly virtual forum where staff are encouraged to share ideas, experiences and dialogue.

Felicity Watson,
Project Support Officer

Claire Jones,
Head of Emergency Preparedness, Resilience and Response

We are immensely proud to be co-chairs of the WiSH network (Women in St Andrew's Healthcare) and that St Andrew's has a 0% gender pay gap, plus a high representation of female leaders and board members. While we celebrate these achievements, we are aware there is further work to do to ensure we continue to promote equality throughout all areas, with our aim to attract and retain women.

"Due to the pandemic, last year was extremely challenging for all St Andrew's colleagues. As a network we recognised this, and we encouraged staff to speak with us in different ways about how the pandemic has affected them. We are proud to listen to stories and take these into our action plans to develop the network and support for the future.

"Recently we promoted a women's health awareness event, and we are continuing our work on supporting Menopause in the workplace as there was feedback to address. We are now reviewing data to ensure we have gender equality throughout."

Gender pay gap

The Gender Pay Gap ratio, published in March 2021, showed that the median pay gap at St Andrew's 0% for the third year.

The median gender pay gap is calculated by listing all pay rates by gender and finding the ones in the middle. A median gender pay gap of 0% means that our median male and female hourly rates of pay are exactly the same. This is a fantastic achievement and one that we should be very proud of, especially when we compare ourselves to the national average gender pay gap of 15.5%.

We're extremely pleased that we have a **0%** **gender pay gap** and that this is significantly lower than the national average of 15.5%.

We are continuing in our efforts to pay everyone fairly and equally.

Research and Innovation

Inequalities and mental health

Social inequality has been identified as a key factor associated with development of mental ill-health, and is particularly relevant to the onset and development of symptoms among vulnerable people. It has been defined as "not being treated the same as everyone else or being treated unfairly".

Links between issues including ethnicity, economic deprivation, abuse, bullying at school and a lack of support low incomes have been identified as having a particular impact. The interplay between individual factors can have a particular effect on the development of mental ill-health. When exploring such interactions, the concept of intersectionality should be considered.

St Andrew's Research and Innovation team were awarded funding from NHS England, as part of the women's blended ward project, to allow the Charity to investigate the impact of inequalities on mental health. This involved discussions with patients, peer support workers and staff to understand their experiences and their understanding of the impact of inequalities. The study gave a very clear insight into how these factors can have a very specific impact on the development of mental ill-health, and how individual inequalities can be compounded to have an additive effect.

The findings of the study have formed the basis of a REDS Academy training course which will shortly be available for both staff and patients. We have also prepared a short animated video based upon the quotes of the study participants which can be viewed on our YouTube channel.

"People tend to make judgments based on the fact that you've had mental illness in the past, and their assumptions are you must be somebody who perhaps hasn't been involved in education, in professional jobs and things like that."

PSW

"I messed up in class to get put in detention, so that I didn't have to go outside, cause when I went outside, I used to get beaten up and tortured"

– Patient

"We must ensure that any inequalities are noticed and addressed at an organisational level, as inequalities exist everywhere and need to be challenged everywhere."

– Staff

Carers

We recognise that a large proportion of our staff members have care responsibilities; some of our staff are parents, and others may support a relative or friend who has a disability, long-term illness or other additional needs.

We aim to offer as much support as possible, including flexible working to assist people with their work and life balance. We are also engaging with our employee networks to understand if our current practices and policies support employees who are carers, or if we can make improvements.

Caring for our patients

Sometimes a few words from someone who understands your situation can be a lifeline for carers. Caring can be difficult and isolating, so speaking to someone who knows what they are going through can make a big difference. At St Andrew's, our friendly Carers' Centre team are on hand to offer support to the carers, family members and friends of the people in our care. Based in Northampton, our Carers Centre is a quiet and welcoming place for carers to visit and recharge.

The rights and needs of our Carers are very important to us, and we regularly communicate with carers to seek out ways we can improve. The Carers Advisory Group includes family and friends of patients from across our hospitals. The group meets every two months and work hard to keep carers visible and valued throughout the year.

Rob: a carer's story

This is my story of a journey into the world of mental illness, which as a mechanical engineer I had very little experience of until my son, and then his mother, became seriously unwell about three years ago. This resulted in both of them being admitted to hospital at the same time. My son J remains in hospital to this day.

J was born very prematurely in 2002 and struggled with his early development goals, and a diagnosis of ASD (Autism Spectrum Disorder) was made when he was around 3 years old. He went to mainstream school and was able to make friends and take part in many activities, and while his behaviour could be a bit quirky he always managed fairly well - for example, he joined the local sea cadets and was awarded Cadet of the Year.

It was shortly after his 15th birthday that we noticed he was becoming ever more withdrawn, and finally one Friday afternoon in February I noticed several cuts on his arms. I sat him down and it all came pouring out about how was struggling to manage his feelings. I took him to his GP who referred him to the CAMHS crisis team, who then referred him to see the consultant. The next available appointment was five months down the line, and during that time his mental health spiralled rapidly downwards. We had ever-greater problems getting him to go to school and he was becoming increasingly paranoid thinking that everyone was watching him and was prone to frequent meltdowns.

Sadly his mental health worsened to the point where we could not get him to go to school, and he was becoming increasingly aggressive towards his mother and sister. One day I came home from work to find his mother sitting on the lawn sobbing uncontrollably, telling me she wanted to end it all. I became involved with another crisis team and this led to her admission to our local NHS mental health unit. My son's condition continued to deteriorate and admission to hospital was planned. Nine people arrived to take him there, including doctors, social workers, police officers and an ambulance crew.

I remember watching him get into the ambulance and he looked quite frightened. After they left I was standing there on my own, thinking they have taken my child, and I must admit I was close to tears. Later in the day, the hospital called to say that J had forgotten his charger and could I bring it to him. When I arrived I asked to see my son and was told that it was not allowed. It was at that point that I realised for the first time that I no longer had control over what happened to my child, that was a difficult thing to accept.

The following day J was transferred to hospital in Nottingham for assessment. The care at the hospital was excellent, but on a number of visits I would hear the crying and screaming of young people in distress and that is something that still troubles me.

After three weeks of assessments it was agreed that J should be transferred to the CAMHS unit in FitzRoy House at St Andrew's, Northampton. On the day my son was admitted I called the ward and was told that he had arrived safely and was invited to visit him. When I arrived I was taken to the ward meeting room and he was brought to me, and the nurse sat and explained to us the basic workings of the ward. At the end of the visit, a young Healthcare Assistant went with J back to the ward, where she sat and talked with him and played chess with him for a couple of hours. I remember feeling relieved that he would be safe, and being impressed with the staff and the facility.

A couple of weeks later I was invited to a welcome meeting with the multi disciplinary team which included nursing staff, ward social worker, phycologist and the consultant psychiatrist (also the Responsible Clinician, or RC). All members of the MDT introduced themselves and explained their role in J's care. The RC took some time discussing J's needs and the basics of a care plan, he also took time to listen and acknowledge J's views. The staff made me feel that I was part of the team looking after my son.

Mentoring

At St Andrew's we have a large number of mentoring pairs, the primary aims of which are professional and personal development of senior leaders, with an opportunity to share knowledge, experience and offer advice and guidance. Through this process, both parties benefit from the insight and perspective of the other person. In 2019 we also introduced a 'reverse mentoring' scheme, which aimed to raise awareness and understanding about the barriers and challenges faced by our BAME community in the workplace and ultimately break down inequalities in the workplace. The difference with reverse mentoring is it is about mentoring 'upwards'; in this case, it is the senior leader who is primarily learning from the less experienced, usually younger colleague.

CASE STUDY

Alex Owen, Chief Finance Officer
Khyati Patel, Principal Forensic Psychologist

Khyati and Alex are a traditional mentoring pair, who share insights from each of their respective professions.

Khyati has found the mentoring relationship very helpful especially in terms of reflecting, discussing and having a plan of how to manage difficult situations at work. She explained: "My mentor is very experienced and is able to give sound advice on a number of areas. She has increased my confidence to assert myself in certain situations better."

Other mentees across St Andrew's have shared that the experience has had mutually positive impact, particularly by opening doors to people the mentee can speak to, building self-awareness, opening up opportunities (for example project involvement and shadowing) and gaining useful insights.

Alex has also found being a mentor to be a positive experience. She said: "Through this process I have learnt a lot more about what it is like to be on a ward and be so personally invested in our patients' progress. It has supported me to more fully understand the wider impact of some of my actions, and as a result I am in a much better position to make the right decisions going forwards. I have also gained a greater understanding of the psychology profession and the challenges it faces, as well as how we are perceived as a leadership team."

Learning and Development

St Andrew's is highly committed to providing career opportunities for all, and we have a focussed learning and development strategy in place to achieve this.

On average, our staff members complete 23,000 days of learning each year, with numerous opportunities for face to face study, e-learning and further education available to people of all role levels and career paths.

Entry level

For many junior staff members, progressing their careers can be a challenge as they may not have achieved the entry level requirements in English and Maths.

To support these individuals we provide free Functional Skills courses to help improve literacy and numeracy skills, and equip e-learners with the practical skills needed to learn and work successfully. After completing these courses, many members of staff have gone on to enrol in further education. In the past year, 119 people have studied for entry level qualifications with us.

Unconscious bias training

The charity is committed to developing staff at all levels, while ensuring we maintain an inclusive and fair culture. Unconscious bias training is delivered as leadership workshop to ensure that all managers have the tools to challenge their own decision making, can ensure they are not swayed into biased thinking and fully embrace the diversity of their team and what we all bring.

Staff also have the opportunity attend an awareness session to better understand their thinking, actions and the impact it could have on others. In doing this, we can work towards celebrating the diversity of our workforce and ensure a fully engaged culture where everyone can bring themselves to work.

ASPIRE and Higher Education: Diversity breakdown

In the past year...

410 people have undertaken Higher Education courses at St Andrew's

Of these:

242 are female, **165** male

12 identify as having a disability

21 identify as being LGBTQ+

50% identify as being white, and **31%** of learners state they come from an ethnic minority background

There is balanced distribution across all age groups

Nursing

There is a national shortage of nurses, and we're are committed to encouraging more people to join this worthwhile and rewarding profession. At St Andrew's we offer three 'career routes' for our nursing staff, which can support them to progress from the entry level role of Healthcare Assistant, to Senior Nurse and then on to either leadership, management, further clinical specialisation, or into education or research.

Each year we fund 20 staff members to undertake their nursing degree via our ASPIRE Programme, at an investment of over £17,000 per person. ASPIRE recognises motivated and talented individuals who are keen to develop, both personally and professionally. To do this the programme offers pastoral and financial support while students study for a degree and qualify in either Mental Health or Learning Disability Nursing. We have a specialised admissions procedure with the University of Northampton which allows St Andrew's staff with healthcare experience to enter at year two of the degree programme, aiming to qualify as a Nursing and Midwifery Council (NMC) registered Nurse within two years.

There are currently over 90 St Andrew's people at various stages of their ASPIRE journey. As of January 2021 we have had over 70 Aspire students return to the wards as Registered Nurses.

Apprenticeships

Over the past year, we have supported 110 apprenticeship learners across our Charity.

Staff have undertaken apprenticeships across many and varied areas, including health care support, business administration, HR, finance, catering, estates, data analytics and leadership.

Apprenticeships are a fantastic way in which we can support our staff to develop their skills – which are then put to good use in ensuring continuous improvement in all areas of the Charity's work.

A selection of our Apprenticeship programmes include:

- Level 2 Health Care Support Worker
- Level 3 Business Administrator
- Level 4 Data Analyst
- Level 5 HR Consultant Partner
- Level 7 MBA Senior Leaders Degree.

With new apprenticeship programmes available each month, the total number of apprentices is ever-growing.

St Andrew's HEALTHCARE

Getting in touch

For more information about our **comprehensive care services** or to make a referral:

t: 0800 434 6690 (We welcome text relay calls)

e: enquiries@standrew.co.uk

w: stah.org

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People Committee

Appendix 3

People Strategy

Paper for Board of Directors	
Topic	People Strategy
Date of Meeting	Thursday, 30 September 2021
Agenda Item	**11**
Author	Lara Conway
Responsible Executive	Martin Kersey
Discussed at Previous Board Meeting	Referred to in May People Committee Board update
Patient and Carer Involvement	Input from carer representatives via People Committee
Staff Involvement	HR team, L&D Group, Employee Forum, Unions, CEC, People Committee
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Charity Executive Committee - 17 March 2021 People Committee - 13 May 2021

Report Summary and Key Points to Note

- The People strategy focuses on delivering the workforce of today and the future
- The strategy has been refreshed and covers 7 core areas: recruitment, workforce planning, leadership capability, reward and wellbeing, systems and data, learning and talent development and values and engagement
- The presentation sets out what has been achieved and the prioritise for 2021/22
- A number of People KPIs and additional measures are used to assess the progress of the strategy
- Feedback has been obtained from various groups including the CEC and People Committee

Appendices: People Strategy presentation

Board of Directors update

People Strategy
September 2021

Transforming lives together

Our Charity strategy

External context

100,000 vacancies in the NHS
44,000 Nurse vacancies

Rise in anxiety and burn out projected
Increase in sickness

Employees seeking work life balance

Challenging economic environment, government spending restraint

Increase in employee relations cases
115% increase in the tribunal service since 2018

Decreasing engagement scores with COVID impact

Significant opportunities in new services, community, education and research

HR Operating Model

St Andrew's HEALTHCARE

Delivering the workforce of today and the future

Recruitment

We will build a reputation for being THE place to grow your chosen career in Mental Health and Developmental Disorders

- Quality of hire and recruitment decision-making
- Values based recruitment and onboarding
- Roll out of assessment centres
- Career stories and role models for key roles

Recruitment

People

We have:

- Rolled out an Employee Value Proposition
- Introduced values based competency assessments
- Moved back to face to face assessments including patient participation and restarted external career fairs
- Hired 99.7% of our external hires directly
- Appointed 49 Nurses since Jan 21 with a further 50 Nurses in the pipeline including ASPIRE
- Appointed 12 Speak Up Guardians across all regions
- Appointed to key posts including Hospital Director and Clinical Directors in Birmingham and Essex
- Developed career stories for nursing and clinical roles

We will:

- Focus on streamlining the on-boarding and induction process
- Assess future growth areas in community, research, overseas medical recruitment and education
- Roll out advanced interview training for recruiting managers
- Ensure hiring managers are 2 levels up from the role being appointed
- Map assessment methods for all posts to ensure consistency and roll out assessment centres beyond our current HCA and Nurse successes
- Manage and build our online reputation

Workforce Planning

People

We will ensure our workforce develop the skills and capabilities aligning to the Charity's strategy now and for the future

- Workforce model review
- Improving scheduling and flexible shift options
- Clear career paths and talent development plans
- Identifying new roles and development areas for the future
- Organisational design

Workforce Planning

People

We have:

- Supported the rightsizing strategy including ward moves and Nottingham site closure in 2020
- Introduced an Employee Relations Team to the HR model in 2020
- Set up the Central Absence Team to support sickness management during covid
- Established a National Centre for Trauma
- Introduced a Nurse Scholarship and Social Work Apprenticeship
- Introduced an occupancy based workforce planning calculator for MDT teams
- Increased the number of Peer Support Workers to 16 (with 7 receiving internal promotions)

We will:

- Undertake a workforce planning review assessing opportunities in education, research and community
- Support MHOST and new e-rostering tool roll out
- Expand DBT Therapists, Peer Support Workers and introduce a Deaf Nurse scholarship
- Collaborate with Health Education England on post graduate programmes
- Launch a School and Community reach out programme promoting healthcare careers
- Ensure talent management plans and clear career paths are in place
- Work with nursing and professions to improve retention
- Assess and re-align the WorkChoice temporary staffing model

Leadership Capability

Ensuring leaders and managers create the conditions for people to perform at their best

- Leadership and management skills at all levels
- Effective performance improvement process
- Building and monitoring key talent
- Collaborative and active development plans

Leadership Capability

People

We have:

- Implemented a project focusing on CNL / Nurse Managers new to role including clearer monitoring of performance
- Carried out capability reviews including those in ‘priority for action’ on talent grid
- Undertaken 60 coaching sessions and 30 mentoring pairs including specific support for new Nurse Managers
- Undertaken a quality audit of Management Supervision and IPDR for all key leaders
- Widened the future Director Development Programme to aid succession planning
- Restarted leadership development programmes post covid

We will:

- Ensure each division/ department has a talent plan with regular reviews of succession and capability
- Review a leadership development competency framework
- Ensure the ‘management basics’ are consistently completed
- Support managers to gain the skills and confidence to have challenging conversations
- Continue to roll out Compassion Focused Staff Support training for all staff
- Further promote/create leadership and management development programmes including coaching and mentoring

Reward

We will enable the Charity and managers to make the right pay decisions aligning to our core pay principles; being competitive, fair, clear, flexible, holistic and affordable

- Continuing to align terms and conditions to internal pay principles
- Focusing on total reward throughout the employment journey
- Defining pay progression frameworks
- Increasing reward knowledge across the workforce

Reward

People

We have:

- Confirmed a 3% pay increase backdated to 1 April 21
- Significantly invested in experienced Nurse pay ensuring staggered pay progression
- 0% gender pay gap and -3.9% ethnicity pay gap
- Harmonised terms and conditions including PMI scheme closure, life assurance change, Whitley contracts
- Enhanced redundancy and pay protection for career levels A-D
- Increased the benefits package including career breaks, volunteering day, improved long service awards
- Introduced reward incentive schemes to support staffing
- Rolled out pension and pre-retirement workshops
- Introduced a new job evaluation system
- Trained all new managers in reward principles via TRANSFORM

We will:

- Define spot rate and staggered pay progression linked to experience, skills and qualifications
- Complete a full market benefits review
- Issue Total Reward Statements in 2022
- Review overtime and enhancements focusing on operational improvements
- Introduce sub levels to our career levels
- Enhance our reward training offer

Wellbeing

Creating an environment where we have happy, healthy, productive and engaged employees linking to our three pillars of wellbeing; Mental, Physical and Financial

Financial

Providing benefits to support financial security and wellbeing

Physical

Providing support, guidance and opportunities for a healthy lifestyle

Mental

Reducing work-related stress

Comms

Ensuring all staff know the pillars of support available

Wellbeing

People

We have:

- Trained 300 staff in Compassion Focused Staff Support
- Supported staff through COVID via risk assessments, Trauma service and additional OH resource
- Offered on-site covid vaccinations
- Raised awareness of the wellbeing support available to staff including REDS team wellbeing support
- Undertaken a tender and reappointment of our EAP provider
- Introduced a hardship fund for employees affected during covid (interest free loan)
- Promoted the ‘system’ wide virtual wellbeing festival in June

We will:

- Roll out the Post Covid Recovery and Restoration Plan
- Train all staff in Compassioned Focused Staff Support
- Hold 1-1 wellbeing conversations with staff
- Offer increased flexible working options
- Introduce wellbeing measures and KPIs to assess progress
- Ensure the balance between supporting staff and managing capability

Systems and Data

Ensuring that our systems and processes support business change enabling visibility of data to allow operational insight and action

- ERP replacement project
- People KPIs and benchmarking
- Process Development
- Integrated data

Systems and Data

We have:

- Improved processes and procedures to support compliance on DBS, Right to Work, Professional registration
- Introduced the eOPAS system in Occupational Health
- Introduced DocuSign for contracts, offer letters and references
- Integrated and streamlined payroll and finance pay processes
- Improved visibility of absence data with new system interfaces
- Added People KPIs to the Integrated Performance Dashboard with a KPI report reviewed at CEC monthly and People Committee including benchmarking data

We will:

- Support the ERP replacement project
- Support the MHOST and Allocate project
- Improve the management of absence via streamlined electronic forms i.e. return to work forms
- Introduce a ward specific dashboard for People KPIs

Learning & Talent Development

1. **Ensure** everyone receives an **inspiring induction**
2. **Deliver** efficient & effective **mandatory training**
3. **Enhance clinical & specialist skills**
4. **Leverage** our **literacy** (digital and functional)
5. **Build leadership capability**
6. **Maximise** talent, **succession planning & grow careers**
7. **Celebrate a learning culture**

Learning & Talent Development

New roles/skills and competencies will be developed to ensure that the Charity workforce is fit for the future

- High levels of mandatory training compliance
- Ensure divisions have specialist clinical skills
- Transition to Safety Intervention Training
- Developing and nurturing talent pools
- Opportunities in the wider education strategy

Learning & Talent Development

People

We have:

- Inducted 1,000 people in line with COVID risk assessments
- Completed 58,000 e-learning modules and launched 46 new e-learning modules
- Completed 268 qualifications
- Gained accreditation from the National Audit of Restraint Training B.I.L.D
- Appointed five additional colleagues to the Future CEC Directors Programme
- Appointed four additional colleagues to the Executive MBA Programme with the first graduates due in Autumn 21
- Appointed the 11th ASPIRE cohort

We will:

- Ensure mandatory training compliance at 90% + meeting all contract requirements
- Support the Trauma Informed Care model by embedding Safety Intervention Training
- Ensure all first line managers have basic skills including IPDR and Mgt Supervision completion at 90%
- Re-start career development programmes paused due to COVID
- Further roll out unconscious bias training

Values and Engagement

A workforce that lives the values, works flexibly and is truly focused on people in our care as enablers of their recovery journey

- Create a sense of community
- Recognise and celebrate success
- Values-based leadership
- Employee Voice

Values and Engagement

People

We have:

- Introduced regular COVID related Teams calls (now Monthly Round Up Calls), a COVID related APP, daily COVID emails and a new CEO Outstanding Contribution Award
- Continued with the CARE Awards, despite the COVID restrictions, holding the Quarterly Awards events online and seeing an increase in the number of nominations from the previous year (+270 to 2,265)
- Given an additional 2 days annual leave to permanent staff (21/22) and thank you badges
- Held the Patient party, awards ceremony, long service events and ‘Festi-vol’
- Rolled out Leaders in Care training
- Launched a Reverse Mentoring pilot focusing on BAME staff allowing learning from different backgrounds
- Rolled out the Employee, Patient and Carer Promises

We will:

- Continue with the Charity strategy roll out
- Launch the Post Covid Recovery & Restoration programme
- Progress the DBT mini-documentary and 'Schools Mental Wellness' Programme
- Implement Your Voice Engagement Action Plans and Survey for 2021

Tracking the People KPIs

	August	August							July			
KPI	Charity wide	CAMHS	ASD/LD	Neuro	Low Secure	Medium	Birm	Essex	Charity wide - Previous Month	Change	Target / Tolerance	Previous Year/August 2020
Sickness (monthly %)	9%	15%	11%	11%	8%	11%	9%	9%	8.3%	↑	6%	5%
Sickness (days over 12 months)	17.6	32	22	20	23	19	15	16	17	↑	16 days	14 days
Voluntary Turnover	14%	32%*	11%	12%	15%	14%	14%	18%	14%	↔	13%	12.5%
Fill rate qualified Nurses	79%**	76%	71%	84%	83%	68%	80%	84%	80%	↓	90%	90%
Fill rate Nurses and HCAs	98%**	93%	112%	96%	86%	95%	85%	86%	102%	↓	100%	112%
Agency spend	4%	17%	1%	2%	1%	2%	3%	9%	3.3%	↑	5%	6%
Mandatory training	92%	87%	93%	92%	92%	93%	94%	93%	93%	↓	90%	91%

Other Measures

Strategy Area	Measure	Target
Engagement	Your Voice engagement	68% 2021 (Actual: 57% 2020, 68% 2019)
Engagement	Your Voice response rate	68%
Engagement	Your Voice score for: I feel valued as an employee of St Andrew's	70% (53% 2019)
Engagement	Your Voice score for: My line manager shows that s/he truly cares about the people in my team	82% (78% 2019)
Engagement	IPDR completion	95%
Reward	Your Voice score for: staff feeling their pay and benefits are favourable	Improve by 20% (39% 2019)
Reward	Remain best in class for gender pay gap and ethnicity pay gap	0% / 0% (2020 0% gender, -3.9% ethnicity)
Wellbeing	Your Voice score for: the amount of stress I experience in my job is acceptable	60% (42% 2019)

People Committee

Appendix 4

Diversity & Inclusion Strategy

Paper for Board of Directors	
Topic	Diversity and Inclusion Strategy
Date of Meeting	Thursday, 30 September 2021
Agenda Item	**11**
Author	Lara Conway
Responsible Executive	Martin Kersey
Discussed at Previous Board Meeting	Referenced in Board update from July People Committee
Patient and Carer Involvement	Input from Patient Advisory Group
Staff Involvement	Feedback from People Committee, CEC, Inclusion Committee and Staff Network groups, Unions
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Inclusion Committee - 24 April 2021 People Committee – 12 July 2021

Report Summary and Key Points to Note

The Diversity and Inclusion strategy covers the period 2021 – 24 and focuses on employees; a separate Patient Inclusion Strategy will be developed. The core focus is on achieving Inclusive Healthcare through 4 key areas:

1. Fix the basics
2. Improve BAME and Female representation
3. Focus on mental health in the workplace
4. Tackle and promote fairness

The charity work with a number of external partners and have an internal Inclusion Steering Committee and Staff Network Groups. The KPI targets related to Inclusion have been developed to provide an on-going measure for success.

Appendices: Strategy presentation

Diversity and Inclusion Strategy 2021 - 2024

Transforming lives together

Our Diversity & Inclusion Strategy*

- Our Strategy is focused on achieving Inclusive Healthcare. This means creating an inclusive culture and employment opportunities that embrace diversity and promote equality of opportunity. It also means not tolerating discrimination for any reason.

- Our goal is to ensure that Inclusive Healthcare is reinforced by our culture and embedded in our day to day working practices.

*This strategy focuses on employees; a separate Patient Inclusion Strategy is being developed.

St Andrew's HEALTHCARE

Context

Current Internal Factors:

- Increase in mental health issues in the workplace
- Increase in levels of absence
- Period of change: IPUs to Divisions, reduced occupancy, relocation of wards, sale of Mansfield

Current External Factors:

- Black Lives Matter
- COVID impact
- Focus on mental health post covid
- BAME access to services

Local demographics vs workforce ethnicity

Category	East Midlands*	St Andrew's based on % of declared ethnicity	St Andrew's based on % of all staff
White	85%	58%	41%
Black	2%	23%	16%
White other	4%	10%	7%
Asian	7%	5%	3%
Mixed	2%	3%	2%
Other	1%	1%	1%
Prefer not to say			19%
Not given			11%

*2011 census

What is the data telling us?

