CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Tuesday 24 August 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): Sycamore Service	Information	Alastair Clegg *(Dr Paul Stankard and Patient)*	✓	*4*	*9.01*
Administration						
3.	Declarations of Interest	Information	Paul Burstow		*5*	*9.25*
4.	Minutes from the Board of Directors Meeting in Public on 27 May 2021	Decision	Paul Burstow	✓	*6-16*	*9.27*
5.	Action Log and Matters Arising	Info & Dec	Paul Burstow	✓	*17-20*	*9.30*
Chair's Update						
6.	Chair Update	Information	Paul Burstow		*21*	*9.35*
Executive Update						
7.	CEO Report	Information	Katie Fisher	✓	*22-28*	*9.40*
Operations						
8.	Performance Report (including Finance and Covid-19 response)	Information	Alastair Clegg, Alex Owen & Sanjith Kamath	✓	*29-36*	*9.50*
9.	Staffing Action Plan	Info & Dec	Andy Brogan & Alastair Clegg	✓	*37-39*	*10.10*
Quality						
10.	Mortality Surveillance Report	Decision	Sanjith Kamath	✓	*40-46*	*10.25*
People						
11.	Armed Forces Covenant	Decision	Jess Lievesley (Catherine Vichare)	✓	*47-54*	*10.35*
Regulatory						
12.	Responsible Officer Regulations – Appraisal and Validation	Info & Dec	Sanjith Kamath	✓	*55-72*	*10.40*
13.	Caldicott Guardian & Senior Information Risk Owner Annual Report	Info & Dec	Andy Brogan & John Clarke	✓	*73-78*	*10.50*
14.	Modern Slavery Act Renewal	Decision	Martin Kersey	✓	*79-81*	*11.00*

Governance / Assurance						
15.	NHS Providers Board Development Programme	Information	Katie Fisher		*82*	*11.10*
16.	**Sub Committee Updates** • Quality and Safety Committee (June) • Quality and Safety Committee (August) • Pension Trustees • Audit and Risk Committee (April) • Audit and Risk Committee (August) • Research Committee • People Committee	 Information Information Information Information Information Information Information	 David Sallah David Sallah Martin Kersey Elena Lokteva Elena Lokteva Stan Newman Paul Burstow	 ✓ ✓ ✓ ✓ ✓ ✓ ✓	*83* *84-85* *86-88* *89* *90-92* *93-96* *97* *98-99*	*11.20*
Any Other Business						
17.	Questions from the Public for the Board	Information	Paul Burstow		*100*	*11.35*
18.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*101*	*11.40*
19.	Date of Next Board Meeting in Public - Thursday 30 September 2021 9.00am	Information	Paul Burstow		*102*	*11.45*
Meeting Closes at 11.45 pm						

Welcome and Apologies

(Paul Burstow – Verbal)

Divisional Presentation (including patient voice) Sycamore Service

Alastair Clegg, Chief Operations Officer
Dr Paul Stankard, Clinical Director and Patient

(Presentation on the day)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 27 May 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

Thursday 27 May 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
Katie Fisher (KF)	Chief Executive Officer
Jess Lievesley (JL)	Deputy Chief Executive Officer
Alex Owen (AO)	Chief Finance Officer
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director
In Attendance:	
John Clarke (JC)	Chief Information Officer
Duncan Long (DL)	Company Secretary
Gary Stobbs (GS) Item 2	Hospital Director - Essex
Annymn Adams (AA) Item 2	Senior/Lead Occupational Therapist
Tom Bingham (TB) Item 14	Director of Communications
Jo Lehmann (JLe) Item 14	Senior External Communications Manager
Melanie Duncan (Minutes)	Board Secretary
Apologies Received:	
Stanton Newman (SN)	Non-Executive Director
David Sallah (DS)	Non-Executive Director
Alastair Clegg (AC)	Chief Operating 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. PB introduced himself and welcomed a number of observers, both from our Court of Governors and from other organisations that are interested in our work.		
DIVISIONAL UPDATE			
2.	**Divisional Presentation (including Patient Voice): Essex** JL introduced Gary Stobbs, Hospital Director (GS) and Annymn Adams, Occupational Therapist (AA), who provided a presentation highlighting the work being done by the Occupational Therapy team, coupled with the way Essex has coped during the last year. Unfortunately, despite the opportunity having been made available to them, no patients were able to take part in the presentation. AA outlined the presentation, explaining how it covered an integrated approach to treatment, utilising the 5 functions described by Linehan (1993): • Enhancing capabilities • Enhancing motivation		

- Ensuring generalisation
- Structuring the environment
- Enhancing therapist capabilities and motivation to treat effectively

AA gave some focus to the Green Gym, which was recently developed. This project gave scope for growth and was developed by Graham, a Technical Instructor with everything being built by the service users themselves using recycled materials. There has been good feedback from the service users especially regarding learning new skills and how the team members acted as role models; this was integral to preparing patients to become productive members of society via having the opportunity to work and develop the skills required.

AA explained that consistent engagement resulted in responsibilities being granted for the service users, this was then utilised to recognise when they were ready for the next stage consisting of a more structured and vocational skills programme. AA then showed a video on New Life Wood which was a charity that was being worked with in order to help with skills development. AA highlighted that education was the next level of development. All the activities run in Essex were linked to an education course. She noted that some service users in the past would not have had a formal education, and that learning in a fluid way helped with preparation for more formal qualifications in the future. This in turn allowed service users to look for jobs in the community, or to enrol in mainstream education.

AA then highlighted the impact on physical health that some of their collaborations had had, one was where they had liaised with Cycling UK and as a result of this, Essex were looking to form their own cycling club with staff members who could learn to be leaders. Coupled with this this, they were looking to develop part of the grounds for a cycling path for those patients who could not use the open road. Staff enjoyed the co-production work with other charities which increased the profile of the hospital and challenged the stigma around mental health. AA also covered how Essex was addressing sustainability. Everything being built was sourced locally and from reclaimed materials; a bike shed was being built using wood from New Life Wood for example. In comparison, to buy a ready-made bike shed would have cost four times more than the actual costs. The pride that the service users felt when they helped to build something was worth it.

AA concluded with the four themes from the presentation.

- To ensure all patients maximise their potential
- Integrated working and co-production
- Seek creative ways to enhance patients' experiences
- Promote physical health.