The numbers tell a good story…

BAME Staff Data	Female Staff Data
Over 22% of staff are BAME vs NHS 22% / 12.5% UK	**64%** of staff are female
15% of the Board are BAME vs UK Board average of 1.5%	**38%** of the Board are female vs 33% externally (FTSE 100)
22% of senior leaders are BAME	**50%** of leaders are female
-3.9% Ethnicity Pay Gap Ratio (median) vs 2.3% externally The calculation considers total remuneration, which means payments such as enhancements for working unsocial hours are included. The figure of -3.9% means that overall our ethnic minority employees received a higher hourly rate of pay in comparison to our non-ethnic minority colleagues when taking into account enhancement payments.	**0%** Gender Pay Gap Ratio (median) vs 15.5% externally

There is still work to do

30% of long term absence is for anxiety, stress or depression, this compares to 47% in the previous year
54% of calls to the Employee Assistance Service (EAP) in the last 12 months were for anxiety, stress or depression
70% of calls for work related issues were for stress
42% of employees felt *'the amount of stress they experience in their job is acceptable'* (Your Voice, 2019)
Work life balance is the top reason for leaving equating to **40% of leavers**

Four key focus areas

- Fix the basics
- Improve BAME and Female representation
- Focus on mental health in the workplace
- Tackle and promote fairness

Fix the basics

We have:

- Increased protected characteristics disclosure from 62% to **88%**
- Ensured disclosure data is captured for new applicants and monitored this within our recruitment processes
- Launched Inclusive policies such as Trans-Inclusive Care and the Transgender Equality Procedure for staff
- Relaunched our Staff Networks ensuring Co-chairs and an Executive Sponsor
- Provided risk assessments and support for BAME staff during COVID

We will:

- Increase protected characteristics disclosure to **95%** by 2024
- Reduce those that ‘prefer not to disclose’ from 19% to **10%**

Improve BAME & Female representation

We have:

- A female Chief Executive Officer and Chief Finance Officer (38% of the board are female)
- Increased BAME representation at the Board to 15%
- Increased female representation at CEC to 35%
- Increased BAME representation at CEC to 15%
- Female candidates shortlisted for all Board and Governor positions
- Appointed 2 female and 1 BAME Non- Executive Directors
- Of the 4 most recent Governor appointments, 3 are female and 1 is from a BAME background
- Ensured diverse recruitment selection panels at Birmingham
- Piloted Reverse Mentoring focusing on BAME staff allowing learning from different backgrounds
- A charity wide WISH network to support women in the workplace
- A Director Development Programme with 86% female candidates

We will:

- Ensure all recruitment selection panels are representative of the workforce
- Increase female and BAME representation on the Board
- Extend Reverse Mentoring to all staff network groups
- Roll out career workshops and mentoring opportunities for all staff
- Continue to identify role models and their stories

Mental Health in the Workplace

We have:

- Developed Compassion Focused Staff Trauma Support (CFSTS) with 300 staff trained
- Encouraged people to speak up appointing 12 Speak up Guardians
- Held three Trauma Conferences and published related journal articles
- Promoted wellbeing services such as a 24/7 EAP and Trauma support
- Introduced a Central Absence Team to support absence during COVID
- Ensured a continued focus on flexible working including working from home
- Supported team wellbeing via REDS
- Trained external organisations in mental health awareness

We will:

- Roll out the Post Covid Restoration and Recovery Programme
- Roll out CFSTS training for all staff
- Increase the number of published contributions on trauma research
- Introduce wellbeing measures and KPIs to assess progress
- Continue to enhance our flexible working offer

Tackle and Promote Fairness

We have:

- A Zero Tolerance approach with a Charity wide steering group
- Established a national centre for Trauma
- Offered REDS training to staff and patients across all regions
- Supported a Deaf patient campaign raising vital awareness
- Rolled out unconscious bias training for staff
- Set up a dedicated Employee Relations team in 2020 to ensure consistent case management
- Created a specific Birmingham action plan to promote inclusivity
- Introduced a Nurse Scholarship programme
- Increased support for Deaf colleagues with a tailored action plan

We will:

- Run a charity wide Anti-racism campaign
- Continue to roll out unconscious bias training for staff
- Increase co-production of REDS programmes for staff and patients
- Offer a Deaf Nurse Scholarship by 2023

How we achieve Inclusive Healthcare

- Inclusion Steering Committee chaired by the CEO

- Four Staff Network Groups with Executive Sponsors:

  - BAME
  - Pride Network – previously LGBTQ+
  - WiSH
  - ABLE

- Celebrate key events throughout the year:

  - Pride
  - Black History Month
  - International Women's day
  - Mental Health Awareness
  - National UK Inclusion week

We work with external partners

NHS Partners:

- Northamptonshire NHS People Board
- NHS Equality, Diversity and Inclusion Leads
- East Midlands NHS Alliance

- Inclusive Employers
- Business in Community
- Gender Intelligence

Measuring our success

KPI	Aim over 5 years	Current	Benchmark comparison
Protected characteristics disclosure	**95%**	**88%**	**95% (NHS)**
Gender pay gap	**0%**	**0%**	**15.5% (UK)**
Ethnicity pay gap	**0%**	**-3.9%**	**2.3% (UK)**
Board BAME representation	**20%**	**15%**	**7% (NHS)**
Board Female representation	**50%**	**38%**	**33% (UK)**
Senior leaders BAME representation	**30%**	**22%**	**N/A**
Leaders Female representation	**64%**	**50%**	**N/A**

Measuring our success

- These will be measured via regular data reporting as well as the Your Voice Staff Survey, annual pay gap reviews, the Diversity & Inclusion Report and benchmarking externally.

- We will also ensure that disciplinary and grievance cases are tracked and reviewed from an ethnicity perspective ensuring there is no difference in approach.

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meetings: : 08 June & 10 August 2021

Chair of Meetings: Professor David Sallah

Significant Risks/Issues for Escalation:

- Not applicable for this update

Key issues/matters discussed:

This update confirms that the following reports and strategy were reviewed and discussed by QSC and subsequently approved for submission to the Board. All three are therefore attached as appendices for review by the Board and the Board are requested to provide final approval.

- **Complaints Annual Report**
  The committee approved the report for submission to the Board at the June 2021 QSC Meeting.

- **St Andrew's Healthcare Annual Safeguarding Report**
  The committee approved the Annual Safeguarding Report for submission to the Board at the August QSC meeting.

- **Nursing Strategy**
  The committee approved the Nursing strategy for submission to the Board at the August QSC meeting

Decisions made by the Committee:

- Not applicable for this update

Implications for the Charity Risk Register or Board Assurance Framework:

- Not applicable for this update

Issues/Items for referral to other Committees:

- Not applicable for this update

Appendices:

- Appendix 1 – Complaints Annual Report
- Appendix 2 – Annual Safeguarding Report
- Appendix 3 – Nursing Strategy

Quality Safety Committee

Appendix 1

Complaints Annual Report

Annual Complaints Report
for the period 1st April 2020 – 31st March 2021

Contents

1. Introduction

This report summarises PALS and Complaints activity and performance at St Andrew's Healthcare for the year 1st April 2020 to 31st March 2021. Feedback from patients, family members and carers provides the Charity with a vital source of insight about people's experiences of our care and how our services can be improved. We listen to and respond to issues being raised and use the information received, or revealed through investigation, to improve our services and, in turn, the experience of our patients.

The PALS and Complaints Team has continued to work on developing a culture that values and welcomes complaints as a way of putting things right and improving service. Training still needs to be finalised in order to upskill staff to feel confident in effectively handling complaints

The Chief Executive Officer remains accountable for ensuring the efficient operation of the complaints policy and associated procedures, and is responsible for approving and signing complaints response letters. The PALS, Complaints and Patient Engagement Manager oversees the daily operation of complaints handling and gives priority and importance to good complaint handling to set the tone and act as an example for all staff. The Divisions and other services are responsible for adopting a fair and consistent approach to the investigation of all complaints and exploring local resolution as the first approach. They are accountable for extracting learning from complaints to continually improve the quality of service provided and involve the person who raised the complaint in the action plan for learning and change as far as is possible.

During the period 1st April 2020 to 31st March 2021 we received **224** complaints, **29** of these were dealt with as Serious Incidents (SIs) or Safeguarding (SG) and investigated under our Incident Management and Reporting policy or Safeguarding policy, and **195** investigated under our Complaints procedure. We responded to a further **110** concerns and we received **468** compliments.

Staff are encouraged to try to resolve concerns at ward or divisional level in the first instance. Where this is not possible, they can direct patients / carers to the PALS and Complaints Team. A dedicated email address and telephone number is available and patient telephones have a direct line to the team using hotkey 2. The PALS and Complaints Team will assess the level of complexity of the complaint and where possible, discuss which level of complaint and process they feel it falls into with the person raising the complaint. If the complexity and / or severity of the complaint is assessed to sit in level 1 or 2, local resolution will be recommended and encouraged. Our Local Resolution guidance and forms help simplify the process and ensure the patient is involved in the resolution and, where possible and appropriate, the changes, and emphasis is put on the level of satisfaction after resolution. Complaints that are deemed to fall into level 3 will be investigated formally. A complaint investigation report template and guidance is provided, again emphasising the importance of the learning and involvement of the person raising the complaint.

PALS and Complaints during the COVID-19 pandemic
NHS England and NHS Improvement advised that they supported a system-wide pause of the NHS complaints process, this was supported by the PHSO (Parliamentary and Healthcare Services Ombudsman) and CQC who also paused their respective services around complaints. Within St. Andrew's, the decision was taken to continue with our complaints process as it was felt that we were in a position to effectively respond to complaints however, when reviewing the data, consideration needs to be given to the impact the pandemic has had on resolving complaints within the 30 working day timeline.

PALS and Complaints drop-ins
Due to COVID-19 and team capacity, we have been unable to provide drop-ins across any of our sites, which will have had an impact on raising complaints and concerns for some patients who prefer to discuss this face to face.

2. Definitions

Complaint: A Complaint is an allegation that something has gone fundamentally wrong and where set procedures have not been followed resulting in a person expressing their dissatisfaction.

Concern: A Concern is an expression of opinion that something is or has gone wrong. It is something, according to the person's perception, that has let them down in regards to what they expected to happen.

We record and respond to all complaints and concerns irrespective of how they are presented; whether this is in writing, in person, over the telephone or by email. The PALS and Complaints Team have continued to strive to speak with all persons who raise their concern in writing, by letter or email, upon receipt, to acknowledge this and to ensure that their concerns or complaint are fully understood and the team understands how the person would like the issue resolved. This conversation also ensures the person understands the process and any support needs are identified; timescales are discussed and agreed and their preferred method of communication confirmed. This also provides an opportunity to resolve any concerns immediately if this is possible.

The first stage of dealing with any complaint is to explore the possibility of resolving this via local resolution. Staff within the service that is the subject of the complaint have a responsibility to work with the PALS and Complaints Team together with the person who raised the complaint, and use the local resolution form and procedure within agreed timescales in accordance with the Charity's Complaints procedure. For any complaint raising issues that require a more detailed investigation, these are managed formally, in accordance with the Charity's Complaints procedure.

Concerns and complaints are recorded and managed in the following ways:

Concerns:
Concerns that cannot be dealt with immediately within the service are usually managed through the PALS part of the PALS and Complaints Team. These are usually queries; requests for information that do not require detailed investigation but may require guidance, signposting, or information. These issues are recorded and dealt with in real time by our PALS and Complaints Team or by a relevant member of staff, who is able to offer appropriate information. If the matter is not resolved to the person's satisfaction, then the concern may be escalated to a formal complaint. If someone raises a complaint, which is low level in terms of complexity and severity, we will strive to discuss with them the option of resolving this as a concern which can reduce the time they are waiting for a resolution as opposed to the formal complaint process. Once people understand this does not mean their concern is given any less attention or taken any less seriously, many are happy to proceed in this way.

Complaints:
The Charity investigates complaints in a manner appropriate to the issues raised and where appropriate we seek and obtain consent for an independent review. We aim to resolve all complaints promptly and efficiently, keeping the person who raised the complaint fully informed as far as is reasonably practicable, as to the progress of the

investigation and any delays. We have maintained regular contact in a number of cases where a response to the person's complaint has been delayed and this has helped to alleviate feelings that they are being ignored or not taken seriously and provides reassurance that progress is being made.

One carer told us:
'Everything was dealt with fine. There was a delay to the reply but this was due to COVID and I was told that, it was very detailed and thorough.'

The PALS, Complaints and Patient Engagement Manager and Complaints Adviser triage each complaint. This ensures a consistent approach and an independent view of the issues raised and actions to be taken. The triage is carried out in line with the complaint levels outlined in the complaints procedure.

We expect all complaints to be acknowledged formally within 3 working days of receipt. This will normally be done in writing and a member of the PALS and Complaints Team will either send an acknowledgement by post or request a staff member on the ward to give this to the patient. When complete, the staff member allocated is noted on DATIX so we can trace accountability if the task is not carried out. A timeframe is identified and if appropriate, negotiated with the person raising the complaint at the start of investigation. This is intended to ensure a realistic timescale is given in the context of the anticipated investigation. The Charity aims to resolve complaints within 30 working days, for complex cases, this may be longer if investigation, external review, or Root Cause Analysis is required. The focus is to provide a quality, thorough, open candid investigation, and response, which sometimes may necessitate a longer period.

3. Activity and Performance

This section provides an overview and detailed breakdown of key performance and activity data for 2020/21. It includes the number of complaints and concerns received; the number of complaints closed; response times; a breakdown of the themes most frequently raised in complaints and other PALS activity. Plans for further improving performance for 2021/22 are detailed in section 5 of this report.

Overview

Table 1

	2019/20	2020/21
Number of complaints received	245	224
Number of complaints investigated as a Serious Incident or Safeguarding	21	29
Number of complaints closed	222	210
Number of concerns received	176	113
Number of compliments received	346	468
Total number of complaints concerns and compliments received	**788**	**834**
Complaints referred to the PHSO	5	4

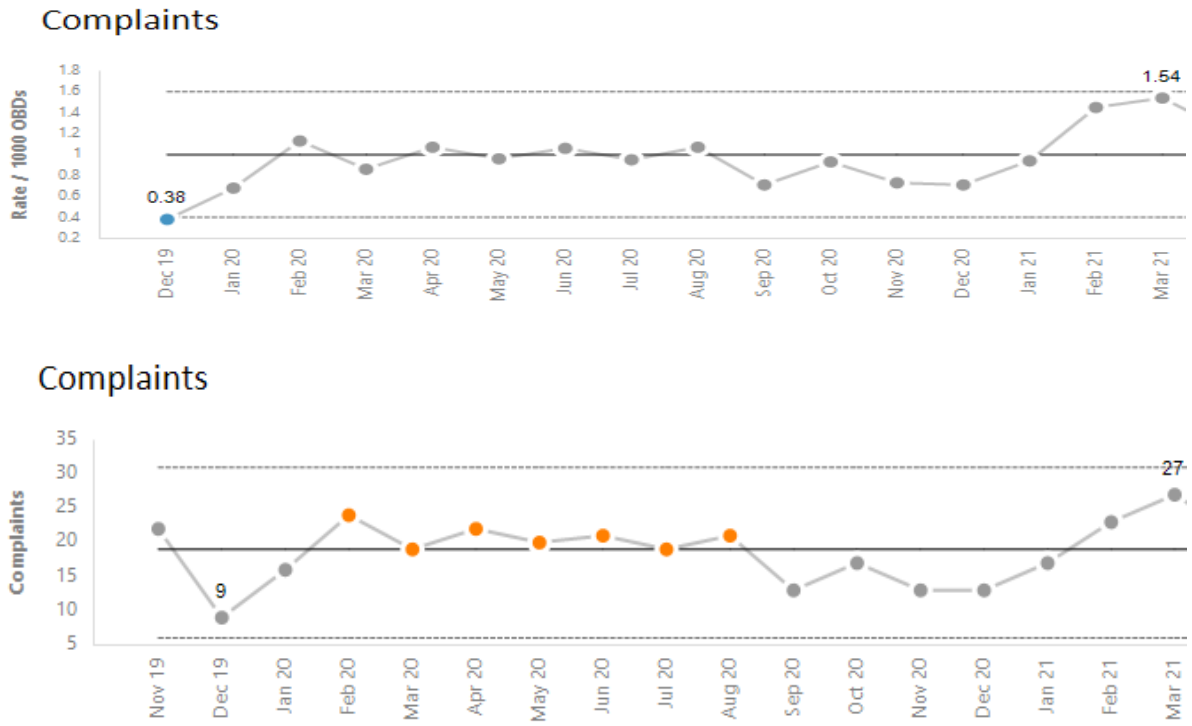
Key points to note from this data:

The numbers of complaints received in 2020/21 decreased by 8.5% compared to 2019/20 and numbers of concerns decreased by 35%. The number of compliments increased by 35%. Whilst complaints have remained relatively comparable to the previous year despite the decrease of in-patient beds, the complexity of complaints has increased by 10%. Our counterparts in healthcare organisations across the UK also identified a significant increase in the complexity of complaints being raised, at the National Complaints Forum in May. The decrease in concerns is largely due to the PALS and Complaints Team being unable to hold drop-ins and face to face meetings with patients as a result of COVID-19 restrictions. The increase in compliments can be largely attributed to Community Services.

Parliamentary and Health Service Ombudsman:
The number of complaints known to be referred to the PHSO in 2020/21 was 4 and of these, 2 were concluded at initial assessment, 1 was withdrawn and 1 wasn't considered to have been properly made.

3.1 Complaints and concerns received
The graphs below show the number of complaints (including those that were handled as Serious Incidents or Safeguarding) by absolute number and the rate per 1000 occupied bed days month on month during 2020/21

Table 2: Number of complaints



Source: Safety dashboard

Table 2 demonstrates the fluctuations that can occur from month to month with a steady increase in complaints from January 2021, largely down to concerns being investigated as complaints by request from the CQC. There was no single emerging theme or reason that this can be attributed to and it does not relate to any annual trend in the rise and fall of complaint numbers. Overall, there is a relatively consistent spread over the year.

Table 3. Number of concerns

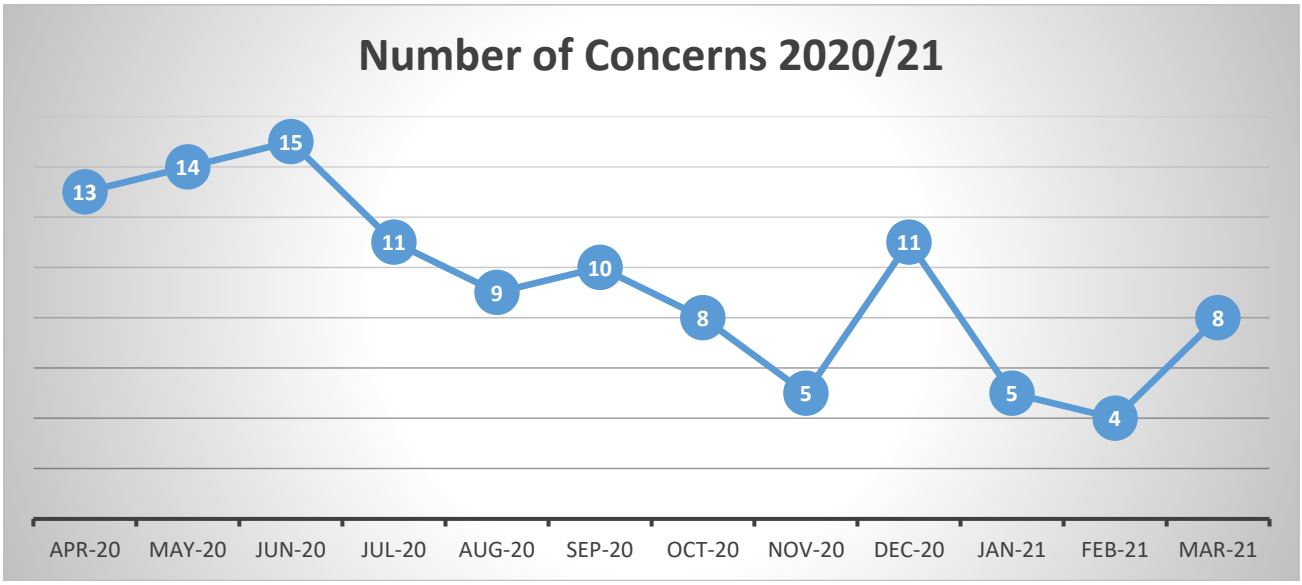
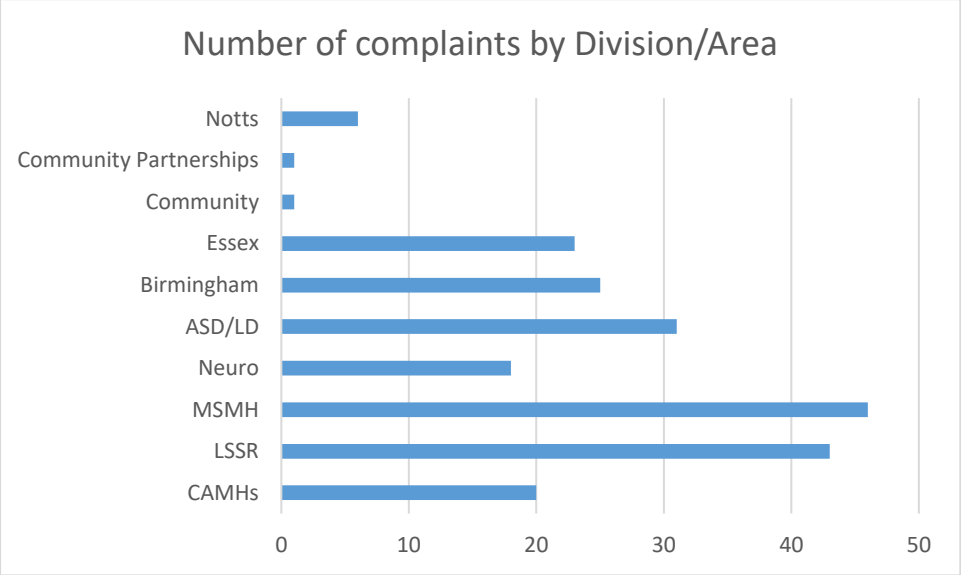


Table 3 demonstrates a decline in the number of concerns received throughout the year, during January and February 2021, this can be attributed to a number of concerns that were recorded and dealt with as complaints as previously highlighted.

3.2 Number of complaints received by Division
The graph below shows the number of complaints and concerns received during 2020/21 by division (excluding complaints that were handled as serious incidents or safeguarding).

Table 4: Number of complaints and concerns by Division for 2020/21



Due to the varying numbers of patients per division, it is difficult to make direct comparisons in terms of figures and our current reporting does not allow us to track complaints per 1000 occupied bed day by division over a year.

3.3 Complaints by method

Written complaints is the main method used. Telephone is the second most popular method of contact with email the third. Face to face contact with the PALS and Complaints Team has continuously been the most favoured method, but due to COVID-19 and team capacity, this has been limited during 2020/21.

4. Closed complaints

This section provides information relating to complaints closed during 2020/21 using the categories reported. The Charity has been committed to providing a response to complaints within 30 working days.

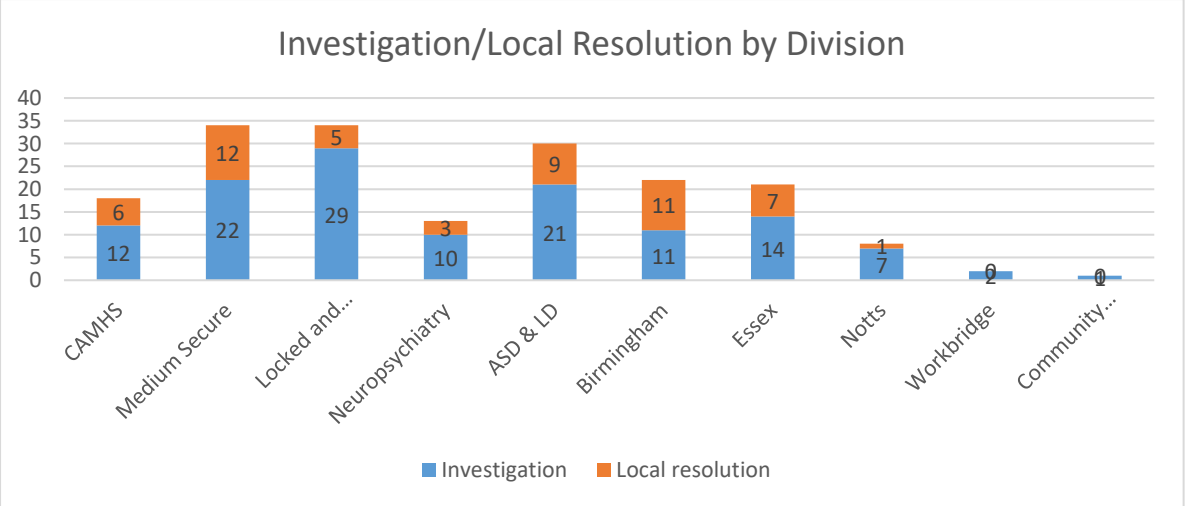
Of the 214 complaints (excluding complaints handled as Serious Incidents or Safeguarding) opened during 2020/21, 184 have been closed. Of the 26 active complaints remaining, 3 are re-opened complaints, 20 complaints are still within the 30 working day timeframe and 3 are overdue - 2 due to a delay in response from the service and another due to the patient being unwell and unable to contribute to the investigation.

4.1 Response times

In 2020/21 the Charity committed to providing a response to all complaints within 30 working days. Our achievement of providing responses within this agreed timescale is 78%. Whilst we have not met the 95% target for the year, the increased pressures on our clinical colleagues have influenced some of these delays: 8 complaints had timelines extended due to complexities, 9 complaints were re-opened due to dissatisfaction with the original response; quality of the service response and achieving patient consent also contributed to delays. The regular weekly update to divisions has evolved to ensure there is clarity on the timelines for complaint responses and what the service needs to provide. The person who made the complaint is kept fully informed of potential delays and they are regularly updated. For 2021/22, we will adopting a more tailored approach to providing timescales for complaint resolution, in line with the new NHS Complaint Standards (see Section 7: Priorities for 2021/22).

The chart below illustrates the ratio of complaints that were resolved at the first stage via local resolution compared to complaints that were investigated formally (excluding those that were handled as Serious Incidents or Safeguarding).

Table 5: Number of complaints resolved using local resolution compared to formal investigation by Division



28% of complaints were resolved using local resolution which is a 10% decline since last year. The increasing complexity of complaints has meant that nearly three quarters of complaints have required formal investigation, which requires greater resource.

Table 6: Number of complaints compared with number of complaints handled as Serious Incidents or Safeguarding by Division for 2020/21

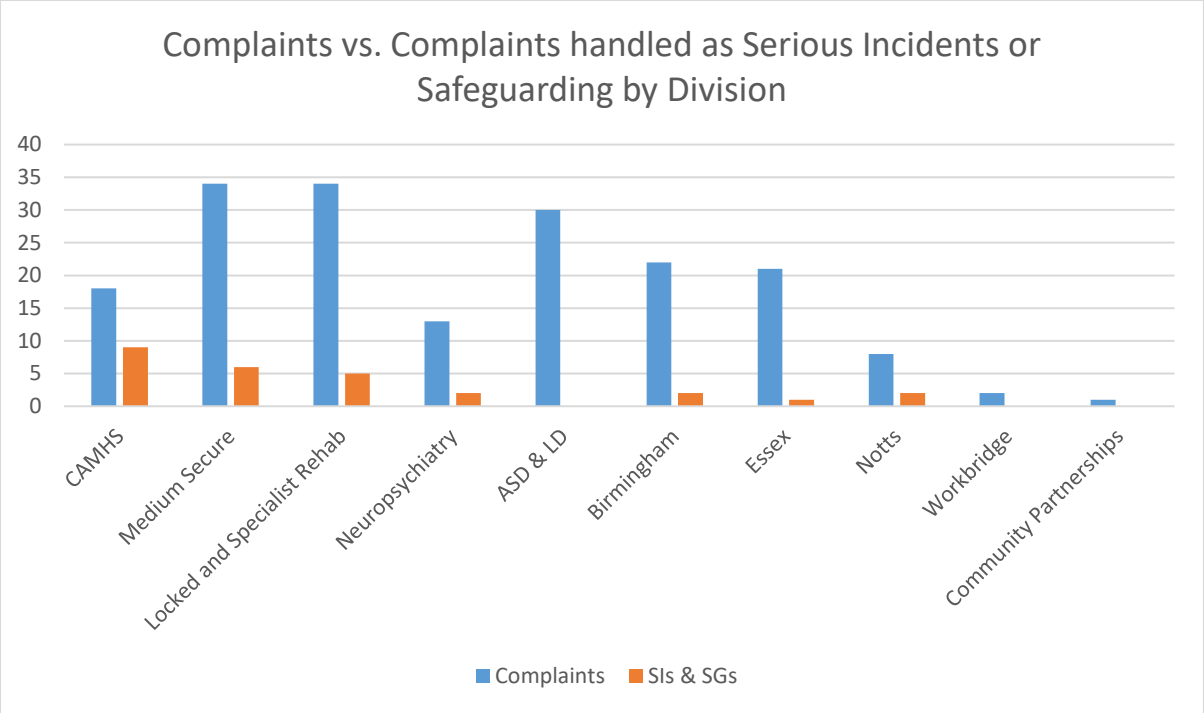


Table 6 shows that CAMHS received the highest number of complaints that were investigated as Serious Incidents (SI) or Safeguarding (SG). In the first half of the year, the complaints DATIX form did not differentiate between SIs and SGs. This was amended to more accurately reflect the investigations that were being carried out. The PALS and Complaints Team has worked with the Serious Incident and Safeguarding Teams over the last few months to try to improve triangulation of issues and ensure that patients and carers are being suitably supported throughout the process. There is still work to be done in ensuring that the PALS and Complaints Team is kept abreast of all investigation developments, including the determination by local authority Safeguarding Teams not to pursue an investigation.

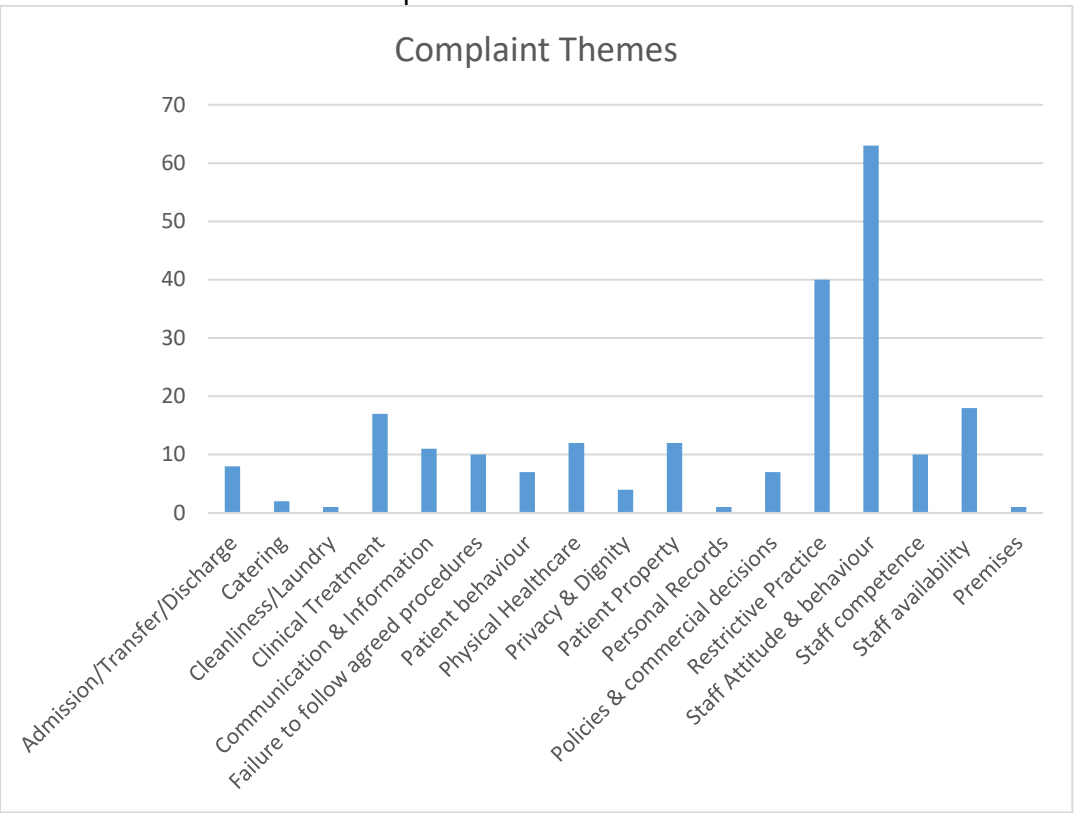
4.2 Extensions

Extensions to response deadlines were granted across 2020/21. Of the 37 complaints that were not responded to within the 30 working day timescale, 8 of these had been granted extensions. In every case, the person who raised the complaint was kept updated about delays and agreed an extended timescale. Extensions are negotiated at the earliest opportunity and agreed with the service team, the PALS, Complaints and Patient Engagement Manager and the person who raised the complaint.

4.3 Themes in complaints

The issues most frequently raised in concerns and complaints are illustrated in Table 7

Table 7: Themes raised in complaints



The category *Staff Attitude and Behaviour* is the most common theme raised in complaints. When investigating a complaint that has been categorised as *Staff Attitude and Behaviour*, staff are guided to consider:

- Do any complaints pertain to particular members of staff more than twice?
- Is it related to a specific career level of staff?
- Are staff who are the subject of a complaint informed / how are they informed?
- Is this reviewed in supervisions?
- What are the opportunities to update relevant training?
- Are staff members who are subject to a complaint receiving appropriate pastoral support?

Restrictive Practice is the next most common theme of complaints, followed by *Staff Availability* and *Clinical Treatment*.

Work is continuing on the Complaints DATIX form to ensure the categories are relevant and more descriptive than they have been previously. This will enable improved triangulation and thematic review locally and Charity-wide, as well as ensuring clearer alignment to commissioners' requested reporting themes.

COVID-19 PALS & Complaints

Total COVID-19 related records between 1st April 2020 and 31st March 2021:
Complaints = 8
Concerns = 6
Compliments = 62

The main themes for complaints related to our policies/commercial decisions, specifically with regards leave and visiting. There were several concerns raised by patients and carers regarding staff not using PPE correctly.

The compliments were mainly from carers and in relation to the efforts shown by staff to keep their loved ones safe and keeping families connected via phone calls and Skype in lieu of visits.

4.4 Outcomes of complaint investigations

With Executive support, the PALS and Complaints Team have continued their campaign to improve the understanding and culture of complaints handling across the Charity. Through the development of strong working relationships with colleagues across all sites, the focus of investigations continues to be identifying where improvements to systems, processes and staff knowledge or performance could enhance the patient or carer experience and prevent reoccurrences of issues. Staff have been encouraged not to fear complaints, and rather to view them as invaluable pieces of information that enable us to improve. Seeking feedback from people who have raised a complaint provides valuable insight into the user experience of the complaint process so we can improve where necessary to increase the satisfaction of those who make complaints.

We continue to observe a lack of learning identified from complaints at a local level, with some identified learning highlighting practices that should be followed as standard, such as patient inclusion in the creation of their care plans and accurate recording of patient property. The repetition of such common complaints is further evidence that some of the learning identified in the complaints process is not resulting in actions that improve patient experience. Whilst not all complaints raised allow for a specific change, there are key learnings that could help prevent an issue from recurring and have a broader impact on service and quality improvements.

Future plans to embed the understanding of how complaints can and should lead to improvements in services will be supported by an e-learning module that is currently in development and a New NHS Complaint Standards CPD session in collaboration with the Parliamentary and Health Service Ombudsman.

There is currently no mechanism in place to monitor the learning and any action / change from a complaint. Lessons learned are captured on DATIX and included in the weekly and monthly reports that Divisions receive. The Quality Team's Quality Business Partners now have oversight of all complaints reports and provide a degree of monitoring and support to the Divisions to create and implement action plans based on lessons learned. Further work is needed to create a Charity-wide mechanism (possibly on DATIX) to monitor and triangulate actions and lessons learned from Complaints, Serious Incidents and Safeguarding, and to embed accountability. Whilst this is being developed, learnings from complaints are raised at the Lessons Learned and Patient Safety Groups, and reported to the Quality and Safety Group and Court of Governors.

Table 8: Examples of learning and actions from complaints

Complaint Theme	**Learning / Improvement**
Staff attitude and behaviour	• Further training / local induction around relational security and working boundaries. • The role of safety nurse undergoing review. Ward to ensure the safety nurse receives more support from other staff during pressurised times. • Consent to be reviewed regularly by care co-ordinator and social work team.

	• Mediation meeting between patient and staff member. • Need for risk assessment and clear plan in place for staff intervention if a patient's mental health deteriorates when being treated in a general hospital.
Communication/Information	• Care to be taken when wording professional reports and minutes to ensure that they are accurate and appropriate. • To ensure physical health referrals and assessments are fully documented if patient seen to become unwell, or her condition shows sign of worsening. • Key staff to involve families in the procedures that are taking place whereby finances are involved; to identify who will be the link in communicating and updating families in such matters; to communicate via telephone or skype as well as email when dealing with such delicate matters to make this communication more personable and to build trust with families and carers. • Review and strengthening of the systems in place for recording and checking electronic devices entering or leaving the ward. Nursing staff will be expected to follow these procedures at all times. • Support patients to read their manager hearing reports and ensure when reports are supplied to relatives that they may be redacted to reflect patient's wishes or permission to share information.
Clinical Treatment	• Staff training – there is now a comprehensive plan to offer specialist training to staff, led by the RC, dietician, and psychology team, that will address issues around meal portioning, and better understanding of the needs of patients with both Personality Disorder and Eating Disorder. • Nursing staff need to order all patient medication on time. • Regularly discuss content of agreed care plan with patient and the importance of following it. • As the ward is developing, it ensures a monthly review of its Standard Operating Procedure to reflect that it will need frequent improvement and changes in light of the actual experience of service delivery, and patient and carer feedback. • Peer review to be undertaken to look at our DNAR processes and how we record patients' wishes for different situations.
Restrictive Practice	• To emphasise the expectations for patients accessing leave in the community during this Pandemic. • Ensure patients are fully aware of the rationale for implementing LTS if this is necessary. • The nursing team to ensure that an entry is made on RIO detailing the clinical justification for the use of security clothing.

	• Patient's care plan to state that a proactive approach to risk may be taken, rather than a reactive one for the protection of the patient. • The service has implemented formal debriefing sessions every week for every ward with the opportunity for ad hoc sessions when required. The need for debriefs are discussed in the weekly operational performance meeting and the head of nursing has started to run sessions for ward managers on how to facilitate debriefs. • Ward managers to ensure all staff are up to date with MAPA refreshers and having monthly supervision.
Policy and Commercial Decisions of the Charity	• The Charity will support the need for a female deaf service and ensure patients' voices are heard to enable them to share their experience with commissioners. • Provide support to carers around the rationale for our visiting guidance in relation to COVID-19 restrictions.
Privacy and Dignity	• Staff to ensure that body maps are completed for every incident that requires one i.e. falls. • Reinforce to ward team about the importance of keeping patient information confidential, and not engage in open discussions.
Patient Property	• Accurate record keeping and monitoring of patient property. • Review of ward property procedure. • Individual staff members assigned to support patients manage their property. • More stringent procedures to be implemented for the handling of any items not being stored in safekeeping.
Staff Availability	• Ensure clear communication with patients about the impact of any staffing issues/concerns on patient requests being dealt with quickly. • Consider impact on perceived support levels available to patients if there is a significant reduction in permanent staff on shift. • Identified the benefit of having more male staff on the ward and action taken to address - moving some staff from other wards within the LD & ASD division to support. • Staffing levels regularly monitored and staff to only be redeployed in emergency to protect the numbers.

Patients who have raised complaints about the use of restrictive practice have been invited to participate in the Least Restrictive Practice Advisory Group.

Carers who have raised concerns or complaints regarding communication and information have contributed to the development of carer engagement training for staff and shared their experiences with members of the Learning & Development Team.

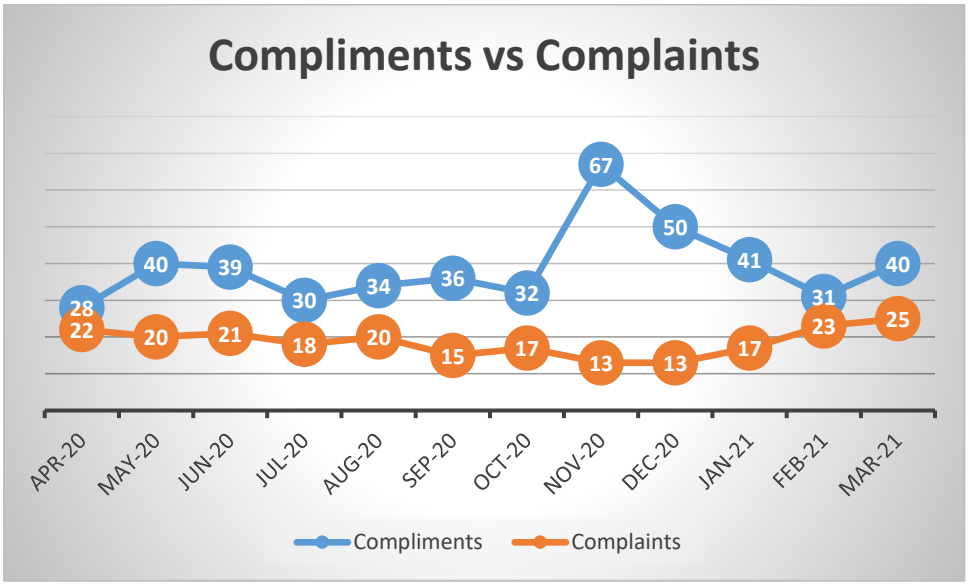
4.5 Compliments

The Charity records the number of compliments received*. These are monitored by the PALS and Complaints Team via a dedicated compliments e-mail address. A variety of methods are used to capture compliments, namely; Care Opinion, Friends and Family Test, letters/cards, e-mail and face to face. Compliments are mainly received from carers and patients, though external professionals do also provide positive feedback.

A log of compliments received is sent to the Communications Team weekly. They then highlight these across social media platforms and internal and external communications.

The chart below shows the number of compliments exceeds the number of complaints received

Table 9: Compliments to complaints ratio 2020/21



There were 468 compliments received in 2020/21

Compassion; Accountability; Respect; Excellence

- Compliments about staff attitude and behaviour comprise 80% of the total compliments.
- Compliments about communication and information make up 13% of the total compliments.
- The remaining 7% include compliments about clinical treatment and the discharge/transfer process

  44 % of compliments were from families, 32% from patients and the remainder were made by other professionals

The team have been brilliant and achieved far more in 9 months than the previous hospital did in 5 years. The care is excellent.

Just to say 'thank you' to your team for the Skype call on Christmas Day. I was so pleased to see him and it does make such a difference in these very difficult times.

You are doing such a good job, we know she is safe in your hands, she's happy and says she is. We're so grateful.

Without your (CTS) help I don't think I would be here today. When I came into your service I was lost and didn't know where to go for help. I cannot thank you enough.

As you know, I am reluctant to leave St. Andrew's because I have formed some good therapeutic relationships with a number of staff. I have always felt that you have my best interests at heart and have supported me in a very caring and compassionate way.

St Andrews help the whole family – not just the child. They do honestly care, there is an awful amount of caring.

* Compliments from St Andrew's staff about St Andrew's staff are not recorded via this mechanism. They are referred to the CARE Awards.

5. Listening, Reviewing, Learning, Improving

5.1 Complaints feedback

Feedback about the complaints process and users' satisfaction with it provides us with useful information about how well we are achieving our aim to work in line with the User-Led Vision 5 principles. During the year, we reviewed how we seek feedback from those that have used the complaints procedure and a new process for seeking feedback will be implemented at the beginning of 2021/22. The review was carried out due to significant resource constraints making it difficult for staff to make feedback phone calls to patients and carers, as the phone calls can take significant time to enable a quality conversation. Additionally, the manner in which closed complaints were assessed for appropriateness for seeking feedback on was considered too subjective and lacking in clinical input. We will continue to work with clinical colleagues to identify different ways we can gain feedback from patients about their experience of the complaints process so that they do not experience "feedback fatigue". One option that warrants further exploration is the use of care co-ordinator sessions to ask patients who have made a complaint how they found the process and whether anything about it could be improved.

The local resolution form has a mandatory field for the person who raised the complaint to complete and prompts staff to ensure they have considered and asked where appropriate, how the patient could be involved in driving change and learning identified as part of their complaint.

This is the second year we sought feedback from patients who have raised complaints by including a section in the annual patient survey. The return rate was 128 completed forms and 132 refusals to participate, this equates to 44% of our patient population, however only 22% of patients engaged in completing the survey. The low response rate compared with the previous year, in which 66% of the patient population responded, makes direct comparison difficult.

Question	Yes	No	Not sure	Comments	Not answered
Do you know how to make a complaint?	73%	16%	11%	This is a slight reduction on last year, when 79% knew. There is an increase in the number of people who were unsure, from 5% in 2019.	8%

Have you made a complaint in the last 12 months?	39%	55%	6%	Slight increase from 34% in 2019.	19%
If the answer is yes, did you feel you were listened to and understood?	34%	66%	N/A	This is a significant change from 2019, when 69.5% answered 'yes' and only 24% said 'no'.	2%
Did you feel that your complaint made a difference?	22%	63%	15%	This is a significant change from 2019, when 42% answered 'yes' and 32% said 'no'. People reported not feeling listened to, and that bullying on the ward still continued.	2%

Only 22% of patients who responded to the survey and had made a complaint felt their complaint had made a difference; this was largely due to patients not feeling listened to and that they continued to experience the issues they had raised. The lack of satisfaction in the complaints process expressed in the survey may have contributed to the reduced number of complaints raised, as a direct result of limited confidence that there will be any benefit.

Resource constraints within the PALS and Complaints Team resulted in limited feedback being sought from patients and carers following the resolution of their complaint. However, when feedback was sought, the User Led Vision 5 principles were used to provide structure to the feedback (My Expectations: Parliamentary and Health Service Ombudsman, Healthwatch, Local Government Ombudsman 2014).

The 5 principles of the User Led Vision are:

- I felt confident to speak up
- I felt making a complaint was simple
- I felt listened to and understood
- I felt that my complaint made a difference
- I would feel confident making a complaint in the future

During 2021/22, we will focus our efforts on gaining this feedback in a way that is both user friendly and sustainable for the team, so that we continue to provide a responsive and effective service. Most feedback over the past year was gained via the local resolution forms, or when speaking with patients or carers after their complaints were resolved.

Anecdotal feedback received:

- I think that it's good and I'm happy things have started happening for me. Happy with the outcome.
- Many thanks for this, much appreciated our phone call originally. Was very heart warming, you nailed the essence and emotion I was trying to convey.
- I was able to raise it and it was looked into quickly. I appreciate someone coming to see and letting me know.
- Katie [Fisher] always responds to me personally in writing and she is always thankful for my feedback. She knows she can rely on me to let her know when things are not right.
- Patient stated that acknowledging the complaint would help improve the system.
- I felt that my complaint made a difference.

- It was easy to complain, all I had to do was make the call – someone listened and it got back to the ward.
- I'm glad it got noticed and that there was not just some generic response.
- It looks like a few things will change on the ward soon. I feel better that someone from the top cares about us and is keeping an eye on our ward.
- Things have started to improve slightly, in baby steps.
- Seeing as the response was genuine and detailed, it does give me confidence I will be listened to if I needed to complain or write another letter again.

5.2 Complaints monitoring

The complaints process is closely monitored to ensure complaints and concerns are handled appropriately. The Complaints policy and associated procedures utilise a triage approach for different levels of complaints; the PALS, Complaints and Patient Engagement Manager and Complaints Adviser triage each complaint. Recommendations are then made to the Division regarding local resolution or formal investigation. A dedicated Complaints Adviser specialises in more complex cases and building relationships, using Root Cause Analysis methodology to improve engagement and compliance, however this role is currently vacant.

DATIX holds a complete electronic record of the complaint history. Work to revise the PALS and Complaints form was halted at the start of the year as a result of the effect of COVID-19 on staffing levels in relevant departments and the necessary Charity-wide focus to improve the 'Risk' module on DATIX. It is understood that the changes to make the PALS and Complaints form fit for purpose will be implemented in Q2 of 2021/22. This will support the accuracy of the Safety Dashboard that is used across the Charity. The completion of this piece of work will mean that greater information will be available on the types of complaints, trends, and analysis of issues using the Patient Safety Dashboard.

All complaints response letters are reviewed and signed by the CEO, with all associated documents including the complaint, investigation reports, statements, local resolution forms, information provided by the service and consent forms if the complaint was made by a third party. This provides high-level oversight of the entire performance of the complaint and adds another level of quality assurance.

Heads of Nursing and Heads of Operations are asked to review response letters for their Divisions and Nurse Managers review responses for their wards. This enables them to identify any actions necessary as a result of the learning obtained from complaints. Each Division receives a monthly breakdown of their complaints activity, concerns and compliments. Additionally, Complaints activity is supplied weekly to Divisions using a Red, Amber, Green (RAG) rating system that clearly highlights actions required and also any areas of good practice.

The Safeguarding, Serious Incidents and Quality Business Partner Teams are provided with a weekly breakdown of all complaints that are handled as Serious Incidents or Safeguarding. A monthly report of all complaints, concerns and compliments involving doctors is sent to the Revalidation Support Officer. A monthly report of complaints and concerns relating to restrictive practice is provided to the Restrictive Practice Monitoring Group with any additional training needs shared with Learning & Development. A thematic review is carried out monthly and Charity-wide learning highlighted to the Lessons Learned group. Complaints are also reported through the Quality & Safety Group and Court of Governors.

The PALS, Complaints and Patient Engagement Manager holds regular meetings with Heads of Nursing to review active complaints, identified themes and their Divisional staff contributions to complaint management and resolution.

5.2 Monitoring Risk

The complaints risk register is reviewed monthly to ensure a high level of oversight is maintained and all mitigation action taken as required. Failure to apply learning from complaints has a residual medium risk rating. There continues to be ongoing work in creating a robust Charity-wide mechanism to monitor actions and learning from Complaints, Serious Incidents and Safeguarding. Relevant learning from complaints is shared with the Patient Safety Group. Local learning is highlighted to all Clinical Directors, Heads of Operations and Heads of Nursing in the weekly and monthly reports. They are expected to cascade this to their teams at Divisional Governance meetings; team meetings; and supervision as required.

5.3 Investigating trends and identifying issues

New senior leadership within the Quality Team has generated a renewed focus on the triangulation of Serious Incidents, Safeguarding and Complaints. Monthly Quality Team meetings provide an opportunity for the identification of common themes noted at ward, Divisional and Charity-wide level. The closer working relationships within the wider Quality Team have already proven to have a beneficial impact in ensuring that complaint investigations have a more holistic view than can sometimes occur when investigated within the division. The use of the newly created Investigations Team to provide independent investigations of more complex complaints will undoubtedly aid in the identification of trends across the Charity. Further work is required to ensure triangulation with Human Resources investigations and Freedom to Speak Up Guardians. The Charity must now create a robust mechanism to monitor the implementation and success of action plans created from lessons learned through complaints.

6. Staffing

We currently have 0.8 FTE Administrator, a 0.4 FTE PALS Adviser and 1 FTE PALS, Complaints and Patient Engagement Manager (however their work on PALS and Complaints is equivalent to 0.6FTE with 0.4FTE spent on patient engagement). During the year, due to a promotion, we were without a PALS, Complaints and Patient Engagement Manager for three months until the position was filled, and our PALS Adviser was on maternity leave for most of the year with no maternity cover. The full time Complaints Adviser left the Charity in early March and that position has not been filled due to recent approval for a 3 month contract. The benchmarking of our PALS and Complaints Team size compared with those across other healthcare organisations is difficult due to the significant variety of patient populations covered (inpatient/outpatient provision, population/geography covered, acute/long stay services, etc.) Attendance at national forums has highlighted that in order to provide the most effective and responsive complaints processes from which significant improvements are identified and implemented, sufficient people resource is essential. This is mainly due to the need for sometimes lengthy conversations with patients or carers who wish to raise a complaint, to truly identify their concerns and ensure they are satisfied with the resolution.

7. Our key priorities for 2021/22:

Many of our priorities for the coming year have had to be carried over from last year as a direct result of the resource constraints already mentioned.

Complaint process

- We are proud to become ‘early adopters’ of the New NHS Complaint Standards. The Standards have been created by the PHSO in conjunction with numerous stakeholders across the NHS and independent healthcare sector. The NHS Complaint Standards set out how organisations providing NHS services should approach complaint

handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services. The Standards are well aligned to our existing vision to provide best practice in complaints handling, from initial contact all the way through to implementing change.

- Stage 1 of implementing the New Standards requires an assessment of our current processes and policies compared with the Standards, to identify the areas we will need to focus on adopting first.

- As early adopters, it will be necessary to provide feedback to the PHSO about our experiences with the Standards, so that they can be refined for full rollout in 2022.

Staff training

- Launch of the new Complaints handling e-learning module.
- New NHS Complaint Standards CPD session in June 2021. This session will introduce staff to the Standards and the need for a culture of openness to feedback and learning from complaints. It will also highlight areas of good practice already present within the Charity.
- The Standards will support us to define the necessary levels of skills, knowledge, experience and responsibility for all members of staff involved in the complaints process.

Improving efficiency and effectiveness

- Continue to improve engagement from staff to provide more robust and high quality responses on completion of local resolution or investigation and reduce the number of complaints which are re-opened
- Reintroduce PALS and Complaints drop-ins across all sites of the Charity.
- Aim for 90% of cases to be concluded within agreed timescales. The New Standards will introduce a more tailored approach to assigning timescales upon receipt of a complaint. Use DATIX to highlight agreed timescales.
- Continue to increase the number of complaints resolved at the first stage and reduce the number of formal investigations where local resolution has not been considered.

Improve reporting

- Implement a revised categorisation of complaints on DATIX
- Review reporting mechanisms to ensure they align with the needs of Divisions and support the timely management of complaints by being as automated as possible.
- Finalise DATIX Complaints form changes to ensure the Patient Safety Dashboard provides more accurate data.

Quality assurance

- Increase the amount of feedback received from patients and carers to measure level of satisfaction and to inform improvement and development.
- Continue monthly monitoring of the risk register for the complaints process.
- Show case best practice from compliments.
- Draw learning from all concerns to identify emerging themes and prevent escalation to formal complaints.
- Implement a process for dissemination of lessons learned and action plan monitoring in conjunction with Serious Incidents, Safeguarding, Human Resources and Freedom to Speak Up Guardians.

8. Conclusion

2020/21 has seen many challenges for the Charity and the PALS and Complaints Team, as it has for everyone.

- Temporary resource deficits brought on by maternity leave and internal promotion were compounded by COVID-19 shielding.
- Social distancing in the office and the inability to visit wards for drops-ins meant we had to navigate new ways of providing a consistent and visible service.
- The inability to provide drop-ins and face-to-face Advocacy support resulted in fewer complaints and concerns being raised.
- Our complaints process provides emphasis on the person who raised the complaint remaining at the centre of the process.
- Implementation of a fit for purpose Complaints form on DATIX was postponed due to competing priorities across the Charity and limitations in support teams as a result of COVID-19.
- We have developed networks with other organisations and national forums to ensure that we share good practice.
- We have continued to develop internal relationships across all services to ensure the best possible outcomes for the people raising complaints and concerns.
- We have developed strong working relationships with our wider Quality Team colleagues to ensure greater oversight of ward, Division and Charity-wide themes.
- We have experienced an increase in complex, multi-faceted complaints that require greater levels of coordination and investigation.
- We have looked for opportunities to empower and enable patients to meaningfully influence and participate in the work of the Charity by providing their feedback.

We want to further increase patient and carer contacts to the PALS and Complaints Team in 2021/22 by:

- Creating more opportunities for patients to provide feedback through the various patient forums across the Charity.
- Increasing presence across all areas of the Charity through drop-ins and awareness campaigns.
- Launching the e-learn module and CPD session
- Continuing to develop staff confidence in welcoming concerns and complaints as an opportunity to learn.

The Charity remains committed to thoroughly investigating, learning from and taking action as a result of individual complaints. Where it is found that standards have fallen below the level we expect and where services could be improved, we will take action to resolve the issues identified and involve the person who raised the complaint in these changes as far as is possible.

We will continue to improve how complaints are handled across the Charity, through the implementation of the New NHS Complaint Standards and continued monitoring of all complaints to ensure where questions are raised about the quality of care we deliver, they can be quickly investigated and responded to.

Quality Safety Committee

Appendix 2

Safeguarding Annual Report

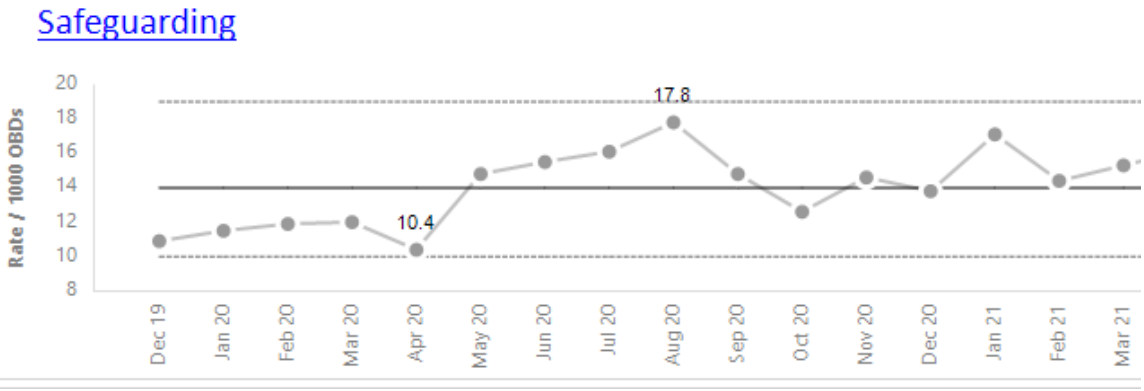
St Andrews Annual Safeguarding Report 2020/2021

Contents page

Key Points To Note:

- This is the initial annual safeguarding report for the charity and will focus on progress and challenges for the last year, however data from December 2019 until the end of March 2021 will be considered to reflect the fluctuations in safeguarding incidents reported within the charity
- The number of safeguarding incidents has increased over the last year with the majority of concerns being rated as internal concerns, (these do not meet the Care Act definition of safeguarding and as such are not referred to the relevant Local Authority Safeguarding Partners). A Task and Finish group is to be set up and will including external safeguarding partners to confirm the parameters for the threshold for safeguarding reporting – once agreed there will be no 'internal' safeguarding incident reporting. Incidents of concern will still be reported and will be categorised under a relevant incident category. This report will only focus on those incidents reported under the Care Act requirements.
- NHSE, CQC and NCC have highlighted concerns about the timeliness of reporting and managing of safeguarding incidents within the charity, responsive actions have been taken by the charity to address these concerns resulting in positive feedback from these partner agencies
- Weekly Safeguarding review meetings chaired by the Head of Nursing now occur within all divisions across the charity in order to ensure that focus remains on maintaining timely submission of investigation report outcomes to the relevant local authorities and that there is an overview of any themes or concerns developing within divisions
- Development of the safeguarding team to include a safeguarding practitioner has increased the support to staff on wards when safeguarding incidents occur. This role has also offered reactive and planned safeguarding supervision to staff in areas of higher concern. Agreement is in place to further develop the safeguarding team and adverts are out for two further nurse-safeguarding practitioners.
- Safeguarding is Everybody's Responsibility is being emphasised across the charity with the process of external referrals being handed over to all staff not just social work, this has been highlighted as a positive step by NHSE and safeguarding partners
- Close links through internal structures and processes has increased communication and information sharing at all levels including closer overview and scrutiny at CEC level
- Working relationships with community safeguarding partners have improved with Northants external colleagues being invited in to meet with charity staff and also visit some of the clinical areas thereby increasing their understanding of what we do and who we care for and the challenges this can bring when working to keep people safe.