PB thanked AA, and noted that he was looking forward to visiting Essex in the near future. SK extended his thanks for the work being done and was pleased to see the Five Function approach used in practice. KF also thanked AA, noting that she could only imagine what the service users would have talked about and the pride felt by them. EL offered her thanks adding how she would be grateful to hear how the patients developed in the future, and how the skills they had learned had been applied.

AL also thanked AA, and asked about when the idea was started, and who helped them develop the practical aspects of the ideas. AA replied that these were developed by using activity analysis in conjunction with a technical leader using the model of creative ability. Then, by working with and looking at the patient, assessing how they can apply what they know and how they can achieve it safely. There were allocations of tasks across abilities in order to make the project happen.

MK thanked AA for her presentation and the passion shown particularly with how the activities had been linked to education. MK offered a suggestion regarding cycling away from the site in Essex. AA replied that unfortunately not

	all patients have Section 17 leave granted, which is why it's perfect to have a path on-site, noting that she did not want them to lose out on taking part in this activity. SRW asked how many people were involved in these activities. AA replied that approximately 60% of patients were involved with gardening across the whole site, even those patients who were ward based, including PICU, had access to this type of activity. AA extended an invitation all to Directors to visit Essex, particularly when many things were planned for the end of June, including the grand unveiling of the Beach Garden. PB enquired regarding the five elements of the model being applied and was interested in the reference to generalised ability being key to recovery in the community, he particularly wanted to know how it was assessed that we were equipping people with this. AA outlined that assessment was made by checking how safe people were by going back into the community. They were given the ability to access public services, starting internally and then developing into going outside the hospital environment. AA gave an example of work with one patient where his interests involved swimming, and how his skills developed over a period of time utilising visits to the swimming pool. GS concluded by thanking AA, adding that it was a shame that the service users could not have been there to show the passion already evidenced, and that he was incredibly proud of the team and the work they did. PB added that it was very helpful to have such a good presentation and that he would love to meet the patients when he next visits.		
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 25 March 2021** The minutes captured at the meeting held on the 25 March 2021 were **AGREED** as an accurate reflection of the discussion, subject to the following change: • Page 12 – Line 3 – remove "not"	**DECISION**	
5.	**Action Log & Matters Arising** 24.09.20 **01 -** Board Development Plans – It was **AGREED** that this action will remain **Open** subject to the completion of the governance review 26.11.20 **01 -** Board Seminars – It was **AGREED** that this action will remain **Open** subject to the completion of the governance review, although a number of sessions have now been scheduled for a variety of purposes, including Board level mandatory training 26.11 20 **04 -** NED Ward Visits – It was **AGREED** that this action will remain **Open** 28.01.21 **01 -** Divisional Lessons Learned – It was **AGREED** that this action will remain **Open** 28.01 21 **05 -** Veteran's Services – It was **AGREED** to **CLOSE** this action. The action was covered at the last People Committee and is included in the People Committee update	**DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION**	

	28.01.21 **06 -** Community Services – It was **AGREED** that this action will remain **Open** 25.03.21 **01 -** Performance Report, Benchmarking – It was **AGREED** to **CLOSE** this action, The item is included within the meeting agenda 25.03.21 **02 -** Transformation Programme Progress Updates – It was **AGREED** that this action will remain **Open** and is due at the next Board meeting 25.03.21 **03 –** Patient, Carer & Employee Promise – It was **AGREED** to **CLOSE** this action. The item is included within the meeting agenda.	**DECISION** **DECISION** **DECISION**	
CHAIR'S UPDATE			
6.	**Chair Update** PB gave his update to the Board, beginning with the annual update on the Fit and Proper Persons Declarations. He explained that the report set out the new process and that St Andrew's Healthcare had a Board composed of Fit and Proper persons and that therefore, assurance is given to the Board. PB then wished to note that as we moved out of lockdown, he has taken the opportunity to be on-site more regularly, visiting wards, with more planned in June. He has found that through engaging with the leaders on the wards he can see the impact that the pandemic has had on our staff and patients, but also the engagement with the rightsizing and transformation projects taking place. However, he noted that although there were a lot of very tired staff, they were looking forward to the future. Not least in our PICU units. The Board **NOTED** the update and **ENDORSED** the Fit and Proper Persons Declaration	**DECISION**	
EXECUTIVE UPDATE			
7.	**CEO's Report** KF presented the report which was taken as read. She highlighted item 2 of the report which covered Health and Safety, and noted that we had been awaiting a report from HSE following their last site visit which has now been received. As part of this report, an improvement notice had been received specific to Board related health and safety training. KF reported that this had now been arranged for 05 July. KF wanted to assure the board that this was the only improvement notice received and that the training was already in hand. AL commented regarding item 5 of the report, noting that the Board Strategic Review Group had taken seriously the post Covid world and that it should be a key part of the strategy for the Charity in the future. AL wished to show his support for this. EL noted that she was pleased to read the discussions and feedback from CQC for the progress made. She enquired regarding the food element of the patient feedback and asked what the main reason was for the deterioration in quality and was anything being doing to address it. KF clarified that there had not been a deterioration in quality, agreeing that this was important. She added that there was always a wide range of opinion on food, and a lot of the feedback centred on greater choice and a desire to have healthier options available. KF explained that there was a project underway and that a trial had been done using a different catering option. It was during this trial that it became obvious that the proposed option was not a better option particularly as a result of the feedback received from patients and staff. KF noted that Facilities were looking into developing the existing offering, and giving greater flexibility across the mealtimes.		

	KF also noted that St Andrew's were are now looking to welcome NHS Wales to Northampton on 7th and 8th June for a visit to the site. The Board **NOTED** the report and the Board Health and Safety training scheduled for July.		
8.	**East Midlands Board Paper in Common** KF presented the paper which was taken as read, explaining that these Board Papers in Common were circulated by the East Midlands Alliance for Mental Health and Learning Disabilities in order to update all board colleagues from all 6 organisations at the same time. KF was pleased to bring the Board's attention to the unanimous decision of the Alliance that the recruiting of an independent Chair is to be facilitated by St Andrew's and that St Andrew's is to host the employment of the new Chair on behalf of the 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. He wanted to note that this paper should not be taken lightly, that this report demonstrated the leadership and input that St Andrew's had in this forum. JL took the **ACTION** to organise this session with PB and DL. KF added that she would like to get all 6 boards together, and that this was still being worked on. PB concluded that there was a marked shift in the input of St Andrew's in the last 12 months, and the significant position now held by it was noticeable. PB highlighted in particular the restrictive practices and technology in seclusion workstreams that the Charity had been involved in. The Board **NOTED** the report	**JL**	**30.09. 21**
OPERATIONS			
9.	**Performance Report (including Finance and Covid-19 Response)** SK presented the report which was taken as read, noting that this was the first presentation of the report in this revised format and that it now included target lines. He pointed out that he wanted to demonstrate the targets in principle at this stage and that they would be agreed at the Quality Safety Committee in future. SK highlighted that there had been a significant rise in incidents which needed to be taken into consideration, however, the harm and seriousness of incidents was low. This increased level of reporting has been welcomed, and we have offered NHSE/I the chance to scrutinise our Serious Incident data for external validation. SRW noted that the incidents and restraints graphs were similar and asked if they were related. SK confirmed that there was a correlation, adding that a large number of restraints are planned, so were recorded twice. EL thanked SK for a clear report and enquired regarding trends, wondering how the data was cleansed and could the trends be disturbed by new patients. SK explained that the report was trying to control for acuity and that it could be clearly seen when a new patient arrived, adding that EL was correct, and that a stable set of data would become more evident as a patient settled in. One way of mitigating this was a stratified set of data, and that a composite measure was being worked on. EL was concerned on how the nuances would appear. KF explained that some new wards had been developed, with some that cater for individuals with highly bespoke packages of care; these would affect the data. We are looking at how we can accommodate these type of influences in our data.		

	SK noted that it was important to keep the Charity's purpose in mind and that one problem with targets was that patients could possibly be curated accordingly to keep the numbers low. Those instances would deprive a large number of people of the care that we can provide. AL concurred with SK on this point. PB enquired regarding seclusion events together with the causes and effects and was wondering how these were reflected with regard to the issues on Sycamore and wanted to know more. SK explained that the patient presented with a particular set of challenges, and as a result, Sycamore was almost a ward for one individual, hence the care was more intensive. There was a specific mode of treatment required, which the team had to administer which took a few weeks to embed. The situation was being watched closely, the reductions would become apparent, but not immediately.		
	Covid-19 Response Update SK then went on to present the Covid-19 update which was taken as read and reported that the data was showing that the second wave of infections appears to be nearly over however, he wanted to note that the Charity was not being complacent, and that high levels of IPC monitoring were still in place with PPE supplies remaining high. With regard to vaccinations, the second phase was proceeding well with no adverse incidents, good uptake and in line with the government's expectations. AL enquired regarding Birmingham, asking if the numbers being vaccinated had improved, and if SK had any thoughts on how we could encourage uptake. SK replied that overall the West Midlands did have lower rates. A lot of intensive work had been done locally. In Northampton, we have control over the programme as we were a vaccination hub, but this was not the case in Birmingham, where we had to rely on staff going externally, with some staff keeping their vaccination status personal. Vaccinations are highlighted whenever an Executive is on site. AL asked if there was a point where we could reflect on where we were. SK clarified that we wouldn't be able to reach a point where we could quantify a figure as the situation continued to change. KF noted that there could be a problem if vaccinations became mandatory like Hepatitis. This topic was being debated currently. She added that the work to encourage vaccine update would continue in the meantime. PB raised the issue of disclosure, noting that employees do not have to disclose their vaccination status at the moment. However, if they do contract the virus, how could this affect their personal liability? SK explained that there was one step prior to this which involved risk assessment where we would have to check our obligations regarding placing an employee that was not vaccinated in a high risk environment. Discussions on this topic are being had with HR internally. We are nevertheless still in a better position than we were previously. AB wished to remind the Board that whilst things were looking at relaxing with freedoms opening up, the rules for the public were not the same as they were for healthcare professionals. It was important to understand that PPE and IPC controls were still in place. AB also noted that he would be issuing further guidance for visitors, Non-Executive Directors and Governors alike. The Report was **NOTED** by the Board		
QUALITY			
10.	**NHS Benchmarking Network** SK presented the report which was taken as read, highlighting that previous discussions on this had been had by the Board, and that in the past, problems had been encountered in gaining meaningful data to work with. This has now been worked on with NHS Benchmarking. SK outlined that he and AB had met with NHS Benchmarking and agreed the data sets and the likely timescales for		

	receipt of the data. NHS Benchmarking have offered to present to QSC (and Board if required). He added that it was not the purpose to produce targets, but to allow us to ask questions if results show that we need to compare to the wider NHS. This will be very helpful. 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. The Report was **NOTED**	**DL**	**25.11.21**
REGULATORY			
11.	**Quality Account update** AB presented the paper which was taken as read and gave an update explaining that the Charity was required to produce an annual Quality Account as a result of the Charity offering services that had been commissioned by the NHS. He added that reporting timescales had been affected this year by the pandemic. He explained that the content of the report was unlikely to change, there are three main parts. With part one covering the past year, part two concentrates on priorities for the coming year, which include; getting the basics right; improving engagement with patients and carers; and supporting our staff. AB noted that it may not seem ambitious, but it is ambitious and this is what we should be aiming for if we wanted to be outstanding. Part three covers the Assurance Statements which indicate our current position in terms of Quality AB recommended Board sign off, and accepted that an Extra-ordinary Board Meeting would be required due to timescales regarding presentation to Quality Safety Committee being taken into account ahead of submission by 30th June AL noted that having as much done as possible beforehand would help, including queries and questions. KF agreed with AL and suggested that the minutes from Quality Safety Committee would help greatly with the discussion as well. AB agreed that It was a challenge to develop this report in the timescales given, especially under the current circumstances. PB noted that the report required the appropriate levels of scrutiny, in conjunction with the most recent minutes from Quality Safety Committee. PB asked DL to schedule an Extra-ordinary Board Meeting via Teams as close to June 30th as possible. PB then asked a question in relation to the content of the report and asked for clarity on 'never events' and how they are viewed within the environment of St Andrew's. AB explained that these included events such as ligature death, and that very few of the national list of never events applied to us as a mental health provider with most of the list relating to physical healthcare. The Board **NOTED** the update.	**DL**	**30.06.21**
12.	**Data Security and Protection Toolkit** JC presented the paper which was taken as read, and outlined that this paper was produced each year ensuring that, as required, we are demonstrating that we continue to meet the NHS standards in-line with our contract. A significant element of meeting the standards is our compliance with the ISO certification. This year a full re-certification has been undertaken and no comments or non-compliances were received from ISO. Internal audit had also checked elements of this report for further assurance. JC outlined that he was looking to extend ISO certification in the future to cover privacy which was a new element and over and above the NHS requirements. This would give would give greater assurance externally. JC noted that the response had been delayed due to the pandemic and that submission would be made in June. Majority of organisations have had the same issue in relation to achieving the mandatory training levels required ahead of submission and		