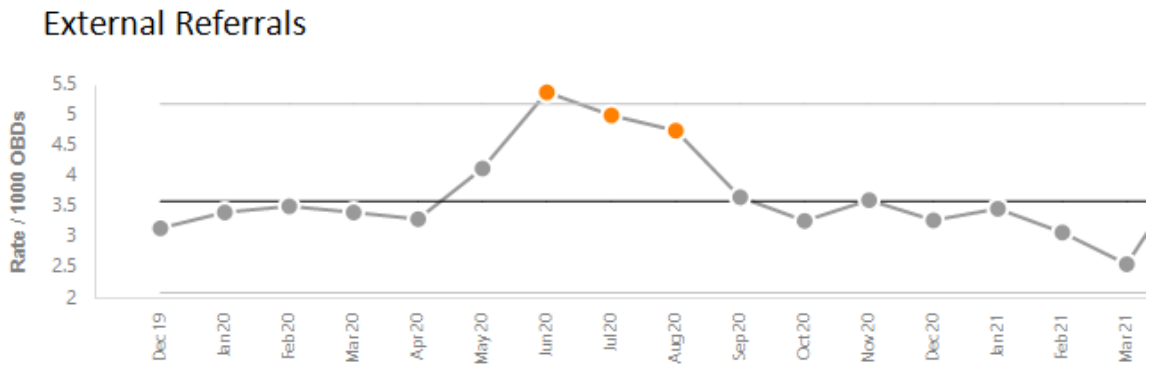
Overview of safeguarding incidents across the charity per OBD



Despite some fluctuations, overall the figures for safeguarding incidents for the last twelve months remain within the variations of the lower and upper levels of control. The above graph shows that there has been an increase in Safeguarding incidents per 1000 (OBDs) from 10.4 in April 2020 to 15.95 in April 2021 with a spike of 17.8 in Aug 2020. It must be noted that the higher figures for internal incidents does skew the overall figures. Currently the term internal safeguarding incidents can relate to staff performance and care issues and there is currently a project for plan for the term 'internal safeguarding incidents' to be removed. The impact of this is that any incident deemed to meet the Care Act definition of safeguarding will be reported to the relevant authorities, currently recorded as 'external incidents' and will enable accurate monitoring of incidents, issues and provide early opportunity to identify themes and trends and to respond accordingly

Although acknowledged as improving, the Covid-19 pandemic continues to have an impact on the availability of consistent staffing on the wards. Safeguarding reports per division note that the higher level of use of agency and workchoice staff has impacted on the knowledge and understanding of patient care plans which could have contributed to the increase in reported safeguarding incidents (particularly if self harm occurs when a patient is being supported with an enhanced level of care and support).

It has been recognised that the outbreak of Covid-19 will have undoubtedly had an effect on the mental wellbeing of all our patients. Leave off the wards needed to be restricted in line with government instructed lock-down guidance as well as family visits needing to be suspended; this added stress and distress for patients may have contributed to increased incidents between patients on wards.

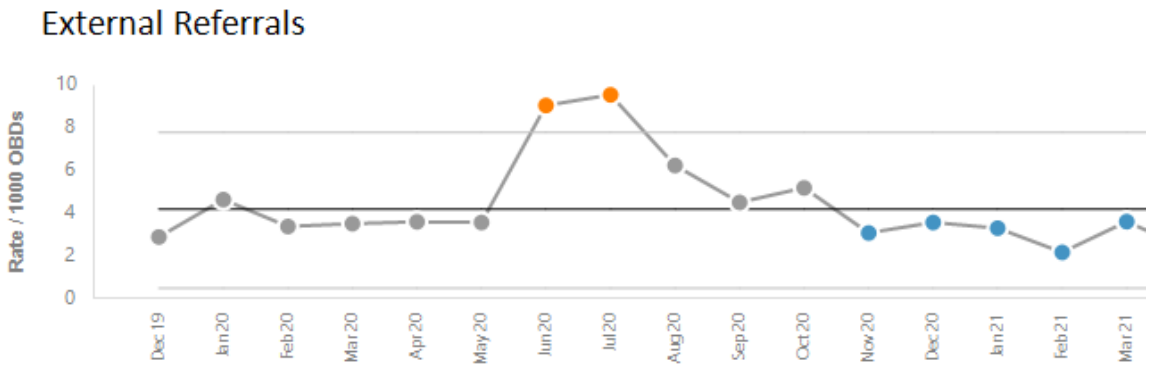


There was a significant increase in the number of externally reported incidents from May 2020 through to September 2020, this steep rise in incidents is related to Covid-19 pressures, when the Charity had a number of staff off sick or isolating in line with government guidance during the initial lockdown. It is evident that the increase in the use of agency staff increased over this period resulting in staff on the wards having less knowledge and therapeutic relationships with patients.

Positively since September 2020 the number of externally referred incidents has generally remained consistent and below the fluctuating average mean level. Externally referred incidents include staff on patient incidents as well as serious incidents between patients e.g. physical and sexual assaults.

Review of safeguarding incidents per Division

ASD/LD



ASD/LD had a significant peak of safeguarding incidents between May and October 2020. Whilst this initially appears to be inline with the overall reporting for the charity for that period it would seem that this rise (along with figures for Neuro) were the contributing factors to the rise of incidents for the whole charity over the summer of 2020.

The areas of concern for this period of time were:

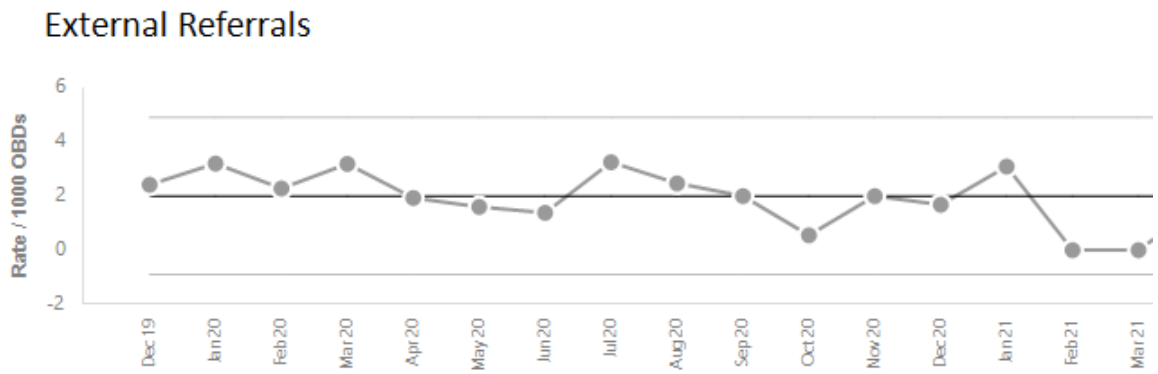
- enhanced support not being carried out as per care plan.
- patient to patient verbal or physical altercations.
- Patient exposure

Possible Causes for this considered at the time were:

- Increased levels of enhanced support on the ward
- Change over of enhanced support
- Shift planning
- Patient dynamic and physical environment
- Individual Patient involved in repeated incidents

It is encouraging to see the overall figures have reduced and have remained under the average mean number since October 2020.

Birmingham

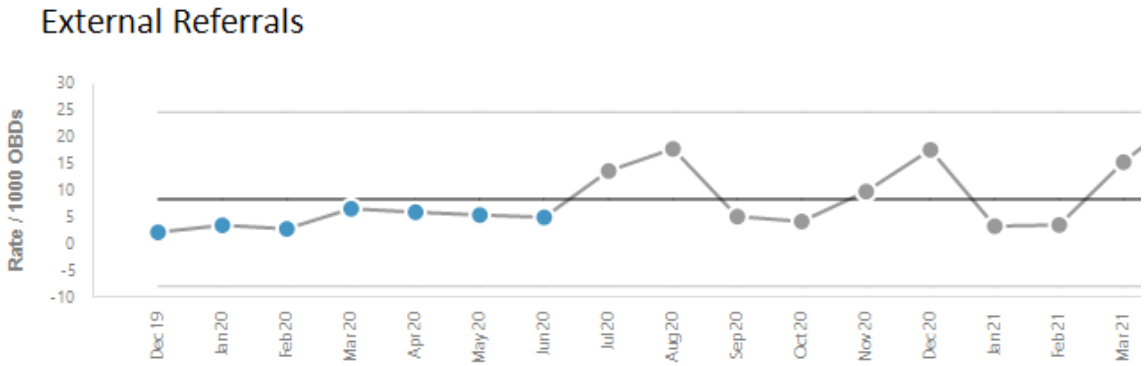


Figures for Birmingham have shown a number of fluctuations, there is a rise in Summer 2020 but figures since then have stayed within the upper and lower controls.

Dr Ali Isa Alfaraj is the safeguarding Doctor for Birmingham completed a review of safeguarding incidents over the period of Jan 2020- Feb 2021. His findings indicate that over half of all incidents investigated, 57% resulted in a substantiated outcome and 8% partially substantiated. 50 Incidents during this review period involved staff on patient concerns, which resulted in three staff suspensions.

Referral processes into the local Authority have very recently changed after a positive meeting with the safeguarding team manager. All referrals will now be submitted through the safeguarding adult portal, which will ensure the appropriate level of tracking by external partners.

CAMHS



CAMHs Have noted a rise in safeguarding reporting figures which relate to a number of concerns raised by patients expressing they have been hurt in restraint, repeated sexualised incidents by one patient which have all been referred as his peers were witness to this. CCTV has been helpful in ascertaining whether allegations of physical assault have occurred or not and some allegations have been found to be untrue when CCTV has been viewed.

The Northamptonshire Designated Officer (DO) remains in regular contact with the CAMHs Principal Social Worker and there are monthly Joint Evaluation Meetings planned to discuss and review completed safeguarding investigation reports and outcomes.

Children Looked After considerations and support

What is meant by the term Looked After Child (LAC)? Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she:

- is provided with accommodation for a continuous period for more than 24 hours
- is subject to a care order Under the Children Act 1989; or
- is subject to a placement order Under the Children Act 1989

A looked after child ceases to be looked after when reaching his or her 18th birthday.

The CAMHs services within St Andrews supports adolescents and young people from a variety of traumatic and difficult backgrounds, a number of which have been and/or continue to be supported within the care system by the Local Authority. The approach of CAMHs professionals is to ensure a full holistic assessment of individual young people's needs is completed on admission, this should identify any extra care, support and educational needs for Looked after Children.

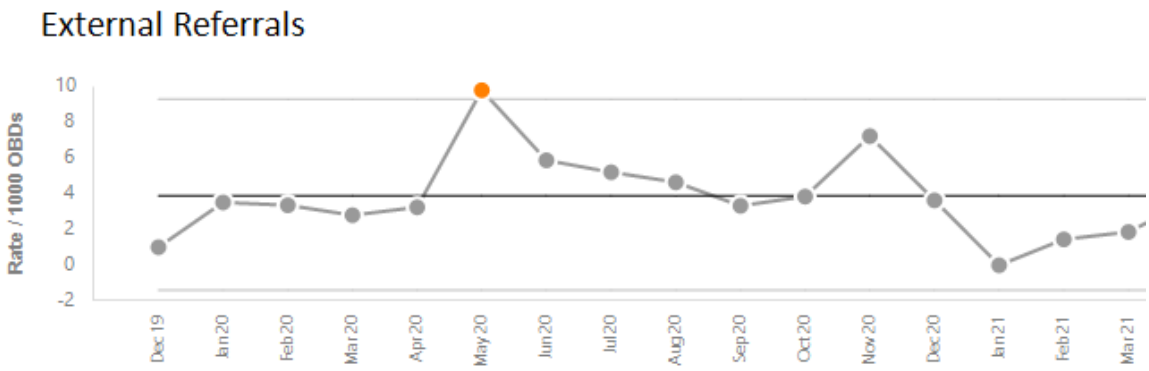
It is acknowledged that on admission to CAMH services that LAC students can be behind in their learning, the college aims to overcome the challenges that this presents for these young people by delivering assessed education in 1:1 or small group lessons. The college SENCo & Designated Teacher for LAC also ensures a second line of assurance in regards to overview and review of educational attainment for all LAC young people.

Social Workers in CAMHS take the lead in liaising and communicating with Local Authority professionals and maintain information sharing in relation to the young peoples needs and

progress. They also ensure that the allocated community childcare social worker is involved in any review of the young person.

LAC children and young people have a nominated professional within the Local Authority who are responsible for them allocated as their Nearest Relative and responsible for undertaking the responsibilities of Nearest Relative under the Mental Health Act. There are additional safeguards in place to ensure review of the needs of LAC young people such as Child in Care reviews, which are undertaken by an Independent Reviewing Officer, and PEP meetings. The MDT within CAMHS facilitate and contribute to these processes to ensure all of the young people's needs are met.

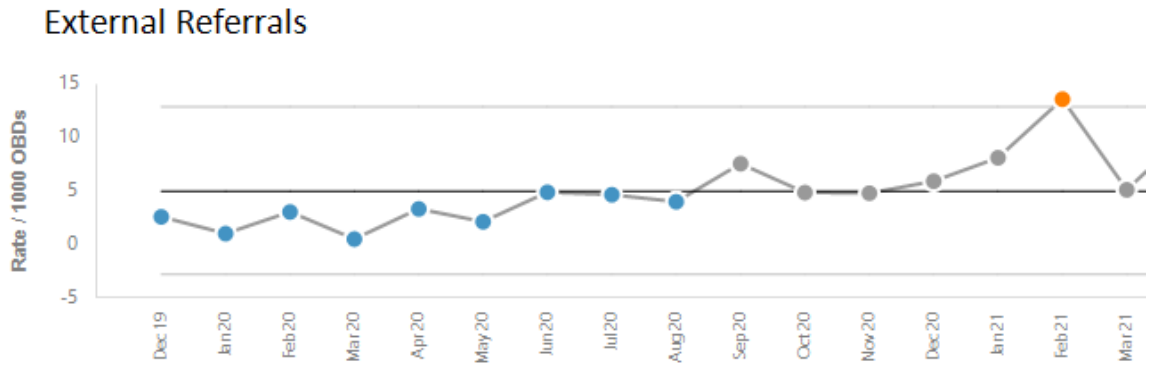
Essex



Incidents within Essex remained within the upper and lower level controls apart from May 20 when reporting was over the upper control level. Incidents in Essex have included medication errors, patient on patient incidents and allegations of sexual assault by patients against staff (police involved and found to be unsubstantiated). Following review of these incidents a number of changes were made to the allocation of staff to enhanced support if an allegation has been made regardless of outcome to ensure the safety of the patient and the staff member involved.

St Andrews Essex continues to work closely with Essex Safeguarding team and attend monthly meetings to discuss any new and current concerns that have been raised.

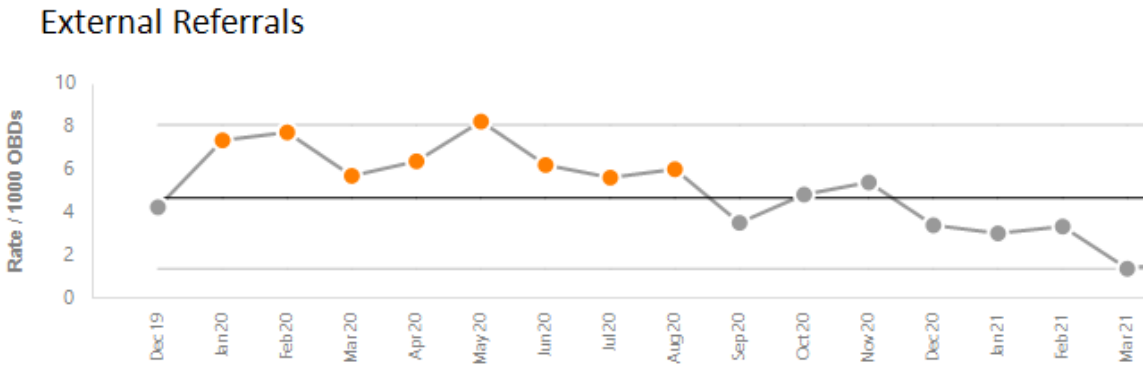
LSSR



Referrals were generally below the mean average throughout the review period and stayed within the upper and lower controls apart form a rise in February 2021. It is worth noting that a number of these incidents relate to a single patient. Close liaison with the Local Authority was developed and following their request a referral was submitted each time they managed to self-harm, these incidents have contributed to the steep rise in safeguarding incidents for the early part of 2021.

There has also been an increased number of complaints and safeguarding incidents on Ashby ward which led to a number of multi-agency strategy meetings being convened. St Andrews evidenced that they were aware of the issues and had already put in a number of action plans and change. We have received positive feedback from partner agencies in relation to this.

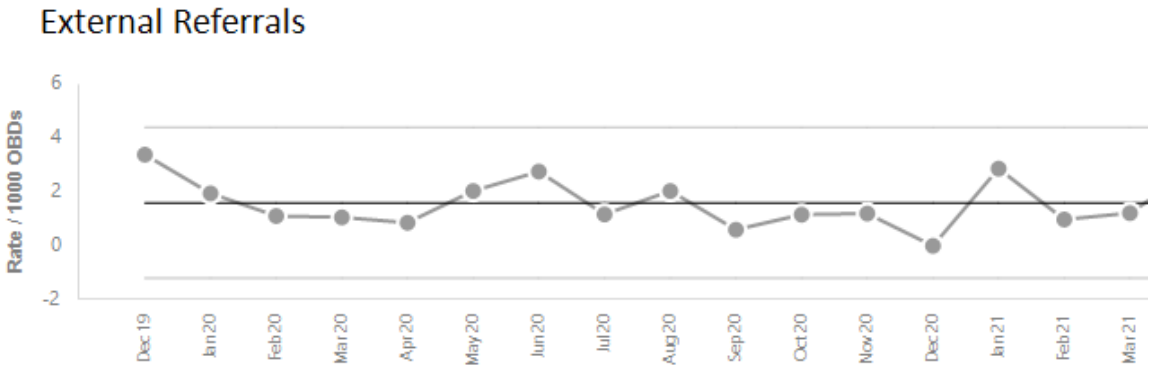
Medium



Safeguarding figures generally remained within upper and lower control levels throughout all of 2020 apart from a peak in May 2020. The majority of safeguarding incidents recorded are within the female wards. An identified small number of patients were involved in a number of self-harm incidents whilst being supported by staff on enhanced support or by accessing items with which to self-harm that should have been restricted. St Andrews assessed that a very small number of women were inappropriately placed and the ward environment and structures made it very difficult to keep these women safe without being overly restrictive and impacting on their quality of life.

Incidents involving these women included ingestion of objects, insertion of objects and head banging leading to injury needing A&E treatment all of which were referred out at the request of the Local Authority. Due to the gradual discharge of these women to more appropriate environments, the number of safeguarding incidents has reduced to below the current mean average level. Partner agencies have noted that the safety of the women supported within the medium secure division and the overview of the safeguarding by staff and senior managers has improved and have subsequently reduced the level of scrutiny that was in place due to their ongoing increased confidence.

Neuro



Safeguarding Incidents increased from Apr 20 to May 20 and then continued to rise until August 20, this could be reflective of the reduction of permanent experienced staff in line with staff shielding due to the introduction of Covid restrictions. The Neuro division has tended to only report a limited number of incidents due to most incidents being patient on patient and tending to be indiscriminate in nature with no specific target intended.

There has been an increase in external reporting recently on Elgar ward due to a number of concerning allegations of a sexual nature and incidents made by one patient involving staff behaviours and performance. A multi-agency strategy including the police was requested by St Andrews. The charity were reactive in dealing with these concerns. Open and candid communication and information sharing has occurred with the local Authority, police as well as CQC and commissioners..

CHARITY WIDE CHALLENGES and PROGRESS

The internal Safeguarding Audit published in June 2020 identified a number of areas across the hospital that needed to change and improve in order to ensure that Safeguarding systems work effectively to ensure that patients are protected from harm. The audit also highlighted that there was a significant amount of work needed on the overarching Charity safeguarding framework to include the development of the safeguarding team, the safeguarding strategy, policies and procedures, safeguarding operational processes and oversight over safeguarding at operational and Board level.

The Safeguarding Lead for the hospital started in role in early July 2020; targeted tasks have included developing an action plan to address the recommendations within the internal Safeguarding Audit and a review of the safeguarding policies, processes and related policies such as the PiPoT guidance. The Safeguarding Strategy for the Charity was also reviewed and updated and in line with CQC developments, a Sexual Safety Policy and Strategy has been developed and written. The action plan in relation to the Safeguarding Audit has been reviewed and actions removed as they are completed.

A thematic review of incidents and reports within CAMHs was completed and shared with the charity in December 2020. The review was requested by the CQC in relation to delays in reporting and poor quality of reports and outcomes within CAMHs. This review was undertaken by an

independent provider and looked at data relating to safeguarding incidents that occurred between April 2019 – December 2019. All incidents that were reported externally were scrutinised and a number of staff were interviewed. The author of the report met with senior staff within CAMHS and shared their findings under the following headings:

- Updates on themes arising from safeguarding incidents: What is working well? What is in development?
- Involvement of young people and advocacy
- Guidance and QA for safeguarding investigations
- Developing safeguarding metrics
- Working with partners – external assurance and DO thresholds

The outcome of this review noted that a number of positive changes had already been put into place and safeguarding processes within CAMHs had been improved resulting in a consistent overview of safeguarding incidents by senior team members. It also emphasised that CAMHs had developed a process of assurance through ward managers that action plans resulting from safeguarding incidents were put in place and completed (uploaded and trackable on the Datix system). An initial action plan in relation to the outcomes of this review has been completed within CAMHs which identifies local and charity wide responses and changes, this is a work in progress.

The Safeguarding Lead attends monthly Named Professionals meetings as part of the Northants Safeguarding Adult and Children's Board (NSAB and NSCP). Engagement with these is a key part of the role to ensure compliance with statutory partners and to keep updated with changes in local and national practices and policy updates. Monthly compliance with external reporting of data is ensured through the completion of agreed dashboards. Data collection and information sharing includes; other responsibilities have included undertaking safeguarding audits to agreed parameters, these audits have identified areas for improvement within our internal investigation reports and outcomes including:

- Not including the patients voice and views
- SI/SG investigations not always having clear Terms of Reference agreed at the start
- Not including carers views
- Not ensuring Advocacy support for patients
- Limited evidence of consistent liaison and engagement with safeguarding partners whilst completing an investigation
- Poor record keeping

Investigation training is due to be rolled out and delivered to targeted staff to ensure improved knowledge and skill in undertaking investigations and to increase involvement of patients, carers, advocacy and external partners. Focus on ToR for investigations will be emphasised so that report completion will focus on agreed areas and parameters.

Intercollegiate practice expectations requires us to engage and participate in inter-agency training and development opportunities. Covid pressures has affected ongoing collaborative engagement re accessing and supporting targeted training within the NSAB and the NSCP. It is hoped that going

forward St Andrews will be able to support training opportunities for external partners and that the Charity will benefit from accessing training offered to us from NSAB and the NSCP.

The Safeguarding Strategy for the Charity identifies a plan to support positive change in practice and processes, this includes ensuring training and learning opportunities in relation to safeguarding are reviewed and developed in line with changing guidelines. The Level 3 training has been reviewed and updated to reflect the requirements of the Inter-Collegiate working documents and covers Children, Young People and Adults. Level 4 Training has not yet been rolled out to all relevant staff and is now a significant priority for the charity.

In January NHSE along with community safeguarding partners conducted a virtual review in relation to Safeguarding which focused on three wards across three divisions. All of these wards had been highlighted due to either ongoing safeguarding concerns or had experienced a significant incident. Virtual Safeguarding Assurance Focus Groups were conducted with a range of Charity staff. Initial feedback was provided on the day including two urgent issues that needed addressing. An in-depth report was then received and in response the Charity completed an action plan in relation to the Thematic Summary and Findings provided by NHSE. There have been a number of review meetings to review progress of the action plan. NHSE have been positive about the changes implemented and have been clear they want to work with and support the Charity in achieving and maintaining constructive changes and outcomes.

Closer working relationships with HR are being developed internally in order to support any safeguarding incidents that include staff practice concerns. HR systems within the Charity have developed to ensure that all staff concerns that relate to safeguarding issues are now logged with the Employee Relations team who support with the investigation process and any subsequent hearings. This allows for a more consistent approach across the charity and allows for the tracking of trends for a particular division or area. There is a much tighter reporting process and paperwork trail, which is now logged in the same place for all employees making it easier to track and identify where there are similar concerns being raised about the same employee. This has been shared with external safeguarding partners to further offer assurance of the Charity's internal overview of Safeguarding.

Concerns re the continuous late submissions of safeguarding investigation reports were highlighted to NHSE (Safeguarding) by NCC in early summer 2020 and an initial meeting was convened in early July. St Andrews agreed a timeline for submission of outstanding reports and outcomes and put in place an action plan that would ensure future reporting and submission timelines would be adhered to. Regular meetings occurred between St Andrews and NCC in a number of areas to include regular tracking of safeguarding incidents in order to ensure timely submission of reports and outcomes. This has resulted in a positive and transparent sharing of concerns leading to more timely submission of completed investigations. Any extensions for investigation outcomes are now agreed in writing with WNC which allows for a better recording system of current outstanding outcomes.

Following a number of review meetings chaired by NHSE and attended by external safeguarding partners it was agreed that the charity had made good progress in completing and submitting all outstanding reports and the ongoing review meetings were ceased. Regular weekly updates with regards to current and new incidents are shared between WNC and St Andrews ensuring a consistent overview of concerns and submission timelines.

The Children and Adult Safeguarding Committee (CASC) has been redeveloped and relaunched to ensure an overview of safeguarding themes and referrals within the Charity. CASC includes external partner agencies and colleagues, discussions with regards to changes and fluctuations in safeguarding are encouraged and advice and views is sought from these partners. The draft Safeguarding Policy was shared with all CASC attendees and feedback was incorporated into the finalised policy. CASC continue to offer an open space for multi-agency discussion and overview of safeguarding practices within the Charity.

Partnership Working

Links with external partners have been developed and strengthened particularly with Northamptonshire safeguarding adult colleagues. Closer partnership working was instigated with both open dialogue from St Andrews and by inviting external partners in to meet with key members of senior staff in areas where there were heightened concerns by NCC (i.e. repeated number of similar issues on one ward or repeated issues with the same patient).

In a small number of areas it was agreed that St Andrews would link in with identified workers within WNC on a weekly basis to ensure open and candid communication re: areas of heightened incidents and concern. This has been highly effective in assuring WNC that safeguarding incidents are being monitored closely and addressed in a timely manner to the point where they have noted they no longer feel that this level of targeted scrutiny is necessary in this specific area. Discussions with the manager for the Northants safeguarding team has led to an agreement for St Andrews to have link workers for each Northampton division so that early liaison and discussion can be facilitated if a safeguarding concern arises, this should continue to support positive collaborative working.

A planned meeting with the team manager of the Birmingham Safeguarding team was positive in its outcome; the process for submitting Safeguarding Adult referrals going forward was clarified. There are no identified link workers from the safeguarding team however; the team manger confirmed that staff could call the duty line for advice and guidance before submitting referrals.

Weekly meetings

Positive changes incorporated into internal practices and processes have included the introduction of weekly divisional safeguarding meetings involving Heads of Nursing as well as social work and ward managers. The focus of these meetings are to discuss and allocate any new investigations and to ensure monitoring and oversight of ongoing investigations. These internal meetings have supported the improved timely submission of investigation reports and outcomes to the relevant Local Authority. Learning from completed investigations is also a focus of the agenda to ensure that specific staff, ward related and wider learning for the whole organisation are considered and shared as appropriate to the wider services.

Part of the weekly reviews include an overview of the use of Datix for submitting actions and documents in relation to ongoing safeguarding investigations. Datix recording of safeguarding incidents and investigations is improving with the expectation that investigators use this system to upload all relevant information and documents; this has resulted in better storage of information and activities conducted during investigations.