	the delay till June allows this to be achieved and was recommending to the Board that we submit as "Standards Met". AL wished to make a note regarding Board oversight, mentioning that other organisations usually had a one-pager submitted to the Board on a regular basis. He wanted to note that no regular reporting goes to Board at the moment regarding data and system integrity. JC replied that in terms of assurance, there was an assurance group internally which covered this, and that previous reporting had been done on an annual basis to Board. He noted that he would be happy to report quarterly with a performance report by including additions to existing reporting that was undertaken. AL noted that it was important that this data reporting was not lost and embedded within other reports. JC added that 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. The Board **APPROVED** the submission.	**JC** **DECISION**	**30.09.21**
GOVERNANCE / ASSURANCE			
13.	**Sub Committee Updates** **People Committee -** PB presented the update which was taken as read. AL requested that employees be referred to as colleagues. PB replied that staff had been consulted on this and that their preference was employees, with MK confirming this. The Board **APPROVED** the Employee Promise and the Report was **NOTED.** **Quality & Safety Committee -** SK presented the update which was taken as read. He noted that the Committee had discussed for escalation the acuity problems within CAMHS, particularly where a few patients who were admitted together all required high levels of enhanced support. SK noted that support for the division was ongoing. He also updated that a new Psychiatrist was being recruited and would be in role shortly. The Board **NOTED** the update. **Audit and Risk Committee -** EL presented the update which was taken as read, noting that the previous meeting of the Audit and Risk Committee had been dedicated to planning for year end. ARC had approved the PwC Audit plan which proved to be highly comprehensive. Also approved was the Counter Fraud Plan. EL noted that the Committee remained conscious that risk management could only offer partial assurance. Active risk management is required and this should be in place by July. The Board **NOTED** the update **Research Committee -** SK presented the update which was taken as read. He noted that 2 interesting presentations had been received, including 1 from Professor Glasby from Birmingham that described the experience of patients with LD & ASD through medium secure care. A number of research projects have been delayed due to Covid, with researchers unable to come on-site. A new refreshed strategy for Research is due to be done by the end of September. SK extended thanks to Sir Peter Ellwood for his Chairing of the Committee, noting that it was this that had moved the Research function forward. The Board thanked Sir Peter as a whole. Professor Stanton Newman has assumed the Chair position of the Committee. The Board **NOTED** the update **Pension Trustees -** MK presented the update which was taken as read, and commented that there was nothing further to add.	**DECISION**	

	The Board **NOTED** the update		
PATIENT / CARER VOICE			
14.	**Service Presentation – DBT Patient Journey video** JL introduced Tom Bingham (TB) and Jo Lehmann (JLe) from Communications. TB gave context regarding the video, explaining that this was part of a programme designed to educate and de-stigmatise, but also to humanise the Charity and help with staff morale. This was about reminding staff what a great job they do. TB thanked all the patients involved in the making of the documentary. JLe was then joined by Kayleigh (a patient), noting that they had been listening to what the Board had been talking about and that it was a good way to involve patients to show their journey and recovery process. The Board was shown a clip of the documentary which would eventually be 15 – 20 minutes long. Following the clip, JLe said that she had been working with Kayleigh for a couple of months and that this was an observational documentary aimed at trying to raise awareness of mental health. Kayleigh gave an outline of her time with St Andrews, and next steps in her recovery. She said that the documentary gave her a chance to reflect on her recovery in a positive way. PB thanked both, raising the question that if the video could have been more than 15 minutes long, what else would they have liked to have seen within it. Kayleigh said that she felt it covered everything she wanted it to. JLe explained that the challenge was showing the array of therapies available at St Andrew's, and that due to patient confidentiality, this could not always happen. Kayleigh spoke about how DBT had helped her in her recovery and changed her life. If it wasn't for St Andrew's she didn't know where she'd be. SK noted that he was pleased to see Kayleigh doing so well and thanked her for the video. JL expressed his thanks to JLe and to Kayleigh, noting that things were starting to change regarding talking about mental illness he acknowledged how brave it was of Kayleigh to do this. AB commented that he liked the style of the documentary, as trying to get messages across can sometimes reinforce the stereotypes, but that this did not do that. This gave a positive way of looking at mental health, that these were people with skills not problems. He asked JLe why she chose that style. JLe replied that a lot of work had been done around other campaigns and in order to capture what happened, it needed to be observational, involving filming over a longer period of time. She was conscious that she did not want this to look staged in any way. JL noted that the filmmaker used had previously worked with the BBC and C4. AL noted that it was really pleasing to see how Kayleigh had been given the opportunity to follow a passion and that that was what was important in allowing Kayleigh to see a path and create motivation; those pathways were so important. AL asked JLe if she could explain how she intended to use the documentary, who would see it and what would be the objectives. JLe replied this would be St Andrew's owned; that we wanted to retain control. It would be used across all social channels. PR would also be a part of it. It was hoped that an opinion piece would also be done in the press. Local press and radio would definitely see it. TB added that internally, the staff would see these documentaries in order to underline what a great job they were doing. TB asked if the Board could talk about this externally. PB agreed with TB, and pledged to speak about the upcoming documentary. AL noted that it could be used to raise money for projects. KF thanked Kayleigh, noting that it took so much courage to do what she had done. It had touched so many people in such a positive way. Kayleigh was a good role model. KF noted how grateful the Board were, and wanted Kayleigh		

	to know how much this was appreciated. KF asked that if the clock was rolled back, what would she have found useful to hear from St Andrew's; how could we help others? Kayleigh said that more information about St Andrew's would have been helpful at the time of admission, showing what was on offer, and explaining the ward environments. KF thanked TB for giving service users a voice. PB asked Kayleigh regarding her college placement and a business course she had mentioned, asking what her future hopes were. Kayleigh replied that she wanted to do catering and business studies as she wanted her own restaurant. PB asked that this video be shown at the upcoming Court of Governors. PB thanked Kayleigh, TB and JLe.	**DL**	**25.06.21**
ANY OTHER BUSINESS			
15.	**Questions from the Public for the Board** No questions were received for the Board.		
16.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
17.	**Date of Next Meeting :** Board of Directors, Meeting in Public – Thursday 29 July 2021		