Safeguarding Practitioner

The new Safeguarding Practitioner for the hospital started in role in early November 2020. She has previously worked as a ward manager within St Andrews Healthcare and was able to undertake tasks and roles within the charity with immediate effect. Her primary role currently is to offer reactive support to areas of higher need in response to safeguarding incidents and ongoing concerns. She provides targeted safeguarding supervision to staff on wards where issues of safeguarding concern have occurred; Ward managers and individual staff members have reported that this 1:1 support has been helpful in recognising safeguarding issues and increasing staff confidence in responses and approaches when an incident occurs.

External safeguarding partners have also noted the positive support this has provided internally, particularly at ward level with staff. Positively agreement has been confirmed to develop the safeguarding team with 2 more safeguarding practitioners (advertising and recruitment is ongoing at time of report)

Training

The Level 3 Safeguarding training has been reviewed and updated to include case studies relevant to the charity and ensure it meets the expectations of the intercollegiate documents. Training KPI figures for the Level 3 Safeguarding training have slowly reduced over the last year to a point where the figure is of high concern and is significantly below the expected levels from commissioning and external safeguarding partners. An action recovery plan has been devised between the Safeguarding team and L&D, which includes extra sessions being offered, and out of staff being targeted to book onto a training session. The plan is for the attendance figures to increase to target levels by the end of June and will continue to be reviewed, however the difficulty in staffing wards might have an ongoing impact on staff's availability to attend this training, and this has been taken to the L&D group for discussion and awareness.

Level 4 Training is still an outstanding requirement for the organisation, previous attempts to provide this training through an independent provider were unsuccessful and other avenues to develop and support this training are still ongoing. Board training was also identified as a need for the charity, this was developed and delivered earlier this year and was well received, ongoing yearly updates will be delivered to ensure appropriate knowledge and oversight at this level within the charity.

The Deputy Director for Quality is now in post with a specific remit to overview and support safeguarding across the charity. This level of senior involvement has increased the sharing of learning from safeguarding investigations through the Make It Count bulletins, which are shared with all staff. Further positive developments have directed that all staff are to have discussions re: safeguarding in monthly supervisions to highlight strengths and to support areas of need. Support and involvement of the Deputy Director for Quality has positively increased information sharing and communication up to CEC as well as to senior managers within divisions.

The Chief Nurse is the Executive lead for the charity, close liaison occurs with the Deputy Director for Quality who ensures that relevant information and data is shared consistently with the chief nurse; this ensures that appropriate and targeted communication occurs directly into the Charity Executive Committee and at Board level.

The Charity has appointed a Non-Executive Director (NED) with responsibility for Safeguarding. Key roles of the NED are in line with the Intercollegiate Documents:

- To ensure appropriate scrutiny of the organisations' safeguarding performance.
- To ensure assurance is provided to the board of the organisation's safeguarding performance.

Training has been developed and delivered to the CEC and Board members including the NED, this training was a tailored package and included the board level requirements as identified in the Intercollegiate requirements for training at board level.

OPPURTUNITIES AND PLANNED ACTIONS for 2021

Training

Investigation training is being developed alongside HR to be targeted at clinical staff who should be able to complete safeguarding investigations and enquiries. This will initially be qualified staff at Band 6 and above with the option of managers recommending staff in Band 5 positions who they feel have the skills and experience to complete enquiries and reports to the necessary required level. This should ensure that all divisions have enough capacity to complete enquiries internally and support timely allocation of safeguarding investigations and subsequent submission of completed reports in line with expected local authority deadlines. This training will also focus on what is needed to complete a quality report and should further increase the reputation of the Charity with external partners.

Safeguarding training at all levels will continue to be reviewed and offered in line with statutory guidelines and good practice. Increasing the uptake of staff completing the Level 3 training needs to be a high priority for the Charity. Level 4 training is to be developed to target the needs within the charity and will be offered initially to Ward Managers and Heads of Nursing to ensure knowledge of accountability and responsibility.

Sexual Safety training is being developed in-line with the recently adopted Sexual Safety Policy and Strategy, L&D are taking the lead in developing this training and are being supported by a number of clinical specialists within the Charity. This training will be offered to all staff and is likely to be adopted into the Level 3 training package.

Safeguarding Audits

The charity conducts a number of audits in relation to Safeguarding as part of our partnership with the Local Safeguarding Boards. Going forward the plan is for a number of regular internal audits to be identified and undertaken in order to review concordance with changes in safeguarding practices and processes. The overall Safeguarding Audit review in relation to all processes, practices and outcomes for the charity will continue to monitor the ongoing implementation of the organisational Safeguarding strategy.

Referral Process Changes

The changes from social work taking responsibility for reporting safeguarding to the expectation that all staff are responsible to complete referrals is anticipated to take a significant period of time to be fully implemented. There is some resistance from frontline staff to these changes, which is felt to be based on lack of knowledge of how to complete referrals, and confidence in understanding what information may need to be shared when reporting incidents externally.

Social workers have been involved in the planned changes and will continue to respond to safeguarding incidents and support colleagues to complete external referrals.

These changes are a major change in the way that the charity reports out safeguarding concerns but are in-line with good practice within healthcare settings as well as agreed expectations from NHSE and external partners. It is anticipated that there may be fluctuations in reporting out incidents as this process slowly becomes embedded within the charity. The Charity Safeguarding team will monitor referrals and themes will be escalated as appropriate, thereby ensuring that any significant changes such as reduced or increased reporting in a particular area will be responded to as a priority.

Specialist Safeguarding Support

The Safeguarding team is expanding to include two more Nurse Safeguarding Practitioners. Positive feedback internally and from external safeguarding partners in relation to the work the current Practitioner has completed with staff on the wards has identified the progress this role has brought to increasing the profile of support for staff in the area of safeguarding. Once the new workers are in post they will be allocated to work in specific areas depending on experience and skill mix. Heads of Nursing within each division will be involved in identifying the safeguarding needs and priorities within their areas to ensure targeted support is provided. it is anticipated that with the development of the safeguarding team, that safeguarding support will develop into planned sessions and address concerns before incidents occur.

Plans to develop the knowledge of ward-based staff are being developed to support frontline staff's skill and ability to support each other. Training will be provided to identified ward-based staff in order to develop a stronger awareness of safeguarding at ward level; these staff members would then role model and encourage positive safeguarding responses and practices on the ward. These staff will be known as Safeguarding Navigators and will remain ward based with the remit for safeguarding being an additional role for them, there is no expectation that these staff will need to be qualified practitioners and the hope is to recruit people with a passion for supporting safeguarding in their area of work.

Investigation Completion and Report Writing

The Charity has progressed well in this area and this reflects the hard work completed by staff within all divisions as well as scrutiny and support from senior managers. Report completion has improved but there are still some areas where reports are not comprehensive enough and/or outcomes and conclusions are not robust in identifying the changes that need to occur to keep patients safe from similar incidents occurring again. Actions are generic and focused on systems and processes rather than individualised patient needs.

Training will support staff to improve in this area and the expectation is that the Safeguarding Practitioners will also support staff undertaking investigations for the first time if needed. Review of reports needs to improve within the divisional weekly meetings so that any amendments are completed before submission.

Patient and carer involvement in investigations needs to improve, as currently there is little evidence of this in completed reports. Patients need to be included at the outset of investigations in regards to their concerns and expectations of investigations. Completed outcomes and decisions are not routinely shared with patients and their families/carers and this needs to change

to ensure the Charity shares outcomes openly and candidly with those affected by incidents (obviously taking into account staff confidentiality as appropriate). Evidence of patient involvement needs to be clearly evidenced throughout all safeguarding investigations.

Review of Policy's and Processes

Although the safeguarding policies have recently been reviewed and updated good practice dictates that the Charity should ensure patient involvement in policy development. Closer working with the Patient Engagement Team to involve patients in reviewing the current policy's and support co-production going forward will be a positive step for the organisation.

Safeguarding Team
May 2021

Quality Safety Committee

Appendix 3

Nursing Strategy

The Nursing Strategy 2021-2023

July 2021

The Nursing Strategy

What is our Nursing Strategy?

The Nursing Strategy has been designed to align with the Charity's Strategic Aims

These include:

- Promote Wellbeing
- Giving Hope
- Enabling Recovery

By following these aims we hope to enable the individuals we support to transform their lives.

We will achieve this through coproduction of the objectives with the Nursing teams.

St Andrew's HEALTHCARE

The Nursing Strategy

Our Aim

To ensure all people who use our services receive person centred, evidenced based, quality care that helps them to reach their recovery goals

The Nursing Strategy

The Brilliant Basics –
Doing it and Doing it Well

St Andrew's HEALTHCARE

The Nursing Strategy

Input – What are we going to do?	Outcomes – How we will know we have done it?
Nurses will be provided with the knowledge and skills to enable care to be coproduced, meaningful and compliant with Policy through nursing led care plans	Care will be coproduced with patients and carers (care plans and PBS). This will be managed through the CPUM and care coordinator sessions and audited through the Quality Team • 95% compliance with coproduction of care plans • 20% increase in patient awareness of their care plan by 2023 • 20% Increase of achievement of goals within the care plan • Improvement in outcome measures aligned to care plan achievement
Nurses will be provided with the appropriate knowledge and skills to recognise the deteriorating patient both in regards to physical and mental health and have the confidence to manage this appropriately	A reduction in harm to our patients – baseline to be established and target identified • Early Intervention • Reduce contributory factors to patient mortality • Reduce unnecessary transfers to Acute Hospitals • Patient Safety related KPI's within SPC limits • Outcome measure monitoring • Knowledge check following training

The Nursing Strategy

Input – What are we going to do?	Outcomes – How we will know we have done it?
Nurses will be provided with the knowledge and skills to be able to offer individuals education around lifestyle choices such as smoking cessation and healthy weight	A reduction in harm and long term health conditions allowing individuals to live their best life comparable to the general population. (Baseline to identified and target established)
Nurses will be provided with the appropriate knowledge and skills to meet the clinical needs of people that they support	90% compliance with service specific training plans Knowledge check following training
Transparent, open and just culture where best practice and lessons learned are equally promoted	Staff Survey Complaints/compliments trends and themes Shared accountability/ownership

St Andrew's HEALTHCARE

The Nursing Strategy

Develop our nurses to be the leaders of today and tomorrow

St Andrew's HEALTHCARE

The Nursing Strategy

Input – What are we going to do?	Outcomes – How we will know we have done it?
Improve the recruitment and induction experience and develop and launch a career pathway Improve exit interview data and respond to the themes to the interviews Introduction of Nursing and HCA forums Diversify the senior nursing leadership	Reducing Nursing Turnover • Reduce the number of new nurses who leave within 24 months of joining by 30% • Reduce the number of established nurses who leave after 24 months by 30% • Improved EDI metrics
Introduction of new nursing roles – NA's and ACP's confirmed further roles under consideration	Confirmed will be in post within the agreed timeframes
Leadership training opportunities (internal and external) and being able to put this into practice	Survey for the nursing body around leadership 75% of our Nursing Leaders (NM and above to have completed a leadership programme)
Aspiring Director Programme	At least 1 nurse leader to be accepted on to each cohort

St Andrew's HEALTHCARE

The Nursing Strategy

Input – What are we going to do?	Outcomes – How we will know we have done it?
Develop a competency framework and the associated CPD opportunities	Nurses matched against the framework with a development plan to bridge the gaps
Secondment opportunities with other providers to allow for an outward facing nursing workforce	At least one Nurse Leader will have had the opportunity to work outside the organisation
Benchmark our offering to external providers	Respond to themes from benchmarking exercise

The Nursing Strategy

Empower our nurses to lead on improving quality through a CQI approach

The Nursing Strategy

Input – What are we going to do?	Outcomes – How we will know we have done it?
Introduce a Ward Accreditation scheme that will measure wards against set criteria	All wards will have achieved Bronze, Silver or Gold rating. Following the baseline measurement Nurse Managers will design targets for the next review period
Alignment between Nursing and Quality Strategies	Improved Quality metrics as input into Integrated Divisional reviews
Imbed a CQI methodology to constantly innovate Enabling the nursing teams to undertake CQI	Being able to evidence improved outcomes as a part of CQI Improved sharing of learning across wards/divisions
Train our nursing staff in Trauma Informed Care and lead on Compassion Focussed work	Improved outcomes for our patients such as a reduction in restrictive practices.

St Andrew's HEALTHCARE

The Nursing Strategy

Utilising an evidenced based nursing model to ensure appropriate skill mix and resource

St Andrew's HEALTHCARE

The Nursing Strategy

Input – What are we going to do?	Outcomes – How we will know we have done it?
Identify and deploy an improved nursing model that has an appropriate evidence base and have been benchmarked against MH/LD services	Services will have the correct number of staff with the correct skill mix to enable all other aspects of the Nursing Strategy
Work with Operations, HR and the Quality teams to ensure that our Workforce model meets the needs of the services and attracts and retains talented nurses	Appropriately staffed services with the flexibility to meet the needs of the individuals we care for
	Improved feedback from the people who we support in regards to staffing levels Improved patient and carer experience – Use of PREMs Reduction in complaints around staffing by 10% Increased engagement score in the staff survey by 10%

St Andrew's HEALTHCARE

The Nursing Strategy

Next Steps

By December 2021 we will have:

- Collected all benchmarking data
- Set individual timeframes
- Developed measurement and monitoring tools
- Set timescales for each KPI/Metric

We will then review and report on progress quarterly.

In 18 months the strategy will be reviewed to allow development of the 2023-2028 strategy.

St Andrew's HEALTHCARE

Paper for Board of Directors

Topic	Board Performance Report
Date of Meeting	Thursday, 30 September 2021
Agenda Item	**12**
Author	Alex Owen, Chief Finance Officer, Anna Williams, Director of Performance and Dr Sanjith Kamath, Executive Medical Director
Responsible Executive	John Clarke, Chief Information Officer
Discussed at Previous Board Meeting	This specific paper has not been discussed at previous Board meetings
Patient and Carer Involvement	As a high-level summary of Charity performance, the data in this report has not been discussed with patients or carers. This view of patients in particular will have greater prominence in this report as the PREMs are embedded.
Staff Involvement	There has been no specific discussion on the report with staff groups, although the various elements of performance are discussed at ward and team level as appropriate
Report Purpose	Review and comment ☒ Information ☐ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	The safety and patient experience elements of the report have been considered and discussed in detail at QSC. The workforce elements at People Committee and the Finance elements will be discussed at FinCom.

Report Summary and Key Points to Note

Core safety metrics, at a Charity level, show no special cause variation – with the majority below the mean.

Advocacy continues on behalf of patients who are ready for / require an alternative placement.

Ward based staffing remains challenging – mitigations are in place, vacancies and absence are in focus.

As predicted in the August Board meeting – the financial out turn is adverse to forecast.

The Charity's current state regarding Covid- 19 infections and an update on the vaccination programme is also provided

Appendices - None

St Andrew's Healthcare – Board Performance Report

September 2021

Summary Overview

Safety

Proposed targets have been added to the SPC charts (red dotted lines); these are based on a reduction from the mean and are under review by the Quality & Safety Committee. At a Charity level the volume of incidents, incidents of violence, serious incidents, safeguarding and restraints are all below the mean. Divisionally, rates in CAMHS and LSSR have areas outside of control limits, with causal analysis and remedial plans presented within.

Patient Experience

The roll out of PREMs continues – as the volume of response grows, insights will be shared. Patients have been active in a variety of co-produced initiatives. Following successful treatment and progress a number of patients are ready for their next steps; disappointingly some have been waiting over a year for an appropriate placement to become available. Alongside this, for a small number of patients the services offered by St Andrews's do not best meet their needs at this time; representations are being made on behalf of all relevant patients, in order to secure a transfer to a more suitable service.

St Andrew's HEALTHCARE

Workforce

Ward based staffing levels are continuing to prove challenging, due to vacancies, absence and reduced uptake from flexible staffing. This experience mirrors that of Healthcare providers across the UK. It reflects the national shortage of suitable skilled staff, exacerbated by absence, linked both directly and indirectly to the pandemic. Mitigations are in place to support wards. Learnings from engagement sessions are being implemented.

Finance

As predicted in the last Board report, the operating and net deficit position of the Charity is significantly behind forecast in the month of August and for the cumulative five month period. This deficit is a result of three main factors: the lower occupancy levels, due Covid IPC guidance and admission restrictions; the backdated 3% pay rise, which has been accrued for the full five month period in August as a result of the Board's decision to match rises seen in the NHS; and the incentive scheme to protect staffing levels over the summer. This position will continue until we are able to address the shortfall in the occupancy position.

Navigating St Andrew's SPC charts

Target line

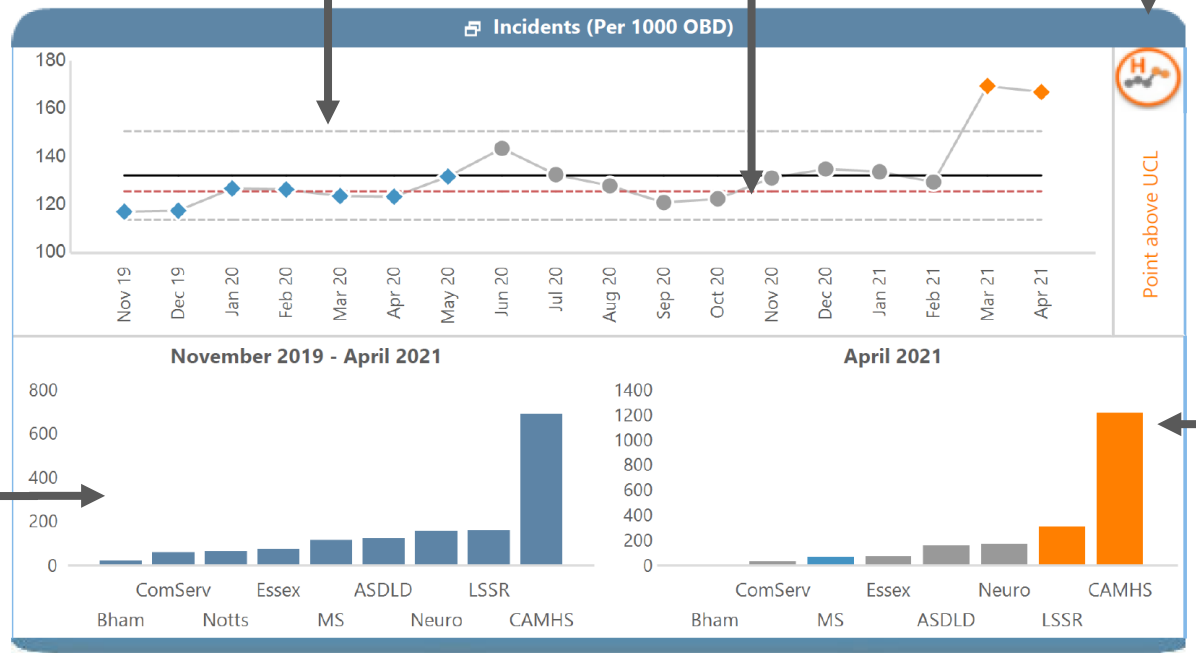
Proposed target for the KPI

SPC icon for the latest month

Orange icon = Special cause concern
Blue icon = Special cause improvement
Grey icon = Common cause variation
Trend line = Not enough data for statistical significance. Icon replaced by trend line.

Charity level SPC chart

Shows the trend for the last 18 months as a per 1000 occupied bed days rate



Division average for the last 18 months

Helps understand how the last 18 months compare to the latest month

Latest month by Division

Shows how Divisions are contributing to the overall charity level in the SPC chart above.

The bar colour illustrates if a Division itself has an SPC concern/improvement

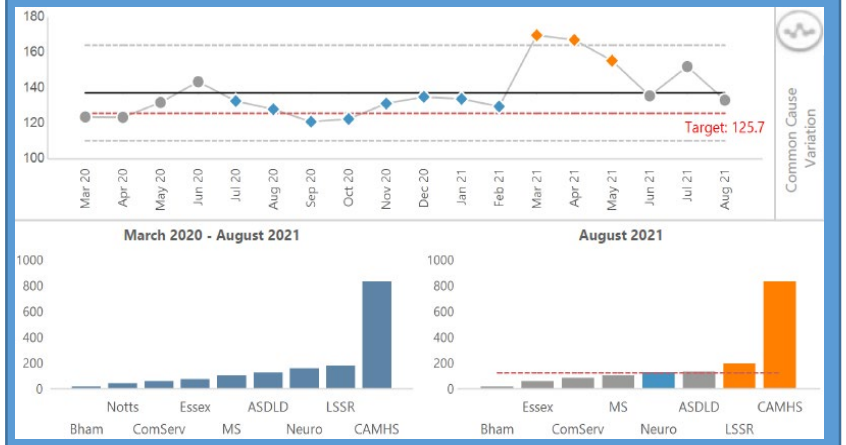
Example Narrative

April 2021 shows an SPC special cause concern as the data point is above the Upper Control Limit.

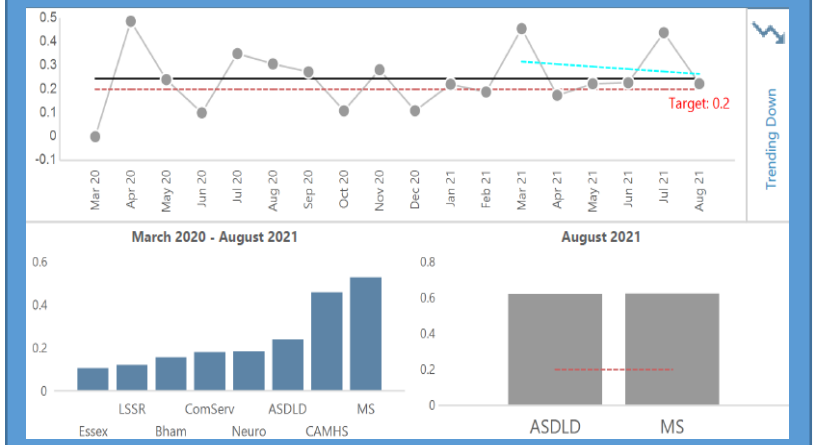
The latest month Division chart shows that CAMHS and LSSR are high contributors, with both triggering an SPC special cause concern in their own data. Although their high contribution is in line with the last 18 months trend, the latest month rate is much higher.

Whilst the charity position is concerning, MS is showing special cause improvement for April 2021.

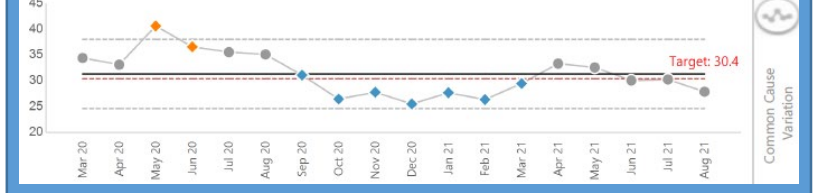
Incidents



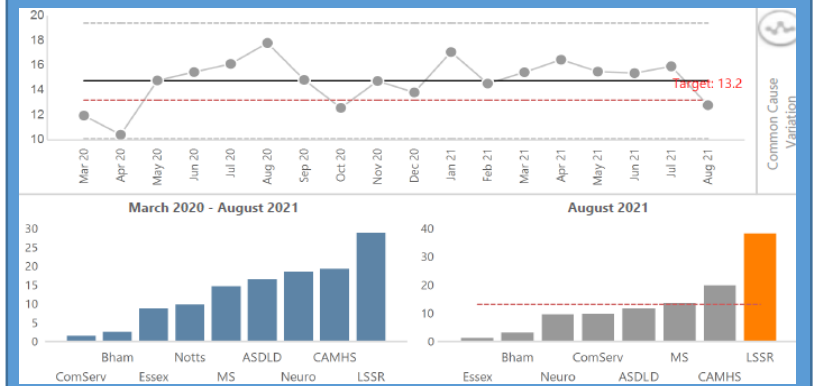
Serious Incidents



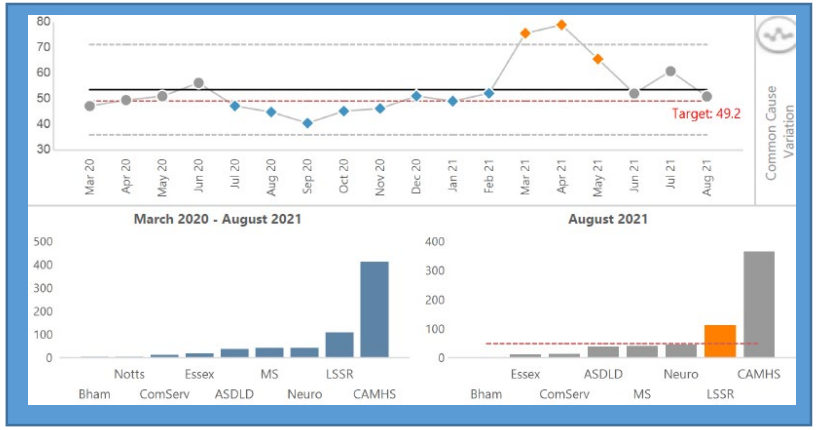
Incidents of Violence



Safeguarding



Restraints

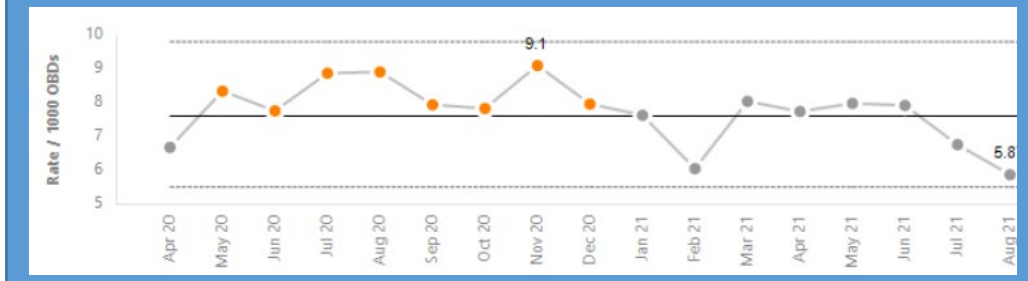


At a Charity level incident rates, incidents of violence, safeguarding and restraints are all below the mean and within common cause variation. Serious Incidents, are below the mean at Charity level and trending down. Divisionally CAMHS and LSSR are above their control limits for incidents (chiefly lower level). LSSR are outside of control limits for restraints and safeguarding.

CAMHS: Causal analysis - increased low level incidents on Seacole are as a result of changes in acuity following patient transfers – level 3 incidents remain below the mean, with five consecutive months with no Serious Incidents. **Remedial actions** – moves were been made within CAMHS in order to match patient needs with ward environments, efforts are on going to improve procedural and relational security and enable increased stability.

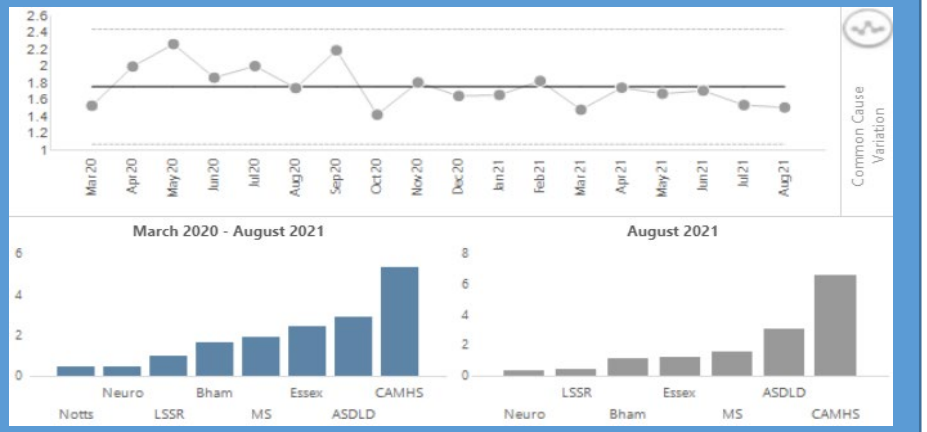
LSSR: Causal analysis – high levels of acuity across a small number of wards has driven the special cause variation in August. There were no Sis, level 2 and 3 were below the mean . The incidents, associated safeguarding and restraints are typically as a result of intervention in order to mitigate deliberate self harm, or are required to administer NG tube feeding. **Remedial actions** – moves have been made within the division in order match the current needs of each patient to the most appropriate available environment. Plans for patients to transfer to other providers with more suitable environments, such as supported accommodation, have been be expedited.

Enhanced Support



Episodes of enhanced support remain below the mean and within common cause variation at Charity and Divisional level. We have identified a number of patients whose necessity for enhanced support is due to the combination of their presentation and a hospital environment, as such our service is not appropriate for them. We continue to work with IMPACT to secure transition to appropriate services that meet each individual's needs.