Approved – 29 July 2021

……
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
24.09.20 **01**	**Board Development plans** EL asked for dates for the Board development programme to be block booked. DL agreed and he would look at whether this could be achieved by using the second half of a standard Board day or by linking into the strategy days.	DL	16.12.20	Open	**Ongoing** - Previously agree at January Board for action to remain open pending completion of external governance review.
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.
26.11.20 **04**	**NED Ward visits** It was agreed that alternative options for completing virtual ward visits were needed, along with adequate PPE and IPC related training for those NEDs completing on site visits.	AC	28.01.21	**Closed**	AB to provide guidance for NEDs to enable in person visits to recommence and for this to be in compliance with IPC requirements. **24/08:** IPC guidance has been issued, along with guidance on how to review the service when on site **Propose action is closed**
28.01.21 **01**	**Divisional Lessons Learned** Following assurance that issues highlighted in relation to the Mansfield closure and relocation of patients, the Board requested a comprehensive review be held at the end of the capacity creation project and all ward moves are completed. The Board is seeking assurance that lessons are learned across the Charity and lines of sight on this are to be maintained by the	DS/SK/AB /AC	27.05.21	Open	**Ongoing:** AB - The capacity project is still ongoing and the review will commence once it is complete. **24/08:**

	Quality Safety Committee (QSC) for future reporting to the Board.				
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. **24/08:** This will be factored into the Board forward agenda and dates are being agreed between the CoSec and service
25.03.21 **02**	**Transformation Programme progress updates** SN commented that it would be helpful to see what the situation looks like before and after (transformation) to the wards and to see them as milestones. PB agreed with this view. AL commented that when we move from transformation into continual improvement, it will be important to know what that looks like. DS added that that we should set out what we want to achieve, so that we can look back on it in the future, and asked if we could we show how the transformation programme could link in to Quality & Safety as it would create a stronger connection.	JL/DL	29.07.21	Open	**24/08:** Summary paper being developed and will be presented to the Board when final ward changes have concluded post Sept 21
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.
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	DL	25.11.21	Open	

	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.				
27.05.21 **03**	**Quality Account** AB recommended Board sign off, and accepted that an Extra-ordinary Board Meeting would be required due to timescales regarding presentation to Quality Safety Committee being taken into account ahead of submission by 30th June. AL noted that having as much done as possible beforehand would help, including queries and questions. KF agreed with AL and suggested that the minutes from Quality Safety Committee would help greatly with the discussion as well. PB noted that the report required the appropriate levels of scrutiny, in conjunction with the most recent minutes from Quality Safety Committee. PB asked DL to schedule an Extra-ordinary Board Meeting via Teams as close to June 30th as possible.	DL	30.06.21	**Closed**	**24/08:** A copy of the final Quality Account, along with minutes from the QSC meeting were shared with the Board. An Extraordinary Board meeting was held on Monday 21st June 2021, at which the 2020-21 Quality Account was approved. **Propose action is closed**
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	**24/08:**
27.05.21 **05**	**DBT Patient Journey video** The Board was shown a clip of a documentary video that was part of a programme designed to educate and de-stigmatise, but also to humanise the Charity and help with staff morale and was about reminding staff what a great job they do. PB asked that this video be shown at the upcoming Court of Governors.	DL	25.06.21	**Closed**	**24/08:** The video showing a taster of the "I'm not mad, I'm me" documentary video was played during the informal session of the Court of Governors, with all Governors being sent a link to the video, along with an invite for the main premier after the meeting ended. **Propose action is closed**

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of meeting	Tuesday, 24 August 2021
Agenda item	**7**
Author	Katie Fisher
Responsible Executive	Katie Fisher
Discussed at previous Board meeting	Updates have been discussed at the Charity Executive Committee meetings
Patient and carer involvement	A number of these items would have been discussed with patients, carers
Staff involvement	Where staff have been involved in topics included within the paper this will be highlighted specifically in the relevant section
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	

Report summary and key points to note

The attached is the Chief Executive's report to the Board of Directors from the Charity Executive Committee (CEC) meetings.

The nature and content of this report is currently under review and will be further refined following the external governance review.

Appendices

CEO Report

This is the CEO report to the Board of Directors to provide information and assurance on the key areas of focus for the Charity Executive Committee over the last reporting period that are not dealt with under other agenda items for the Board.

1. NHS Wales inspection update

   The NHS Wales Quality Assurance Improvement Service (QAIS) team undertook a full Performance Review of the services they use on the Northampton hospital site between 7th - 9th June 2021. Some verbal feedback received after the visit was "*the difference between this review and the review at the end of 2019 is remarkable"* and "*the general consensus is that there is a notable improvement across the site"*. Notably the QAIS team did not identify on any of the nine wards visited, any actions required to be taken around Enhanced Support which historically has always been an area of concern for them.

   Out of the nine wards inspected, five wards (Cranford, Sunley, Fern, Spencer South & Seacole) achieved 154 out of 154 for the core service requirements noting areas of good practice and positive patient views where they'd been sought: *Patients spoken to described good relationships with staff describing them as "very good" and "supportive".* For the four wards (Hawkins, Fairbairn, Brook & Church) that did not meet all 154 core service requirements, the common themes were care and treatment planning, staffing and environments. Performance Improvement Notices were issued and improvements have subsequently been made with Fairbairn already having these improvements verified and their '3Q' rating sustained. The other 3 wards await their verification feedback.

2. European Convention on Prevention of Torture

   From 16-19 June 2021, The European Convention for the Prevention of Torture and Inhumane Treatment visited St Andrews Northampton site.

   The 4 inspectors visited a total of 10 wards Heygate, Upper Harlestone, Sitwell, Seacole, Cranford, Sunley, Berkley Close Ground Floor, Church , 38 Berkley Close and Billing Lodge, they met with a number of patients and staff including the Clinical Directors and a Peer Support Worker.

   Data from the last two years was requested, and they collected information on

   - The Charity structure, governance and policies and procedures
   - staffing levels, vacancies and use of bank and agency across all job roles
   - clinical treatment models and especially the non-pharmacological interventions
   - number of restraints and seclusions including the length of time these were applied and a sample of restraints for all divisions with the number of staff that were involved in the restraint and further detail about prone restraint
   - use of Rapid Tranquilisations,

   They showed particular interest in

   - restrictive practices

- disciplinary processes and safeguarding
- feeding with restraint
- management of complaints, especially mistreatment by staff with outcomes of allegations
- delayed discharges and the reasons for these
- death registers and subsequent level of review
- documentation of reviews against MHA being within the legal timeframes and the application of Section 63

Feedback immediately following the visit was largely positive with them stating this was a targeted visit. They felt we had been very cooperative facilitating rapid access to the site, with people and access to electronic patient records.

Ill Treatment: no evidence of deliberate ill treatment from staff. The majority of patients when asked were positive about staff. They received a small number of reports that some staff had used inappropriate language, were rude, or used mobile phones whilst on duty and that some disclosed personal aspects of their care plans in front of other patients.

Material environment – was good with a friendly design. The patient bedrooms were well ventilated and appropriate size. The variety and access to outdoor space was good with patients able to move freely around their communal areas.

Staffing: Staffing was felt to be appropriate, with good involvement from the MDT. They received a few comments from staff that due to the number of patients on enhanced observations they were limited in capacity to offer meaningful interactions/ therapy with other patients. They made specific comment about the positive impact of Peer Support Workers.

Treatment: good treatment options available, treatment plans were in place and the patients had been involved alongside the whole MDT. Complimentary about the very high quality of both pharmacological and non-pharmacological care and treatment.

Risk & Restraint: staff were trained and engaged with the reducing restrictive practice approach being implemented. They noted that although the number of restraints in use was high, the length of these was short and well documented.

Concerns:

- the ease of locating some key documentation in RiO
- they will be raising a concern nationally that the electronic T2 forms do not allow a patient signature
- the T3 process and that the use of video conference should be stopped in light of the easing of Covid restrictions
- Section 63 MHA process including the review process
- Some patients raised concern about lack of access to a MHA Advocate and this would be an area for improvement
- Nationally they will be raising the issue of delayed discharges

Recommendations:

- Patients not restrained in front of other patients where possible and especially where feeding was required.

- Some seclusions were recorded for an extended period of time, these need to be for as short a time as possible and should be measured in minutes rather than hours.
- There was a point raised on Upper Harlestone with the access to bedrooms locked during the day. The inspectors also raised concern about the restricted access to outside space and would recommend that this be increased.

They ended by thanking the whole of the SAH team for their positive engagement with their process and noted many areas of best practice.

3. CQC update

The CQC undertook a full inspection of the Northampton Women's and Men's services, which commenced on 5 July 2021. 28 members of the inspection team were on site between 5–8 July, with a further inspection team of six returning on 20–21 July.

This was a comprehensive inspection of 17 wards, and throughout the inspection we responded to any issues and concerns raised by the inspection team.

Although the site visits have concluded, a very substantial number of information requests were made by the inspection team which are now being processed. The Charity will not receive a draft report for some time.

The quality improvement plan, with all actions associated with CQC inspections included, is managed through the patient safety group, CEC and assurance is provided by the Quality and Safety Committee.

4. Health and safety

As part of the formal Improvement Notice received from the HSE the Charity had until the 29th of July to fully respond. The substantive requirement was to put in place health and safety training for the directors/executives to enable them to fully understand their obligations. This training has been provided and the Charity are confident it meets the needs of the HSE. Separately, a full Training Needs Analysis (TNA) has been completed and a comprehensive programme of training is planned with the Learning and Development Team that is better focused and relevant to specific roles and responsibilities.

Work on improving the health and safety management system continues and good progress is being made in implementing the prioritised plan for the year. This is in addition to the significant ongoing work programme associated with ensuring appropriate mitigation is in place to continue to manage health and safety Covid related risks.

5. Capacity utilisation update

The Capacity Utilisation Programme is in its final phase of implementation. On the 13 July, Thornton was vacated. As the last ward in the Main Building, this was a significant milestone for the programme. The remaining moves are within the Neuro division. The dates of these moves are under review whilst lead times for infrastructure works and remaining requirements are confirmed with suppliers and clinical teams.

New Services Programme

The Men's Medium Secure Mackaness Ward environment is ready for patients however, the opening is deferred until the Autumn, recognising the current workforce challenges that are being managed across the Northampton site. Joint working with Nottinghamshire Healthcare NHSFT and IMPACT has commenced; the timeline of joint activity will be adjusted to align with the deferred opening.

6. Partnerships update

   Across the Charity we continue to engage with partners across the Midlands, principally as part of the East Midlands Alliance, which has held a series of workshops for the Boards of the 6 partners during July. We also continue to progress our role locally within the Northampton mental health collaborative, which forms part of the local Integrated Care System.

7. Staffing

   In line with other providers across Healthcare, staffing at St Andrew's continues to represent a significant challenge, most notably impacting ward based staff. Nursing days lost to absence have doubled compared to pre-pandemic levels. This is exacerbated by the increased staffing need arising from the heightened acuity of patients admitted following the first wave, increased Covid related isolation requirements for patients, coupled with the reduced availability of agency support.

   There is a healthy pipeline of new recruits which will ease current pressures in the medium term. In the short term nursing leadership are stepping in to offer ward based support, clinically trained members of enabling functions are being redeployed to bolster wards, alongside non-nursing multi-disciplinary team members being ward based to undertake their planned therapeutic activities with patients as much as possible.

   In parallel, a new, evidenced based, care model is being developed which will be supported by the implementation of e-rostering. This is anticipated to be in place by the end of October 2021.

   The CEC continues to be hugely grateful to our incredible colleagues for their continued service and recognises the exceptional efforts of everyone in very challenging circumstances.

8. Communications

   DBT Documentary – I'm Not Mad, I'm Me
   We recently filmed and shared our own short documentary, which followed three patients with complex mental health conditions to document their journey of recovery. The film aimed to raise awareness about the Charity's work and explore how mental health can affect anyone. I'm Not Mad, I'm Me followed Kayleigh, Charlie and Jo as they prepared to leave St Andrew's. All three were sectioned under the Mental Health Act and have been receiving care at our hospital for a number of years. The trio agreed to waive their right to anonymity and share their stories because they wanted to educate people about complex mental health problems, and the role that St Andrew's has played in their recovery.