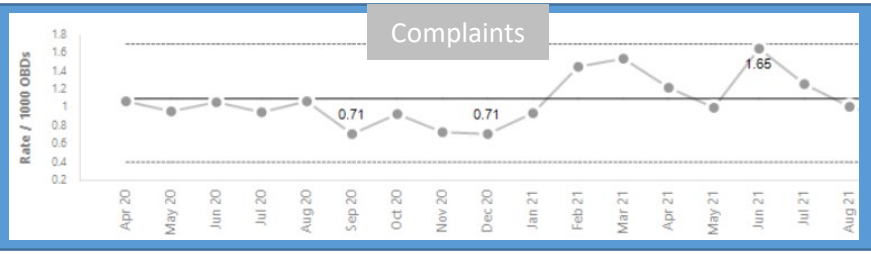
LTS episodes



At a Charity level and Divisional level there is no special cause variation with long term segregation episodes.

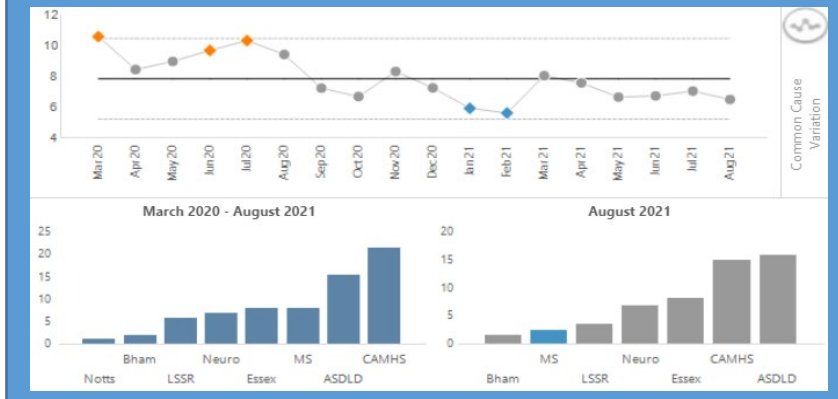
St Andrew's HEALTHCARE

Patient Feedback



The PREMs roll out continues. As the volume of feedback builds – insight will be provided. BENs attendance has been low during the last two virtual meetings. Awareness building activities are underway. The Patient Engagement team have supported co-production with patients across seven different focus areas, including: Awareness videos, Language campaign and managerial appointments. There were 43 complaints and 71 compliments across July and August. Staff attitude is the main theme in both, learnings are being actioned.

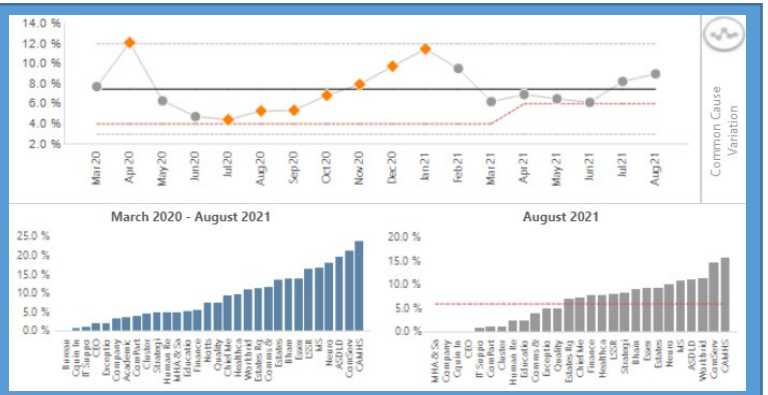
Seclusion events



Seclusion events at Charity level are showing no special cause variation. Individually, Medium Secure have a positive shift with a special cause improvement following seven months below the historical mean. **Causal analysis** - for Medium Secure, this trend correlates with reduced incidents of violence.

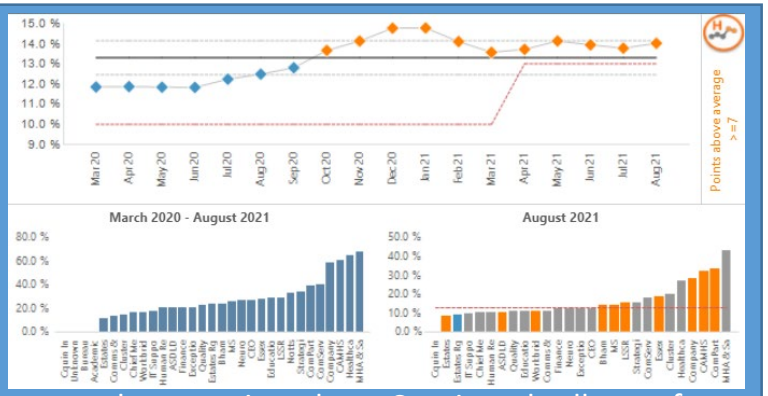
Sickness %

Sickness remains above the 6% target at 9%. With other types of absence remaining high. The combined impact of absence remains significant for the Charity. Other providers are reporting similar challenges with absence impact. **Remedial actions –** Targeted incentives plans to mitigate absence impacts. Vaccination roll out continuation and booster planning. Self isolation for Healthcare exemption mobilised. Absence strategy – sustained focus on reducing LTS and episodes of short-term sickness. Refreshed wellbeing focus.



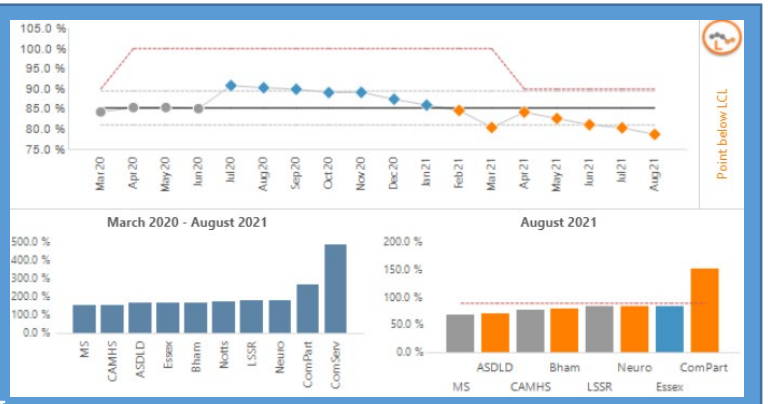
Voluntary Turnover

Voluntary turnover remains above the upper control limit and target. **Causal analysis** – in line with sector norms, work-life balance is the lead indicator from exit interviews (40%). For nursing this correlates with fill ratios and absence. **Remedial actions –** Covid recovery and restoration plans. Continued roll out of staggered nurse pay progression plans. Profession retention reviews for nurses, psychologists and doctors. New engagement session and measurement – enabling greater insight and benchmarking. Deep diver focus for CAMHS. Supervision and IPDR supporting flight risk minimisation.



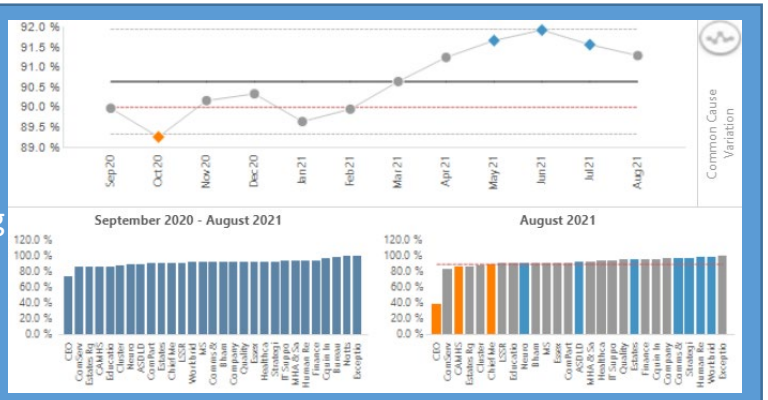
Registered Nurse fill ratio

Registered nurse fill ratio stands at 78.76%. It is below the lower control limit and below target. **Causal analysis –** National Skills shortage, strong local competition. **Remedial actions –** the deep dive Nursing model benchmarking has been completed. A new evidence-based model, utilised by the majority of Mental Health Trusts, has been identified and is in the process of being implemented. There is a strong pipeline, of 48 registered nurses plus an additional 13 Aspire students graduating this year.



Mandatory training

Mandatory training for the full Charity sits at 91.3%. With the exception of CAMHS, divisions are above the 90% target. Informal benchmarking puts Trust compliance rates between 65 and 80%. **Causal analysis –** availability for training is impacted by fill ratios and absence rates. Courses with the highest proportion of face to face content have been most impacted by social distancing requirements, this includes: ILS, BLS, Safeguarding and MAPA. **Remedial actions** – innovative delivery approaches, ensuring competence and confidence remains high. CAMHS focus.



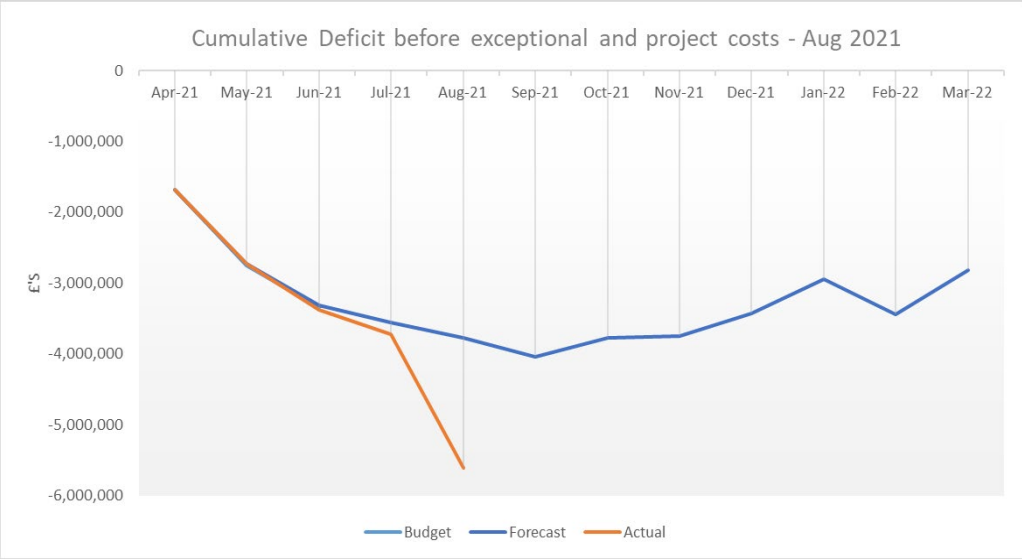
Finance Overview

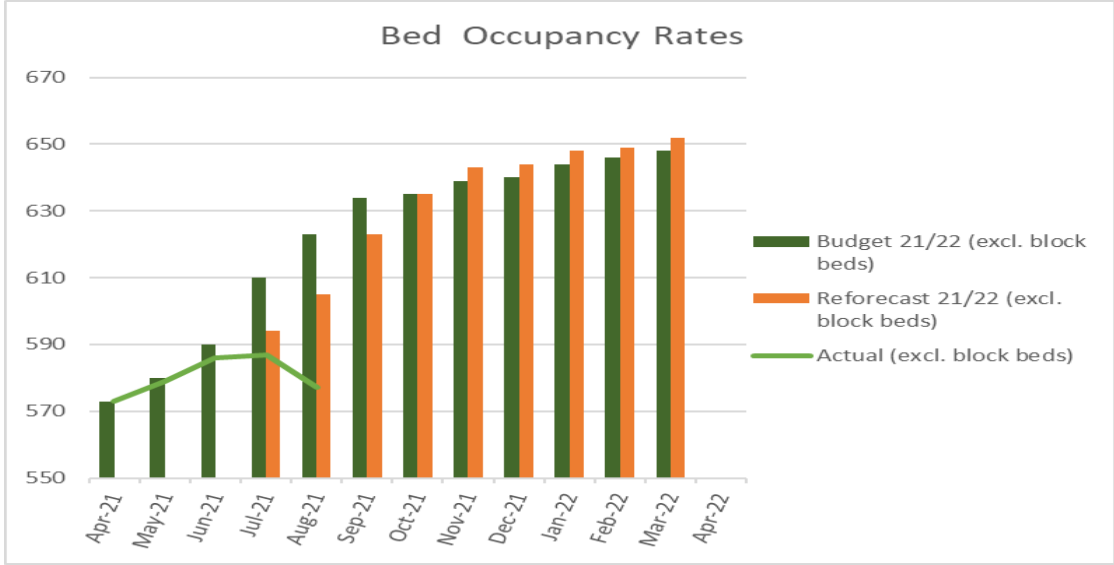
Commentary
Operating surplus and Net surplus positions have been significantly impacted by the continuing Covid restrictions on PICU wards significantly slowing admissions and the impact of the admission restrictions on occupancy throughout August 2021. In addition, the full five month impact of the 3% pay rise and summer staffing incentives have increased costs in the month. All of these factors were expected and had been discussed in CEC and other meetings. The discussions with NHSE concerning additional funding for the 3% pay rise are ongoing; no financial impact of this has been accrued for in the August figures. If agreed, these will be accounted for in future months . All other areas performed in line with the financial forecast. Details of the occupancy variance and additional expenditure are given in the financial update.
As detailed earlier in this report, the staffing challenges that the Charity is experiencing have resulted in lower than expected direct staffing costs but these have been offset by the summer staffing incentive, which has resulted in both in-month and cumulative overspend . As shown in the cumulative snapshot bridge diagram the direct staffing costs were in line with forecast, excluding the 3% backdated pay rise for direct staff for the five months to August 2021.
Occupancy has decreased over the month of August; a change to the trend seen in earlier months and in line with July report predictions, due to the CQC and Covid related restrictions and staffing challenges. We continue to meet with divisional colleagues on a monthly basis to review occupancy and predict future months activity; weekly meetings with the CQC will be held to approve admissions to the 14 remaining wards, subject to enhanced monitoring, and we are preparing a targeted incentive scheme for the wards where acuity levels mean that staffing is challenging.
The planned cost savings across the enabling functions continue to be met across the five months of the financial year. We continue to accelerate certain cost saving plans in an attempt to mitigate some of the financial impact of the current occupancy and staffing challenges.
It is not anticipated that we will be able to achieve the planned financial out-turn for the year due to the factors described above. Efforts will continue to control costs across all areas with the exception of direct staffing where all efforts will be directed to maintaining planned staffing levels to admissions can take place. If admission restrictions continue over a sustained period, or if maintaining planned staffing levels continues to be a challenge then this will put the Charity at significant financial risk. This is being discussed at all levels of the Charity and has been flagged as a risk with commissioners such as NHSE/I as part of our contractual obligations.

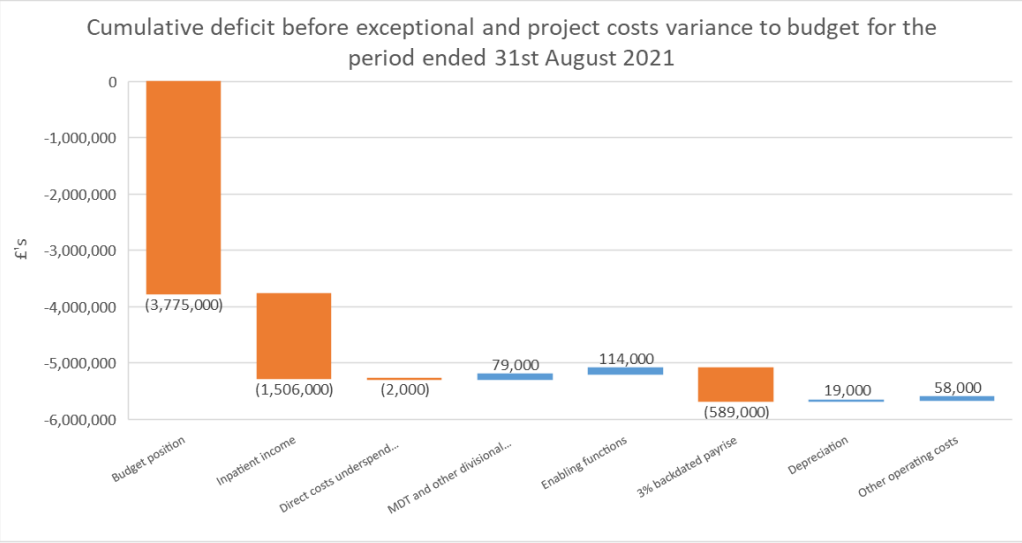
St Andrew's Healthcare – Board Performance Report

September 2021

Finance Snapshot







Cashflow summary to August 2021	(£'m)
Opening cash position at 1/4/2021*	(14.0)
YTD Capex expenditure	(0.7)
YTD working capital movements	(6.2)
YTD net deficit	(6.4)
YTD Depreciation	5.8
Closing cash position at 31/08/2021*	(21.5)
YTD Capex expenditure	(5.2)
YTD working capital movements	5.5
YTD net deficit	(2.4)
YTD Depreciation	7.9
Forecast closing cash position at 31/03/2022*	(15.7)

** Excludes stock market Investments*

St Andrew's Healthcare – Board Performance Report

September 2021

Finance Update

	Aug 2021 MTD			Aug 2021 YTD		
	Aug 2021 MTD Actual	Budget	Variance to Budget	Aug 2021 YTD Actual	Budget	Variance to Budget
Available beds	696	704	(8)	698	698	0
Occupied beds	577	605	(28)	580	588	(8)
Occupancy %	82.9%	85.9%	-3.0%	83.1%	84.2%	-1.1%
Total Income (£'000)	**13,148**	**14,141**	**(993)**	**66,918**	**68,424**	**(1,506)**
Total Direct costs*	(7,466)	(6,914)	(552)	(35,145)	(34,860)	(285)
Gross surplus (£'000)	**5,682**	**7,227**	**(1,545)**	**31,773**	**33,564**	**(1,791)**
Total Indirect costs*	(3,785)	(3,629)	(156)	(18,308)	(18,181)	(127)
Net Contribution (£'000)	**1,897**	**3,598**	**(1,701)**	**13,465**	**15,383**	**(1,918)**
Enabling functions (£'000)*	(2,389)	(2,414)	25	(12,172)	(12,185)	13
Depreciation (£'000)	(1,165)	(1,187)	22	(5,839)	(5,858)	19
Operating Surplus/(Deficit) (£'000)	**(1,657)**	**(3)**	**(1,654)**	**(4,546)**	**(2,660)**	**(1,886)**
Non-operating costs (£'000)	(227)	(220)	(7)	(1,056)	(1,114)	58
Exceptional costs (£'000)	(52)	(50)	(2)	(311)	(254)	(57)
Project costs (£'000)	(107)	(346)	239	(533)	(840)	307
Disposal of Fixed Assets & Impairment	0	0	0	0	0	0
Unrealised Movement on investments (£'000)	0	0	0	0	0	0
Net Surplus/(Deficit) (£'000)	**(2,043)**	**(619)**	**(1,424)**	**(6,446)**	**(4,868)**	**(1,578)**

** - includes 5 months backdated 3% pay award*

Net Surplus/(Deficit) Movement Summary	£m
FYF Net Deficit for August 21	**(0.6)**
Lower In Patient Income (relational to occupancy)	(0.7)
Summer Incentive Scheme (not included in FYF1)	(0.3)
Backdated 3% Pay Increase (April to Aug 21)	(0.6)
Savings on Project Expenditure	0.2
Actual Net Deficit for August 21	**(2.0)**

	Income £000	Occupancy
August 2021 FYF1	**10,655**	**605**
Essex	(164)	(9)
Northampton PICU	(118)	(6)
Birmingham	(8)	(1)
CQC Restrictions/Staffing		
ASD & LDD	(285)	(7)
CAMHS	(65)	(4)
Low Secure & Specialist Rehab	(15)	(0)
Medium Secure	(50)	(1)
Neuro	(2)	0
Community Services/CQUIN	(38)	0
August 2021 Actual	**9,910**	**577**
Movement	**(745)**	**(28)**

St Andrew's Bank Covenants

	Mar-21	Aug-21
Covenant 1. Interest Cover - Ratio of EBITDA to net finance charges in respect of any 12 month period. **Should not be less than 3.00 : 1.**	4.1 : 1	4.5 : 1
Covenant 2. Net Leverage - The ratio of total net debt (borrowings less cash and cash equivalents) at period end to EBITDA for the preceding 12 months. **Should not exceed 3.00 : 1.**	-0.4 : 1	1.5 : 1
Covenant 3. Loan to Value - Total Net Debt **should not exceed 70%** of the market value of the securities.	-1%	2.25%

St Andrew's Consolidated Balance Sheet

	Mar-21	Aug-21
	£M	**£M**
Intangible and tangible fixed assets	209.0	203.8
Investments		
Stock market investments	15.7	15.8
Investment properties	5.7	5.7
Current Assets		
Stock	0.6	0.4
Trade debtors	7.3	10.3
Other debtors, prepayments and accrued income	6.9	6.7
Cash	5.8	3.4
	20.6	**20.8**
Current Liabilities		
Trade creditors		
Capital creditors	(0.4)	(0.3)
Operational creditors	(6.8)	(2.7)
Taxation and social security	(3.1)	(2.9)
Wage accruals	(3.8)	(3.9)
Other creditors, accruals and deferred income	(11.7)	(12.6)
	(25.8)	**(22.4)**
Net Current Assets/(Liabilities)	**(5.2)**	**(1.6)**
Total Assets Less Current Liabilities	**225.2**	**223.7**
Bank Loans (between 1 and 5 years)	(19.8)	(24.9)
Pension Scheme Liability	(0.7)	(0.5)
Total Assets Employed	**204.7**	**198.3**
Reserves	**204.7**	**198.3**

St Andrew's Healthcare – Board Performance Report

September 2021

Covid 19 Update

Current state (22 September)

4 patients positive
0 patients symptomatic
1 ward in isolation
1 ward in outbreak

Cumulative position since the start of the pandemic

Total number of positive patients 281
Wave 1(Feb 20 – May 20) 111 (98 recovered, 13 deaths)
Wave 2(Sept 20 – June 21) 145 (137 recovered, 5 deaths, 1 discharged positive)
Wave 3 (Jul 21 to date) 26 (21 recovered, 1 discharged positive, 4 current)

St Andrew's HEALTHCARE

Staff data (22 September)

	Covid-related absence
Operations	55
Estates	2
Enabling functions	10
TOTAL	67

Vaccinations

Covid Booster vaccine programme for staff will commence on 4 October 2021. Pfizer vaccine will be given alongside the flu vaccine in line with the NHS. Patient vaccinations will also commence in line with the JCVI guidance, 6 months after their 2nd dose earlier this year. Essex and Birmingham will receive staff vaccinations through the regional vaccine hubs

Paper for Board of Directors	
Topic	Information Security Metrics
Date of Meeting	Friday, 15 October 2021
Agenda Item	**13**
Author	Alexandra Vujcich, Info Sec & Digital Forensics Manager
Responsible Executive	John Clarke, Chief Information Officer
Discussed at Previous Board Meeting	Not previously discussed by the Board
Patient and Carer Involvement	No involvement at this point in time as this is a first pass at the potential metrics that we can provide from an Information Security perspective.
Staff Involvement	No involvement at this point in time as this is a first pass at the potential metrics that we can provide from an Information Security perspective. Going forward we want to include some of these metrics into the IT IPR which will be showcased to staff members
Report Purpose	Review and comment ☒ Information ☐ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☒ Innovation and Research ☐
Committee meetings where this item has been considered	None at this point as it's a response to an action from a previous Board meeting

Report Summary and Key Points to Note

The paper is an overview of a number of key IT Security metrics including, but not limited to; Attempted attacks on St Andrews Healthcare, Vulnerabilities, Security Incidents and Compliance.

- The paper highlights that St Andrews Healthcare is a regular target for attackers, however the technical controls currently in place are working as designed in ensuring these types of regular attacks aren't likely to become breaches or high impact security incidents. We have had 1 significant security incident this year

which was a result of credentials being compromised through phishing; basic multi-factor authentication has been implemented across high-risk teams to mitigate against this.

- Cyber controls are constantly evolving, and we are continually evaluating the new benefits/opportunities, within the technical and financial constraints of the charity, as they come available to us.
- *Please note: An organisation will never be completely immune to a cyber-attack; the goal is to ensure a compromise is unlikely and with minimal impact if it occurs.*
- There is still work to be done around phishing awareness for staff which is a priority that the IT Security team are working on and a number of activities are planned over the next 6 months.
- Vulnerabilities are being proactively managed across the estate, with a handful of internal systems that account for the majority of the 'unfixable' vulnerabilities. These systems require upgrading and there are either in flight projects/plans for these or business cases which require approval e.g. patient infrastructure upgrade, CCTV replacement.
- St Andrews has an overall cyber security maturity of 'Intermediate', which is similar, or better, to many of our peers. Without further significant investment, there isn't much opportunity to increase this maturity any further.

Appendices - None

Why is Healthcare a Target?

There are 4 main reasons why Healthcare has been such a target for attackers over the past 10 years

1

Outdated IT Systems

2

Less Security Controls & IT Staff

3

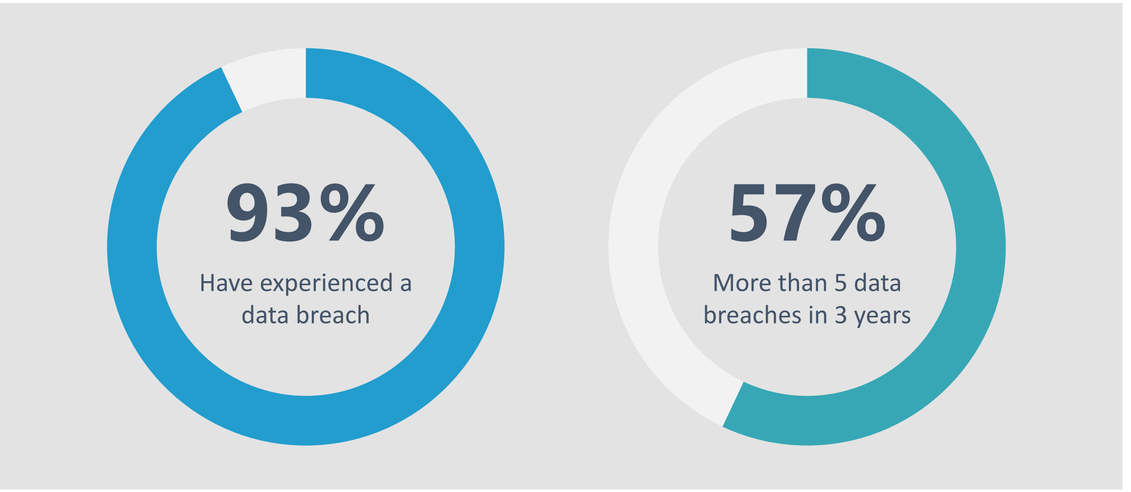
Valuable data

4

Need to pay ransoms quickly to regain data

- More than 93 percent of healthcare organisations have experienced a data breach over the past three years
- 57 percent have had more than five data breaches during the same time frame.

Breaches in Healthcare



Risk

Threat Landscape - 2021

On the 8th of May, the Colonial Pipeline in the US suffered a cyber attack involving ransomware due to insecure external access. Due to the impact, the ransom of £3.1 million was paid.

On the 14th of May the Irish Health Service was hit by a criminal group who used ransomware to impact their network. This group utilise phishing attacks to gain access to networks. The ransom was not paid, however the attack is estimated to cost them at least £86 million to restore their network & upgrade a number of services. Patient data was also leaked as part of the blackmail attempt.

Below are a few of the total universities/education bodies that have all experienced cyber attacks in 2021 which led to downtime and media scrutiny;

1. Newcastle University
2. Northumbria University
3. University of Northampton
4. Hertfordshire University

% of Breaches due to Compromised Credentials

20%

Healthcare Industry as a Target

3rd in 2020 (+5)

Average cost of a data breach

£3.09 million

StAH as a Target - Attempted Attacks

Mail Filter

In the last 7 days, our mail filter has blocked;

- **1,243** phishing messages
- **16** emails with ‘newly released’ malware embedded
- **17** advanced phishing messages (usually sent by criminal groups)

Anti-Malware Software

In the last 30 days our anti-malware solution has;

- Blocked **24 malicious files**

Web Filter

In the last 7 days our web filter has;

- Blocked **377** compromised websites
  Blocked **239** malicious websites
- Blocked **222** phishing websites

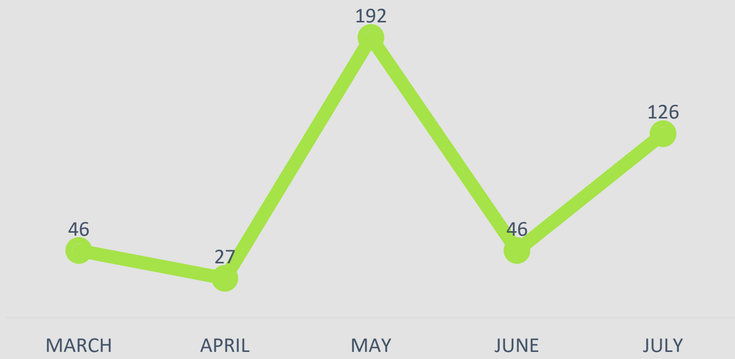
Perimeter Firewall

In the last 30 days our perimeter firewall has blocked;

- **995** attacks (port scanning, connection attempts)
- **1004** attempted inbound connections from malware (ransomware, worms)

Attempted Attacks – Staff Account Metrics

TOTAL MALICIOUS ATTEMPTED LOGINS



Top 5 Attacking Countries

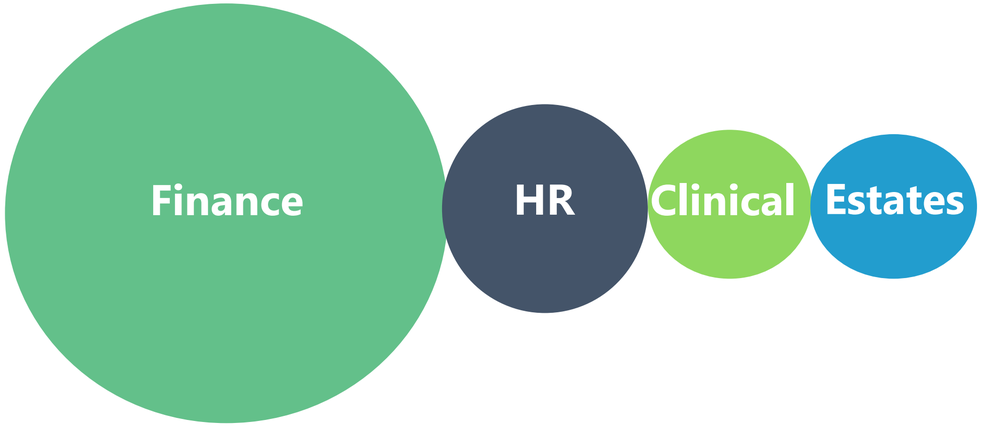
Top Country

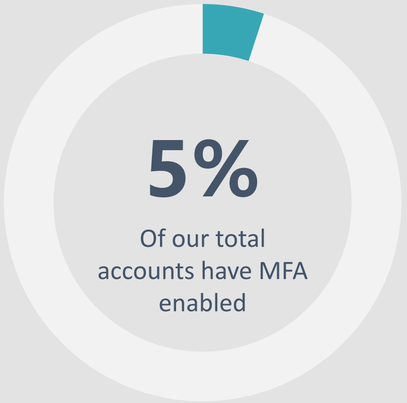
Iran

Attempted Logins

113

Most Targeted Accounts (Ratio per 100 staff)





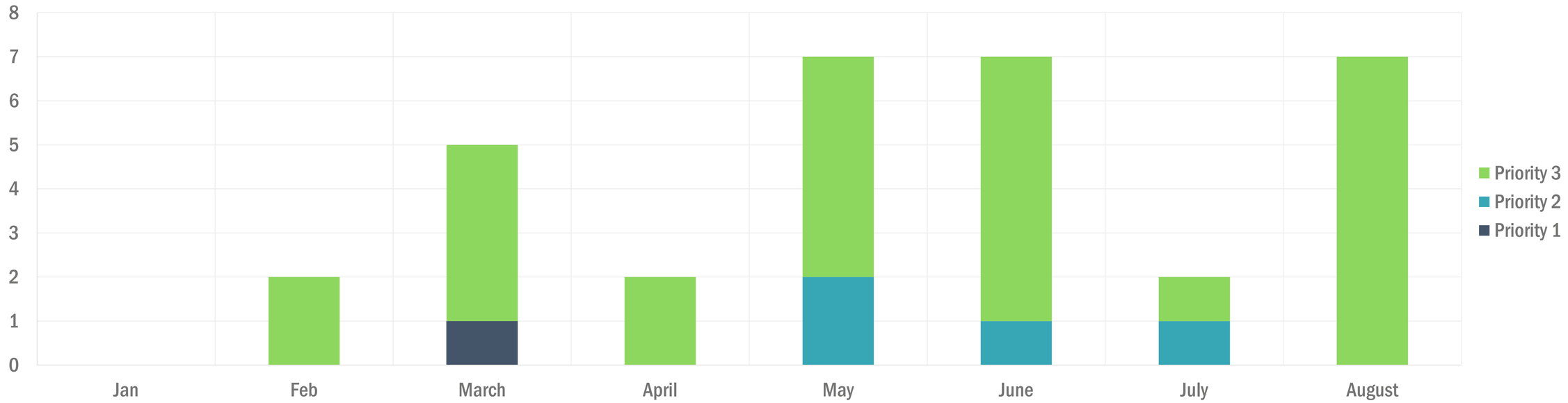
Accounts that have MFA enabled;

- **HR**
- **Finance**
- **Estates**
- **IT**

Security Ops

Cyber Security Incidents - Trend

Total Incidents per Month and Severity



Phishing

91% of the **total incidents** were categorised as phishing attacks

94% of these **phishing incidents** were classed as near misses where the mail filter allowed the emails into the Charity, but IT removed these before links were clicked

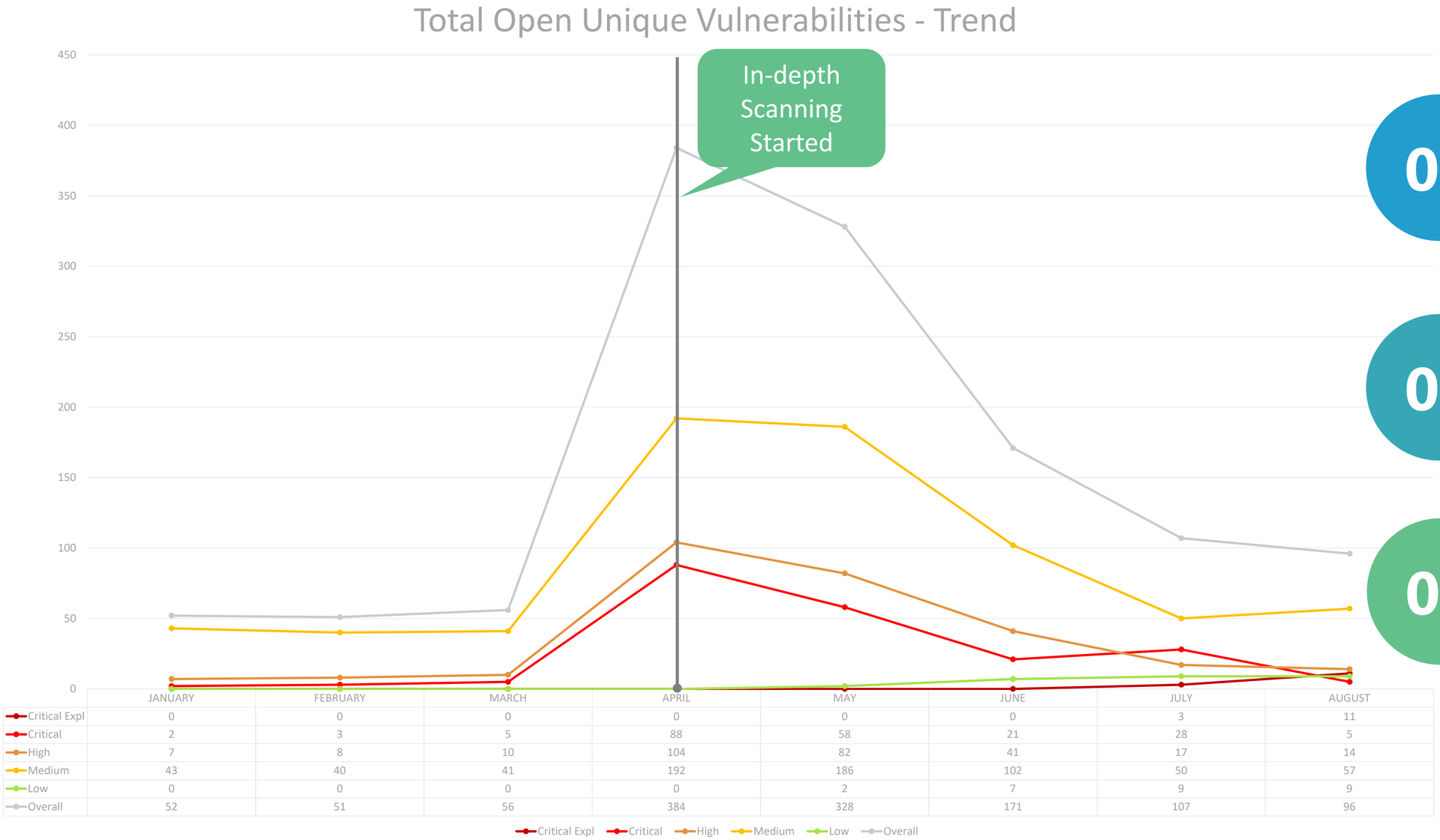
The remaining **6%** of these **phishing incidents** were also near misses where staff have clicked on malicious links in phishing emails before IT were notified of the phishing campaign, but the web filter blocked access

P1 Incident - March

The security incident in March was related to an account compromise of an Office 365 account which started through a phishing attack that obtained valid credentials

Security Ops

Securing our Devices- Vulnerabilities



Narrative

01

There were 11 unique ‘Critical Exploitable’ exposures detected in August. All are related to Windows Patching and are being fixed ASAP. They are all on internal systems which sit behind our firewall

02

The IT teams are continuing to work on vulnerabilities and have been consistently bringing the levels down

03

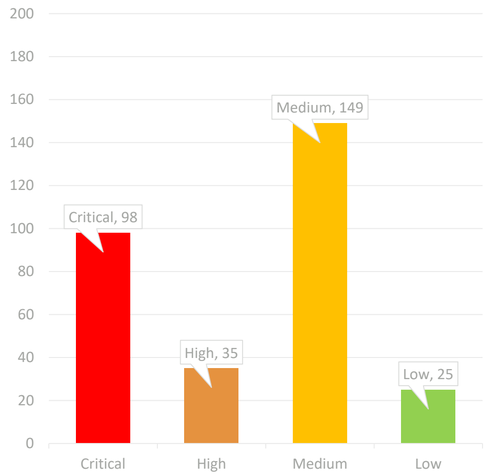
There are no vulnerabilities that are external. They all sit on our internal infrastructure and require bypassing a number of key security controls to exploit e.g. the perimeter firewall

Security Ops

Securing our Devices - Top 3 Vulnerable Systems

*All figures also include vulnerabilities that are being managed via risks because they cannot be fixed until an upgrade occurs

Building Management System

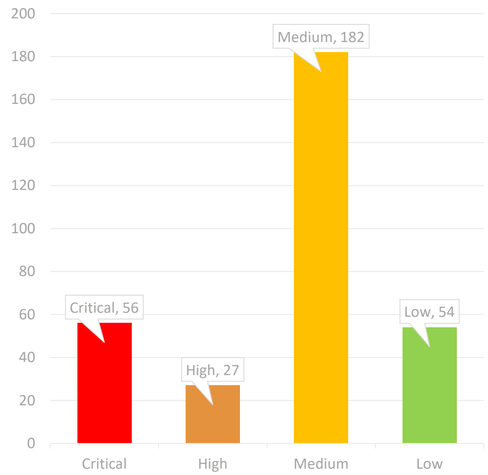


Criticals relate to a component called Oracle Java that needs upgrading & is being investigated by the IT teams

There is a project to upgrade the building management system which will remove these vulnerable older servers

These servers are internal (behind our firewall) and have anti-malware protection installed. An attacker would need to compromise our network to exploit these

Datix

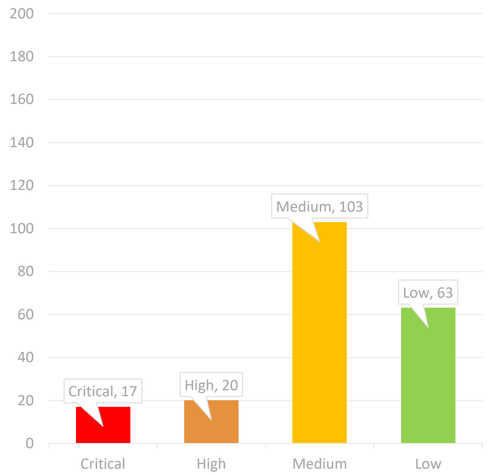


90% of the criticals relate to a component called Oracle Java that needs upgrading and is being investigated by the IT teams

Datix is due to be upgraded to the cloud version of Datix which should remove these vulnerabilities.

These servers are internal (behind our firewall) and have anti-malware protection installed. An attacker would need to compromise our network to exploit these

CCTV



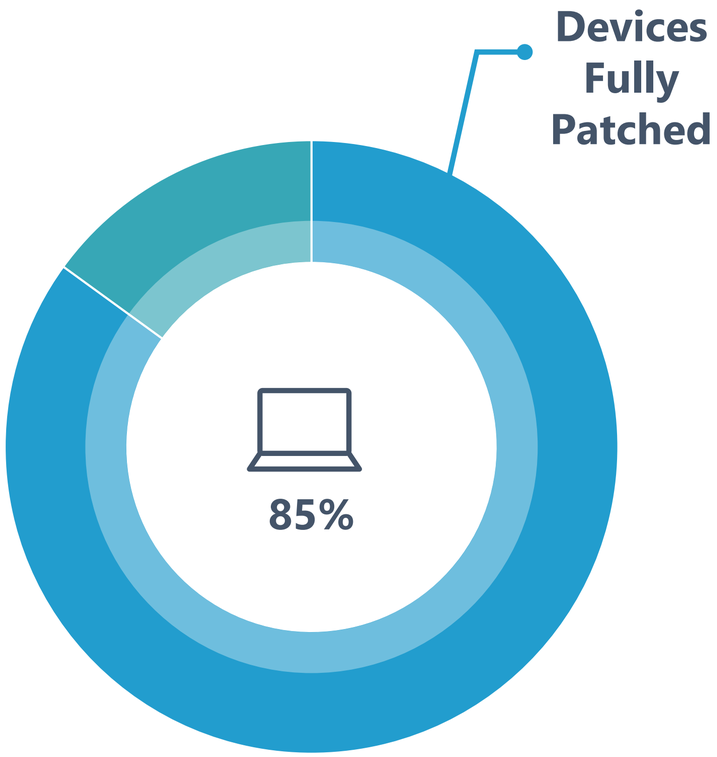
All criticals relate to windows patching. They cannot be applied as the servers are out of support

A business case has been created to upgrade CCTV. IT are supporting Estates on this.

These servers are internal (behind our firewall) and have anti-malware protection installed. An attacker would need to compromise our network to exploit these

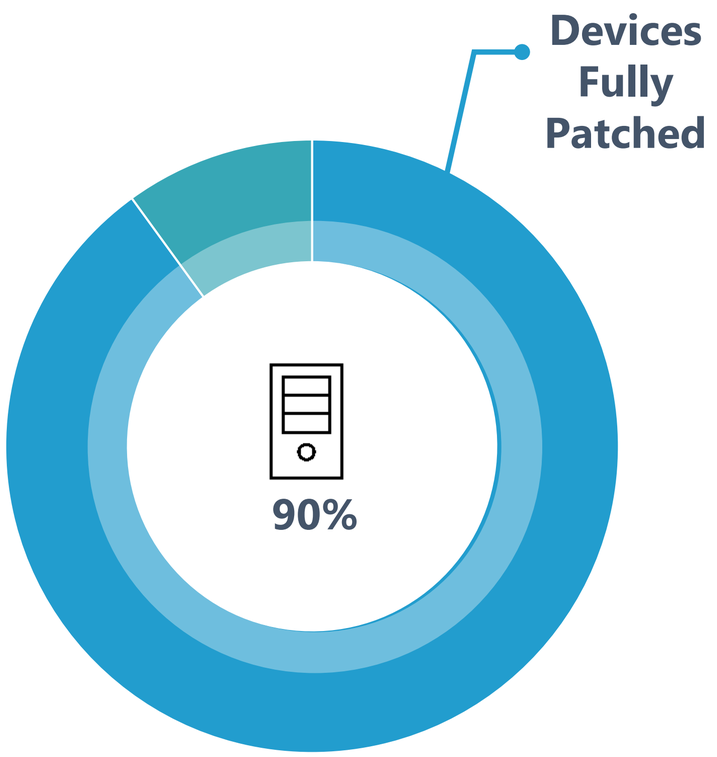
Security Ops

Securing our Devices- Patching & Anti-Malware



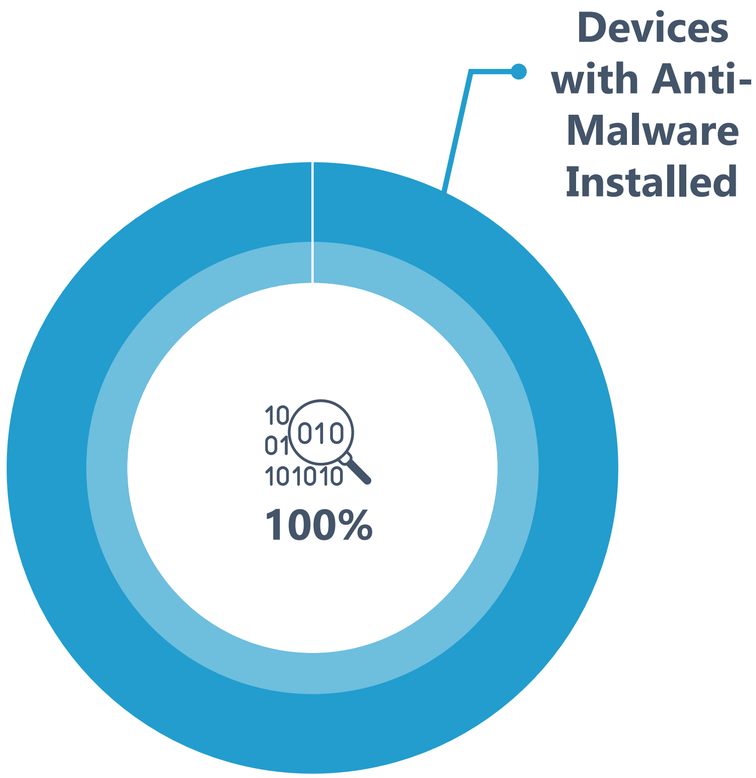
Client Devices – Monthly Updates

An average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). Client devices are all built to a government secure industry standard, have anti-malware installed, are protected by the web filter even off the network and have firewalls enabled



Servers – Monthly Updates

An average tolerance of 10% each month is expected. A number of servers are patched manually on an agreed schedule which isn't monthly. This is due to instability of these servers and the level of manual interaction. There are also some servers out of support that cannot be patched

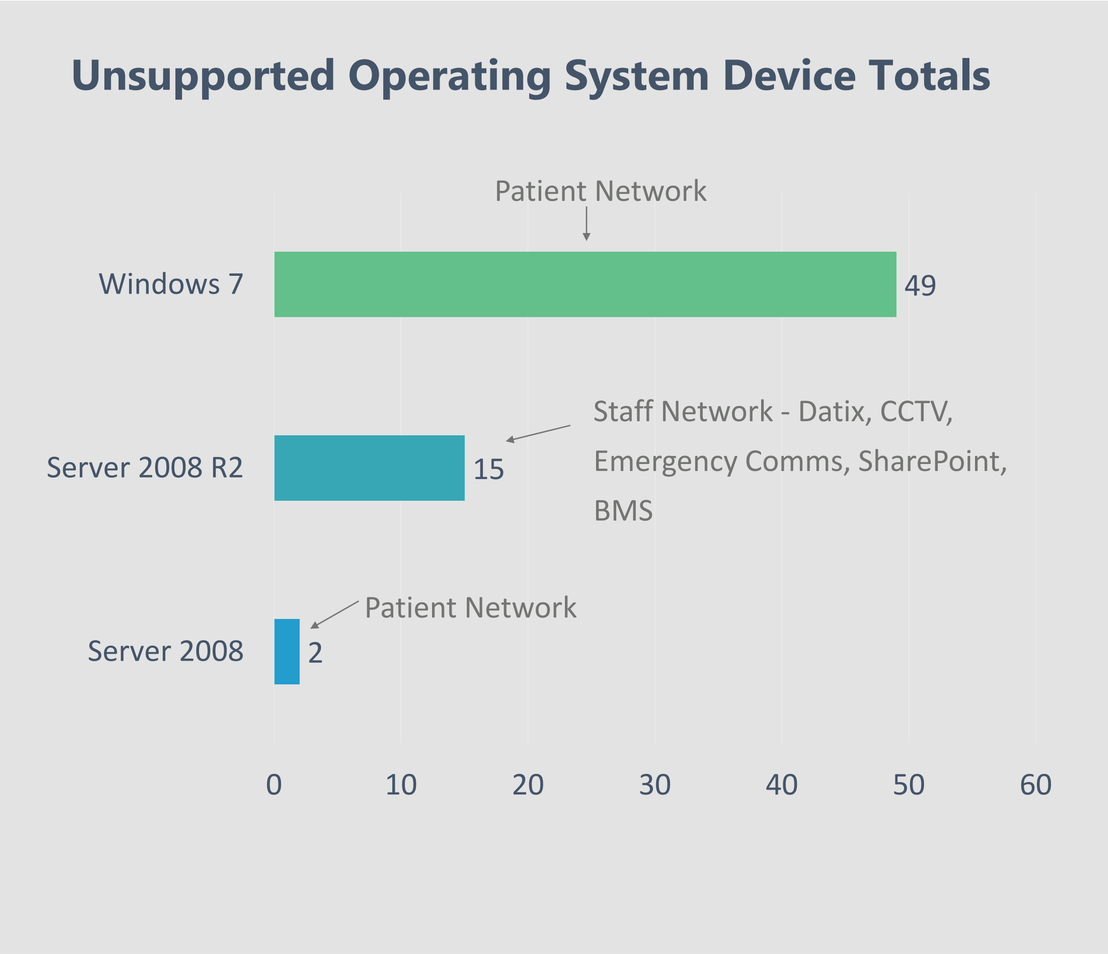


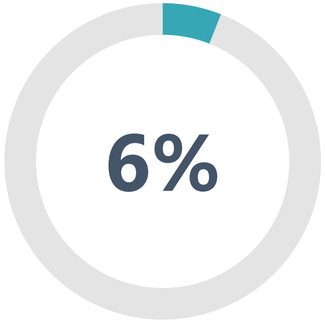
Anti-Malware Protection

All workstations and servers have anti-malware protection installed and fully operational

Security Ops

Securing our Devices – Unsupported Operating Systems

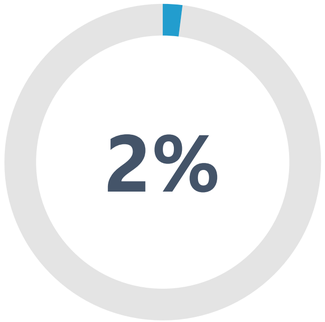




Servers

6% of our server estate is unsupported. These servers require upgrading or decommissioning. The servers include:

- Datix – (plans to move to Datix cloud)
- CCTV – (IT supporting Estates on the business case)
- Emergency Comms – (in flight project to resolve)
- Sharepoint – (Planned decommission)
- Building Management System – (Planned upgrade)



Client Devices

2% of our workstations are out of support. These are all on the patient network and are fully separated from the staff network. They all have anti-malware and are behind a perimeter firewall

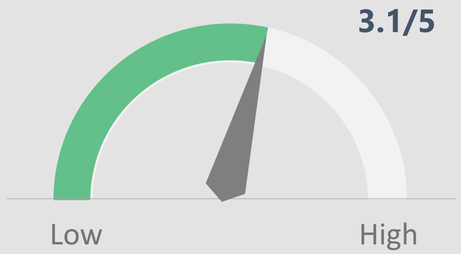
Governance

Cyber Security Maturity Assessment – 2021

Overall Cyber Maturity Score

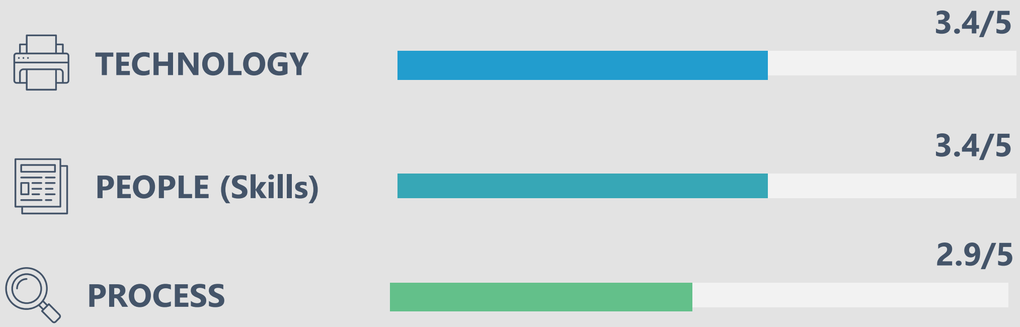
St Andrews Healthcare

INDUSTRY AVERAGE

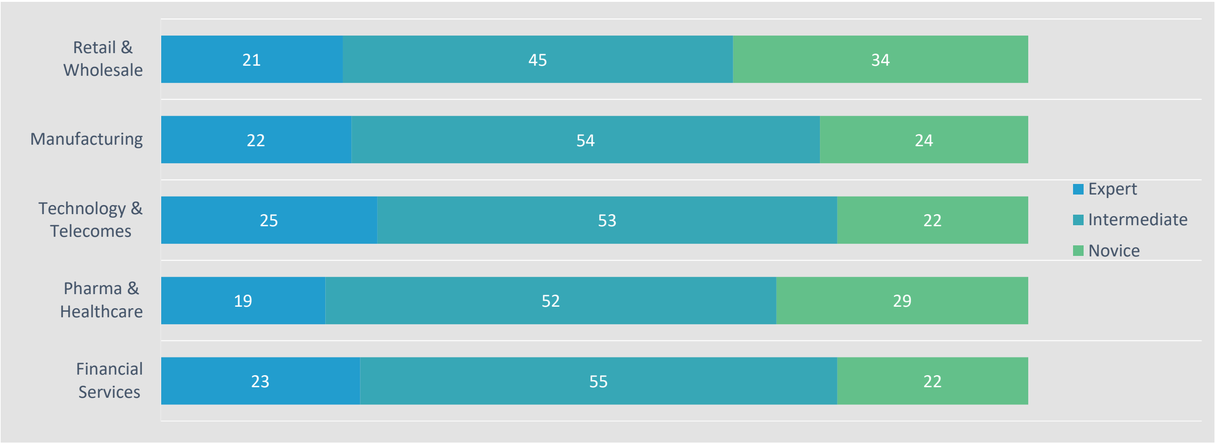


This puts St Andrews in the Intermediate category

StAH Scores per Section



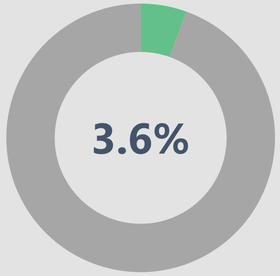
Cyber Maturity by top performing industries (%)



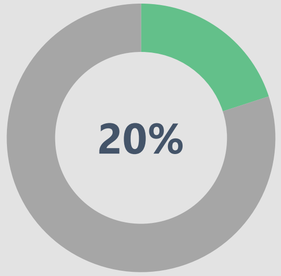
Novice = 2.5 and below
Intermediate = 2.51 to 3.9
Expert = 4 and above

% of IT budget devoted to cyber security in 2021

St Andrews



Average across UK orgs



The average across Healthcare in 2020 was between 4-7%. Given the budget, the security capability will struggle to mature any further