   Kayleigh, who has been an inpatient for three years, said: "When I first arrived at St Andrew's I didn't really see a future I was that depressed. I want people to understand that mental health can affect anyone. I want people to realise that just because you've got a mental illness, it doesn't define you as a person, it's just a part of who you are."

The 30-minute documentary premiered online on Thursday, July 8 with a live YouTube screening. A panel of experts, led by Chair Paul Burstow, took part in a question and answer session straight afterwards. To watch the film click here.

Grow, our annual education report
We have recently published Grow, our annual report exploring our progress in education. Every individual in our care is given access to learning opportunities to enhance their lives and provide them with the skills they need to live independently, and we know that education and learning contributes to the recovery of our patients. Grow contains various facts and figures about our education offering, as well as case studies from patients who have studied while in our care, enhancing their skills and knowledge while boosting confidence and self-esteem. The report is online here.

Volunteering campaign
Our volunteering campaign is ongoing, encouraging both staff and members of the public to give their time and energy to support our patients. Elvis, a volunteer Assistant Psychologist, recently shared his story in a short video, available here.

Quarter 1 CARE Awards
Due to the ongoing Coronavirus situation we've not been able to hold the CARE Awards events in person for over a year, but that hasn't stopped us celebrating with virtual events. Deputy CEO Jess Lievesley recently presented our Quarter 1 winners with their awards. The winners were: Compassion: Moor Green Ward in Birmingham, Accountability: Denmark Chikowe, Healthcare Assistant on Frinton Ward, Respect: Paul Hanrahan, Teacher of English and Excellence: Tallis Ward, Neuropsychiatry.

Media coverage:

ITV News (Anglia)
ITV Anglia broadcast a news piece on the documentary 'I'm Not Mad, I'm Me'. Cameraman and producer Jon Stevens visited our hospital and interviewed Kayleigh, as well as Deputy CEO Jess Lievesley. Jess explained that one of the main aims of the documentary was to break the stigma of mental ill health.

The three-minute news package was broadcast on the evening regional programme, showing thousands of people in the area the incredible journey that Kayleigh, Jo and Charlie have been on during their stay at St Andrew's. To watch the news clip, click here.

ASPIRE Nursing Scholarship
We have recently launched a new scholarship programme to encourage talented nurses of the future to apply and pursue a nursing career in Mental Health or Learning Disability nursing. The three-and-a-half-year programme is called ASPIRE Nursing and there are 10 scholarships available. It is aimed at 18-24 year olds who are passionate about a career in nursing and have the drive to attend university, but who do not have the financial support or qualifications needed.

The campaign has received some fantastic local news coverage, including pieces in the Chronicle and Echo, BBC Radio Northampton (starts at 2 hours 10 mins) and OnRec.

Thresholds, British Association for Counselling and Psychotherapy
Rev Philip Evans has been working on a framework which assesses, values and measures the impact that faith and spirituality has on our patient's outcomes and recovery. He features in an article, recently published in Thresholds (a publication by the

British Association for Counselling and Psychotherapy). To read the article in full click here.

Paper for Board of Directors	
Topic	Performance Report
Date of meeting	Tuesday, 24 August 2021
Agenda item	**8**
Author	Anna Williams, Director of Performance
Responsible Executive	Alastair Clegg, Chief Operating 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 ☐
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

Key points to note:

Core safety metrics, at a Charity level, show no special cause variation.

Advocacy continues on behalf of patients who are ready for / require an alternative placement

Ward based staffing is challenging – mitigations are in place, vacancies and absence are in focus

Finance – slightly behind forecast for the month of July, focus on managing costs to mitigate occupancy challenges

Appendices

St Andrew's Healthcare – Board Performance Report

August 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, safeguarding and restraints so no special cause variation. Divisionally, rates in CAMHS and LSSR are outside of control limits with causal analysis and remedial plans presented within.

Patient Experience

The roll out of PREMs has been extended to more wards and is being tailored for services in the community. 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 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 proving challenging due to vacancies, absence and reduced uptake from flexible staffing. This experience mirrors that of Healthcare providers across the UK. It reflects the nation shortage of suitable skilled staff, exacerbated by absence linked both directly and indirectly to the pandemic. Mitigations are in place to support wards. Engagement sessions are planned in order to understand from permanent and flexible staff, steps that could be taken to improve the current situation.

Finance

The operating and net deficit position of the Charity is marginally behind forecast for the 4 months ended July 2021. The financial result for July has been impacted by lower occupancy due to continuing Covid restrictions and staffing challenges on our PICU wards and towards the end of July the s31 restrictions on a number of wards on the Northampton site which has not been offset by a lower cost base. This position is expected to worsen until a resolution is found which will significantly challenge the Charity's ability to achieve the forecast.