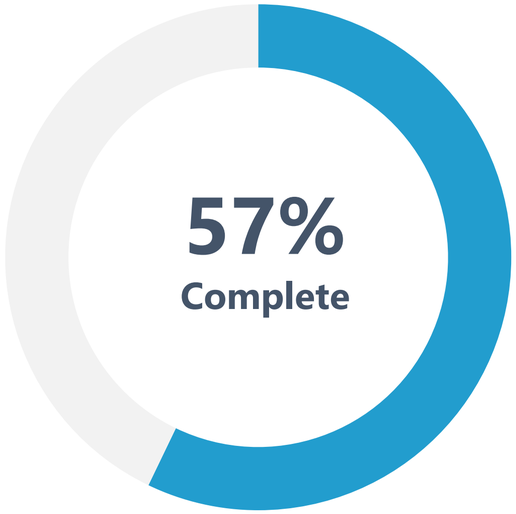
Compliance

Audit & Compliance

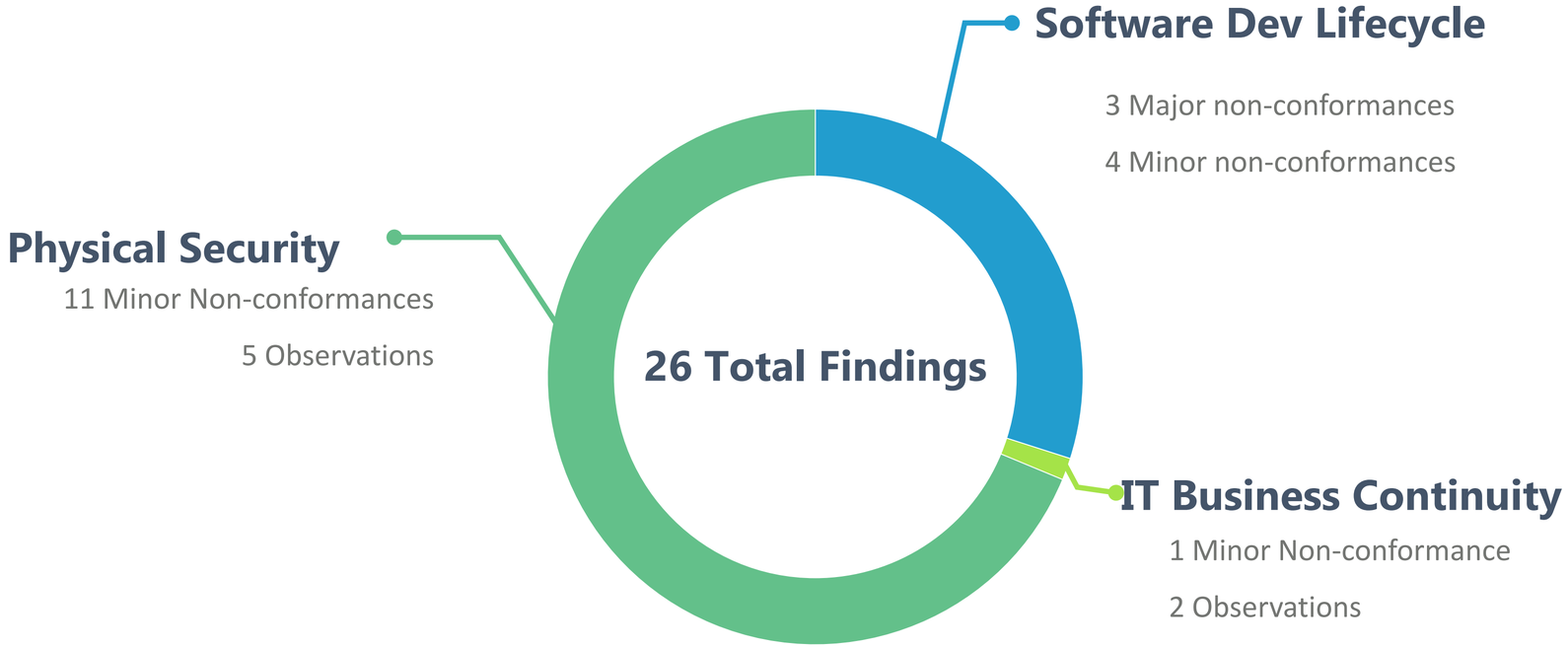
ISO27001 Internal & External Audits

Audit Completion

Planned activities for 2021



Open Audit Findings by Area



Upcoming Audits

- Access Control – September
- Re-audit of previous findings – October
- External ISO27001 audit - December

Finding Narrative

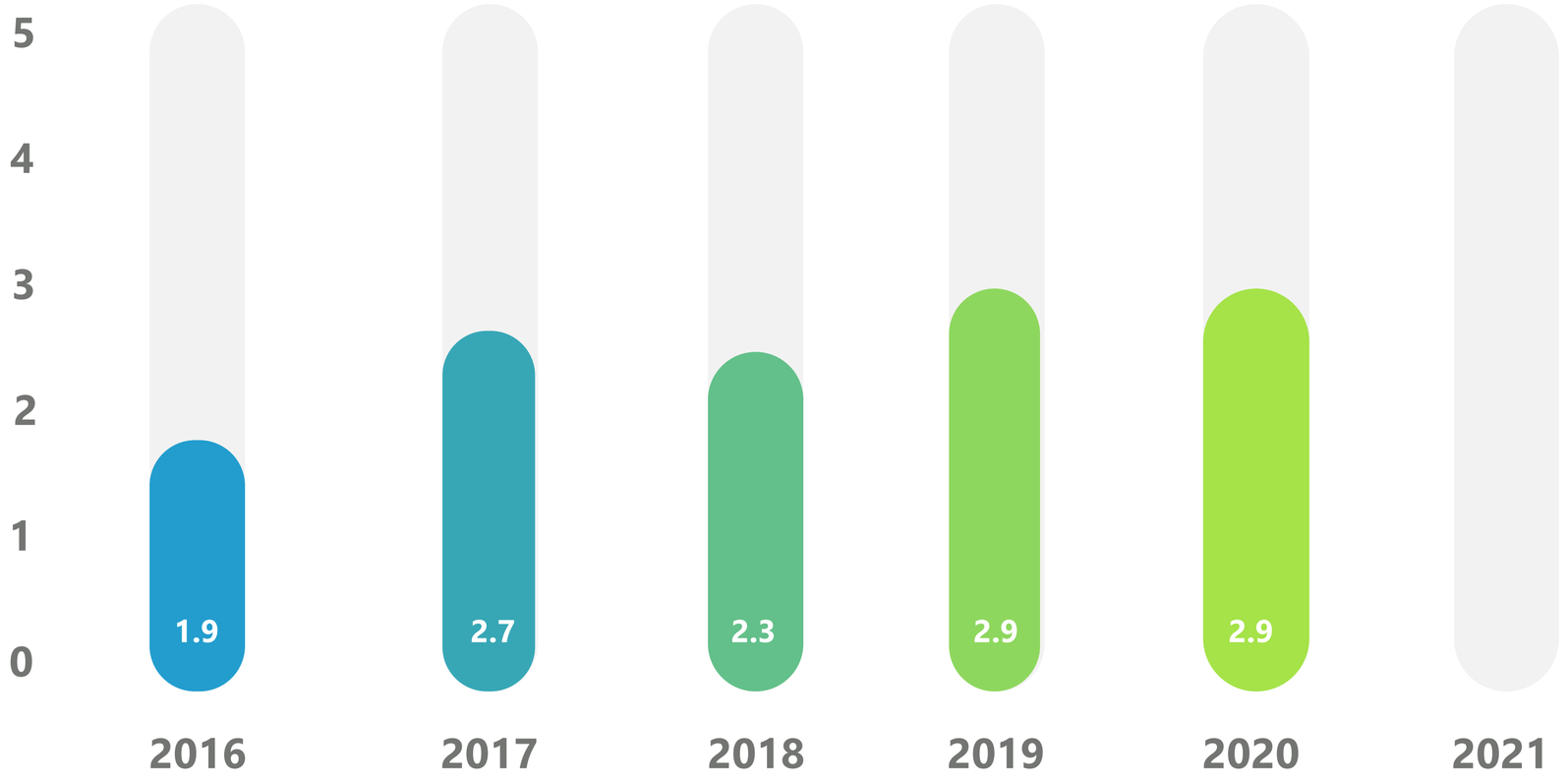
1. SDLC - Security Testing, Security Evaluations, Documentation
2. Physical Sec - Physical Security Perimeter, Physical Entry Controls, Delivery & Loading Areas, UPS, CCTV
3. Business Continuity – Redundancy (UPS)

Compliance

Control Maturity – ISO27001

Control Maturity Assessment – 0 to 5 (target of 3)

To achieve a rating of 5 the control has to have automation
We aim to have a rating of 3 across all controls under ISO27001



Significant digital change & resource issues which led to a breakdown in a number of controls

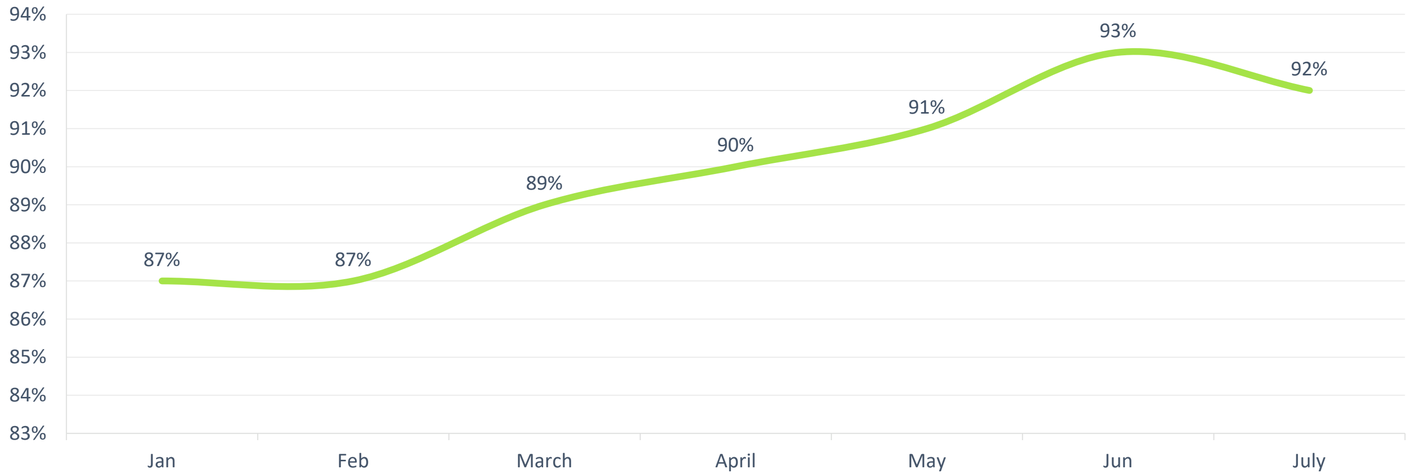
The current control categories that do not have a rating of 3 are:

- Software Development Lifecycle (In Progress)
- Vulnerability Management (In flight project)
- Identity & Access Management (relies heavily on SAP project)
- Network Security (In flight project)

Compliance

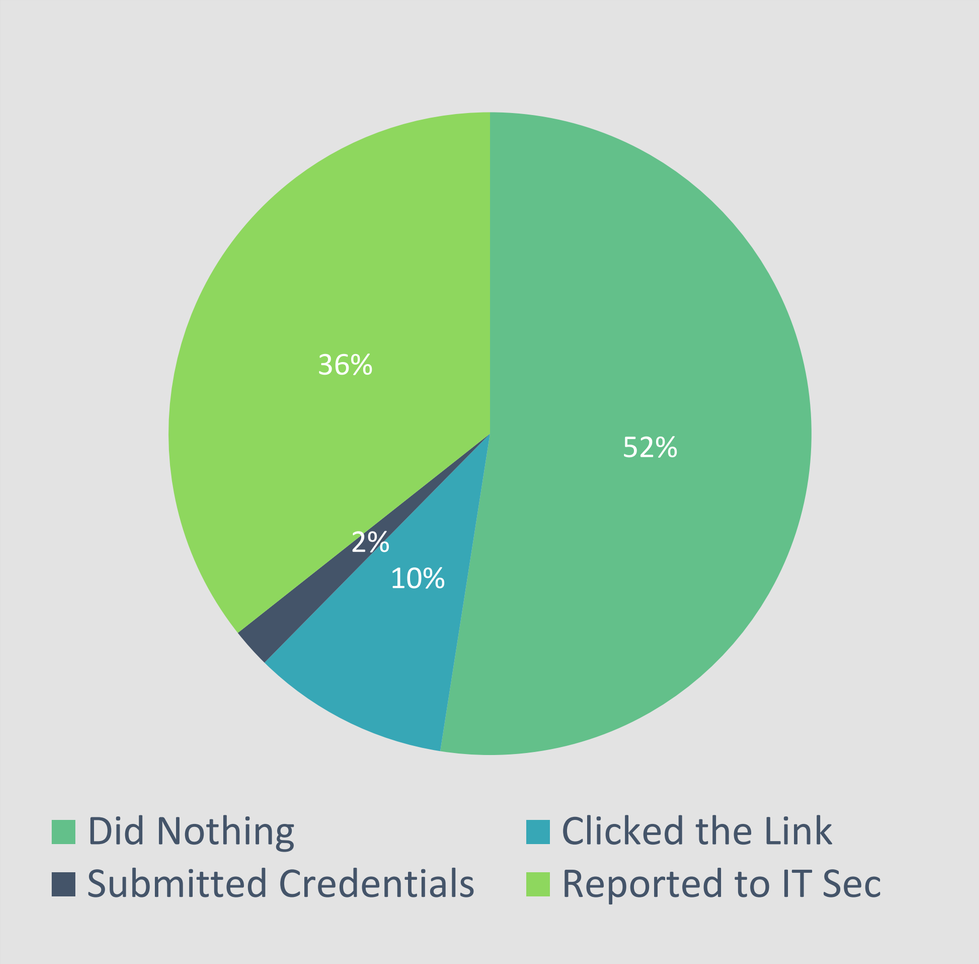
Security Awareness

eLearning Compliance - Trend



- As of July, 92% of all applicable staff have completed their cyber security online training
- There is more analysis being done around which departments are struggling with phishing awareness based on the recent simulation
- All individuals who did not follow the right process will be provided with additional awareness
- IT Security have created an Awareness Plan with a variety of methods to tackle the issues identified

Phishing Simulation Stats - July



Paper for Board of Directors	
Topic	Continuous Quality Improvement (CQI)
Date of Meeting	Thursday, 30 September 2021
Agenda Item	**14**
Author	Dr Ash Roychowdhury & Michaela Roberts
Responsible Executive	Sanjith Kamath, Executive Medical Director
Discussed at Previous Board Meeting	23 January 2020
Patient and Carer Involvement	Patients involved in co-produced initiatives
Staff Involvement	Staff involved in leading CQI initiatives, attending training and part of CQI monthly forum
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	N/A

Report Summary and Key Points To Note:

St. Andrew's has recognised the importance of embedding a culture of Continuous Quality Improvement (CQI) across the Charity and as such, has built this into its strategic vision and associated objectives. To really focus in on CQI as a vehicle to deliver important cultural change, improvements to quality, safety and patient outcomes, a small Continuous Quality Improvement Team has formed to commence the delivery of small change initiatives through cycles of PDSA and associated in-house training.

Our aim is to encourage strong local leadership through developing CQI Ambassadors, who can deliver our Quality Improvement (QI) training within their own teams, teams across the Charity, together with teams across our health and social care system networks. We will achieve this by building both individual, team and therefore the Charity's capacity and capability, through a systematic approach to using improvement tools and techniques.

To enable us to move from delivering in-house training to delivering accredited training, we are working with NHFT as a buddy NHS Trust who will assist St. Andrew's to become a QSIR (Quality Service Improvement Redesign) training facility and faculty. We are hopeful that our first cohort of staff will be trained early in 2022. Following this, we will be launching our own QSIR Faculty, and begin to roll a programme of QSIR training across the Charity.

Critical to this approach is a Board level CQI training session, to raise awareness of the importance of CQI and equip the members with core CQI skills, to facilitate the role modelling of CQI leadership.

Recommendations

The Board are asked to note progress and next steps to embed CQI, and endorse a Board level CQI awareness and training session, which will be co-faciitated by St. Andrew's and NHFT CQI teams.

Appendices

Developing a Culture of Continuous Quality Improvement

Dr Ashimesh Roychowdhury,
Deputy Medical Director

Michaela Roberts,
Head of Continuous Improvement & Transformation

30 September 2021

What is CQI?

An essential part of total quality management (TQM) that supports and is supported by other methods of improving quality:

St Andrew's HEALTHCARE

Key features

- A focus on ‘customers’: patient experience and outcomes
- Empowerment of employees to identify problems and act to solve them
- Use of proven QI methods e.g. PDSA
- Systematic, data guided activity
- Iterative development and testing
- Underpinned by beliefs and values (a culture): top leadership support, the power of daily incremental improvement by the many and not the few, solutions are more effective when from the staff/ patients closest to the problem
- QI initiatives are not projects; they deal with areas where a clear route to the goal is not known, and therefore resilience and tolerance for failure are essential
- A part of QI will be aligned to the key strategic priorities and issues arising from QA; most CQI should be happening, everywhere, every day as part of ‘the way we do things’

Why CQI

- National and international evidence base supporting the association of CQI and better safety, effectiveness and experience

- The CQC State of Care Report 2017 found that most outstanding trusts have an embedded CQI culture:

> *'When QI is used well, it gives us confidence about the long-term sustainability of the quality of care. More informally, when we visit trusts that have an established QI culture, they feel different. Staff are engaged, they are focused on the quality of patient care, and they are confident in their ability to improve. This is also reflected in surveys of staff and patient satisfaction'*

- Without CQI, even excellent quality planning and assurance will not deliver the Charity's vision of quality

Recap from 2019

- The Well Led inspection in 2019 gave us a real mandate to progress our CQI vision throughout the Charity.
- Our vison was to support our leaders from ward to board in delivering our mission to improve quality and safety, and embed CQI.
- By developing our CQI Engagement plan we aimed to promote opportunities for staff, patients and carers to get involved.

CQI strategic direction 2021

Our purpose is to be

a Charity that promotes wellbeing, gives hope and enables recovery

The Charity has set out its ambitions to in its recently refreshed Five-year Strategy, and Continuous Quality Improvement sits within the 'Leadership Voice' strategic priorities. Our CQI strategy to achieve this strategic vision is broken down into the following 4 objectives:

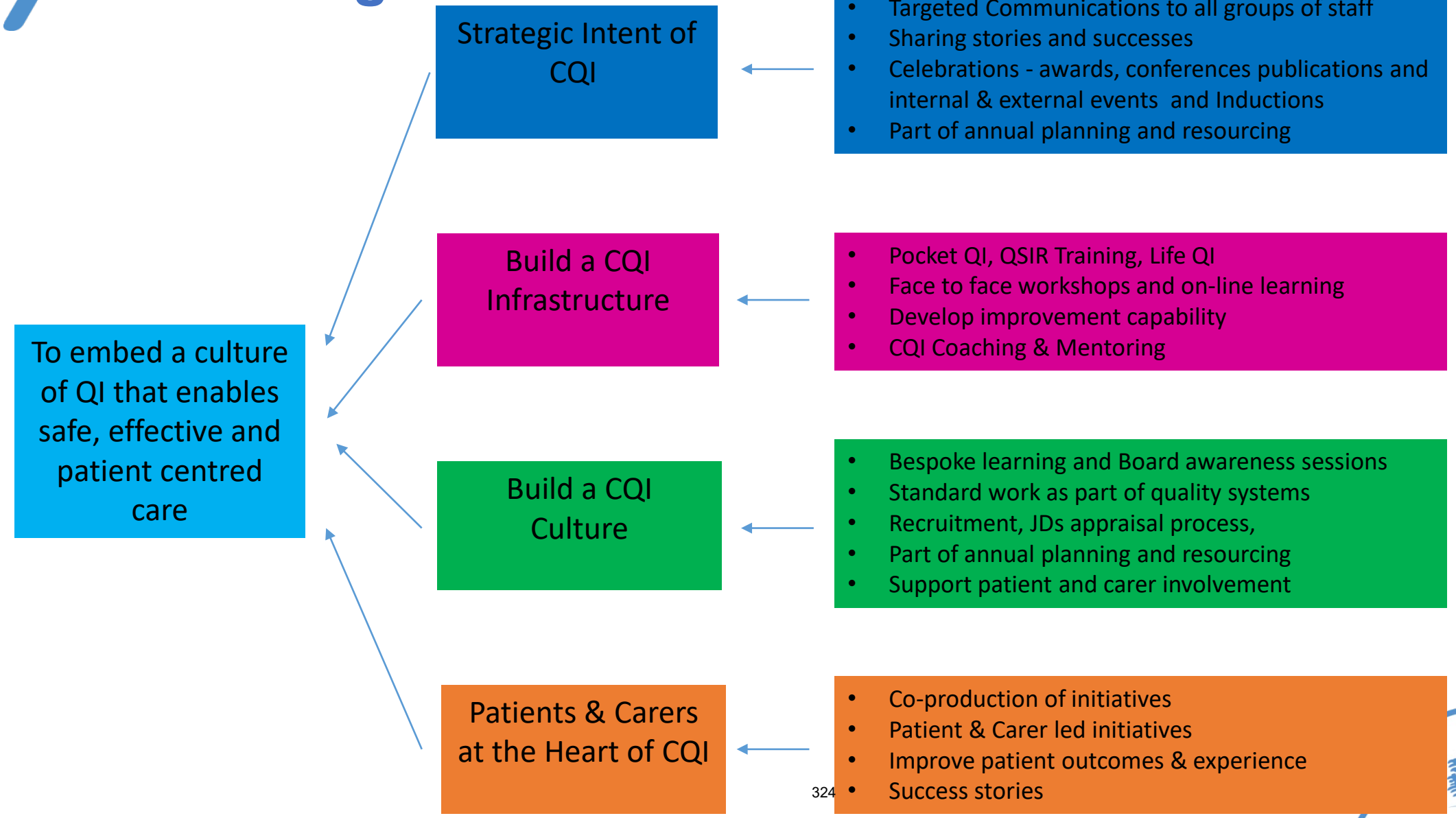
Strategic intent for CQI: Supporting leaders to explore and identify CQI opportunities linked to strategic and annual planning. Applied systems thinking which results in improvement beyond organisational or functional boundaries

Build a CQI infrastructure: Delivering a systematic framework for building and demonstrating a range of CQI skills for all levels, facilitating sharing learning and success

Build a CQI Culture: Delivering CQI by unwavering commitment from senior leaders, who model appropriate improvement focused leadership behaviours and visible hands-on-approach whilst building a culture of QI at all levels, which is modelled by our leaders empowering staff at all levels to engage with and become problem solvers

Patients at the heart of delivering CQI: Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient experience

Embedding CQI



St Andrew's HEALTHCARE

What's happening now

- Small CQI Team created to support early QI adoption across the Charity
- Team supports Model for Improvement methodology & PDSA cycles of change
- Range of tools, resources and QI reading materials available through CQI Intranet Pages
- CQI PDSA updates are reported through to Divisional Governance and QSG meetings via a CQI 'Dashboard'
- CQI Awareness month took place in September 2020, including Executive sponsorship, a CQI competition for best QI proposals, spotlight on the team, launch of intranet pages and a focus on some PDSA cycles
- Internal newsfeed of CQI success stories
- CQI embedded into development training (EVOLVE), and local and corporate inductions
- Initially working with NHSE/I colleagues, the CQI team have facilitated 7 cohorts of 5 day QI training, increasing CQI awareness and capability across all areas of the Charity
- By partnering with NHFT, we are planning to establish our QSIR Faculty, where we will be able to deliver the NHS Improvement QSIR Practitioner Programme throughout the Charity

Future plans

- With support from NHFT, facilitate a Board level CQI training and awareness session
- Initial cohort of CQI experts to commence QSIR Practitioner Level training, facilitated by NHFT
- Become a QSIR (Quality, Service Improvement and Redesign) registered training facility, set up a QSIR Faculty, and join the QSIR national network
- Cascade ‘dosing’ model of accredited CQI training across all levels of the organisation
- Right size resourcing and infrastructure to support CQI capability and growth
- Focus on building the CQI Capability at all levels of the organisation

Timeline for change

2019

- Journey for Continuous Quality Improvement commences
- Small team formed
- CQI awareness Month took place in September
- CQI tools and Information HUB launched
- Team focused on early change adopters using CQI tools and principles

2020

- Developed and delivered In-House CQI programme of change focusing on IPC improvements
- 2 Cohorts of training delivered
- Partnership relationship with NHFT commenced
- Dashboard of CQI change created

2021

- CQI included within Charity's Strategic Vision
- CQI training in-house continues
- CQI Forum launched
- NHFT agree to train initial QSIR cohort of StAH staff
- Develop our CQI Strategy
- Pocket QI established
- Medical Lead appointed

2022

- Initial cohort of QSIR P training takes place (facilitated by NHFT)
- Candidates undertake further QSIR training to become QSIR Associates
- QSIR Faculty is established
- CQI investment is secured

2023

- First Cohort of QSIR P is delivered within the Charity
- Demonstration of our improvement journey
- Improved patient outcomes
- Improved CQC ratings

2024 Beyond

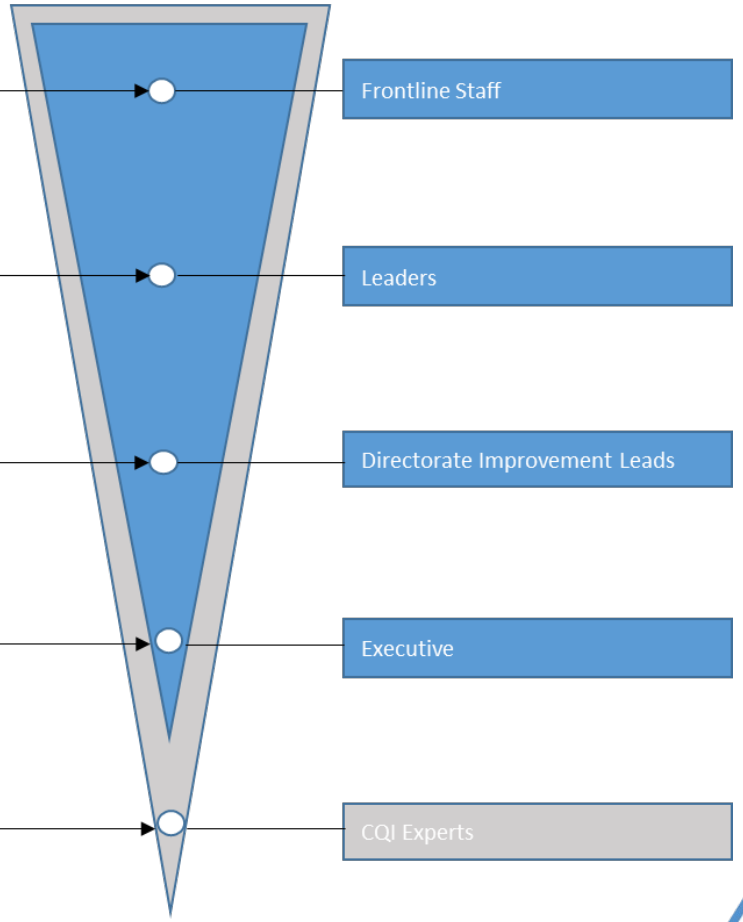
- Embed our approach to CQI and QSIR

St Andrew's HEALTHCARE

Capability

BUILDING CAPACITY AND CAPABILITY FOR CONTINUOUS QUALITY IMPROVEMENT

Where are we now, 2021	
New need recognised. QI awareness delivered as part of BAU. All new staff receive introduction to CQI at induction. Pocket QI.	**Requirement:** Introduction to quality improvement, identifying improvement, identifying problems, change ideas, testing and measuring change. **Estimated Number = 4000** **Time-frame = train 20-40% in 2 years**
In-House developed 'CQI Awareness Programme' being cascaded	**Requirement:** Deeper understanding of improvement methodology, measurement and using data, leading teams in QI. **Estimated Number = 200** **Time-frame = train 50% in 2 years**
New need recognised. QSIR Practitioner	**Requirement:** Deeper understanding of improvement methodology, understanding variation, coaching teams and individuals. **Estimated Number = 50** **Time-frame = train 50% in 3 years**
New need recognised. QSIR Practitioner	**Requirement:** Setting direction and big goals, oversight of improvement, being a champion, understanding variation lead. **Estimated Number = 10** **Time-frame = train 100% in 2 years**
New need recognised. QSIR Practitioner & Associate. Currently have a team of 3 WTE deployed to deliver CQI. Will need to build in more capacity to sustain training levels, manage governance and reporting.	**Requirement:** Deep statistical process control, deep improvement methods, effective plans for implementation and spread. **Estimated Number = 5 (3 CQI Leads, and 2 CQI Clinical Experts)** **Time-frame = train 100% in 2 years**



In addition, 1 CQI Advisor, 1 CQI Coordinator required to support Faculty/ Training

Continuous Quality Improvement

St Andrew's HEALTHCARE

Recommendations

- The Board are asked to endorse a Board level CQI awareness and training session, which will be co-facilitated by St. Andrew's and NHFT CQI teams

Questions from the Public for the Board

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public – 25th November 2021 9.00am

(Paul Burstow - Verbal)