Navigating St Andrew's SPC charts

Target line

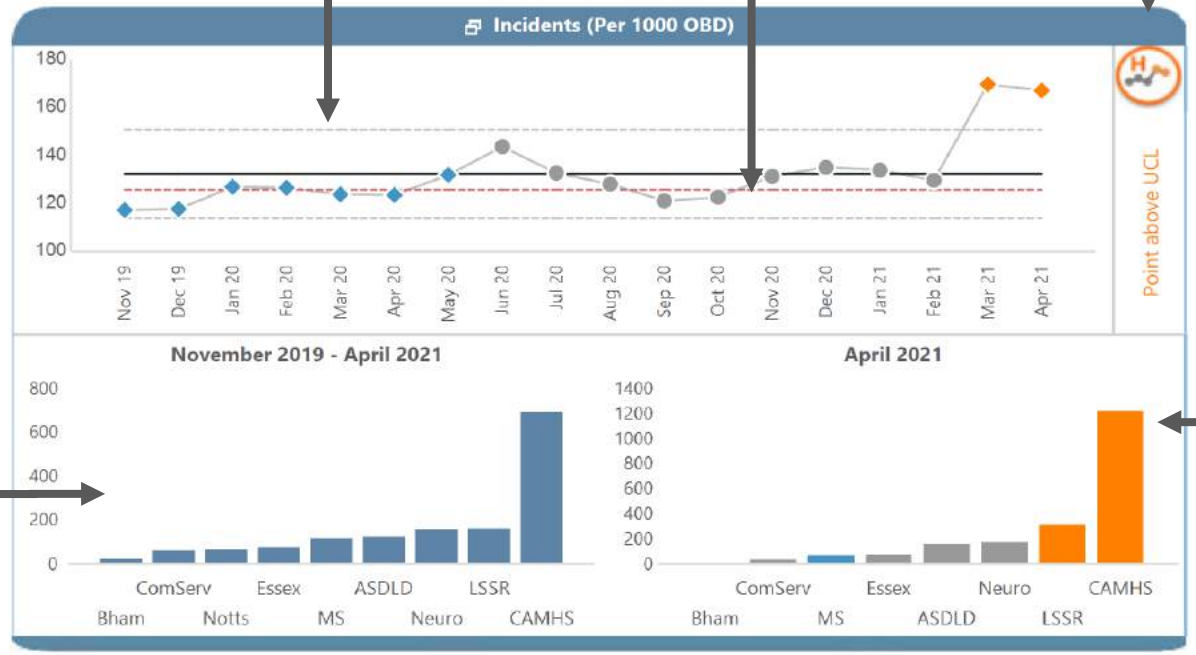
Proposed target for the KPI

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

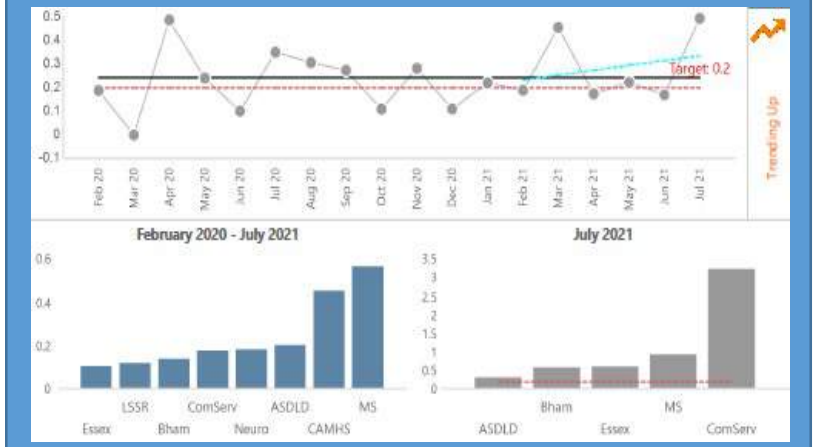
April 2021 shows an SPC special cause concern as the data point is above the Upper Control Limit.

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.

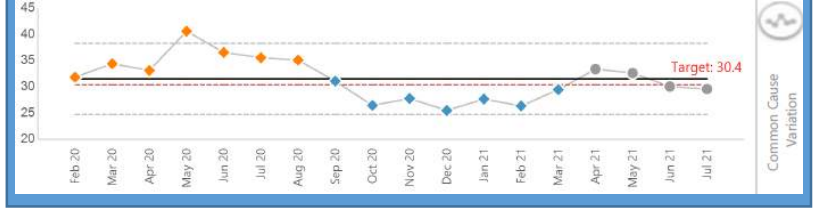
Whilst the charity position is concerning, MS is showing special cause improvement for April 2021.

Incidents

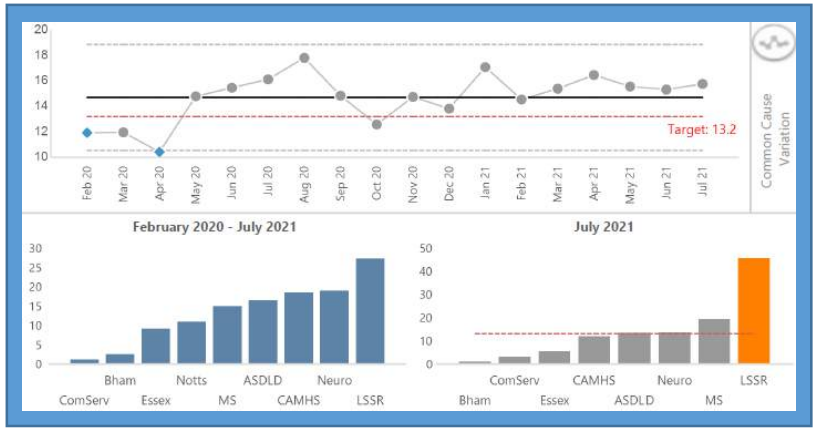
Serious Incidents



Incidents of Violence



Safeguarding

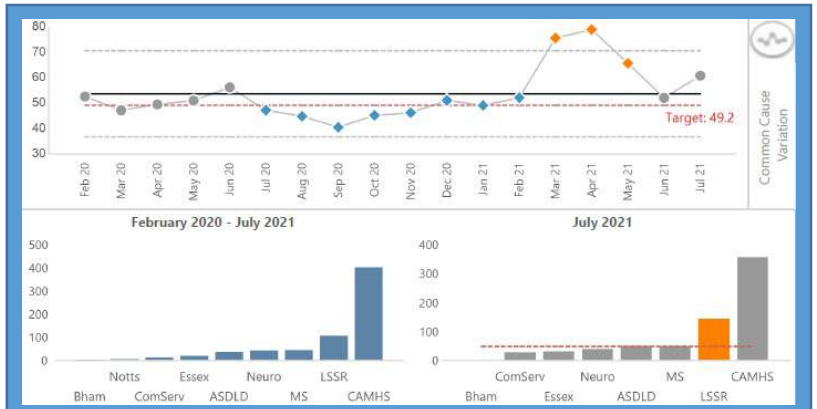


At a Charity level incident rates and restraints are within common cause variation. Divisionally CAMHS and LSSR are above their control limits for incidents (chiefly lower level). Serious Incidents, whilst not breaching control limits, are trending adversely. Of the nine SIs initially reported July (included in the graph), two have not met the National Patient Safety Framework definition of an SI. Systems are being updated to mirror this framework. Incidents of violence are below the mean at Charity level – with MS showing a special cause improvement and the remaining divisions being clustered around the mean. 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 – this is source of the special cause variation in CAMHS. **Remedial actions** – moves have been made within CAMHS in order to match patient needs with ward environments, 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. There were no SIs – incidents were level 1 to 3. The incidents, associated safeguarding and restraints are typically as a result of intervention in order to mitigated 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.

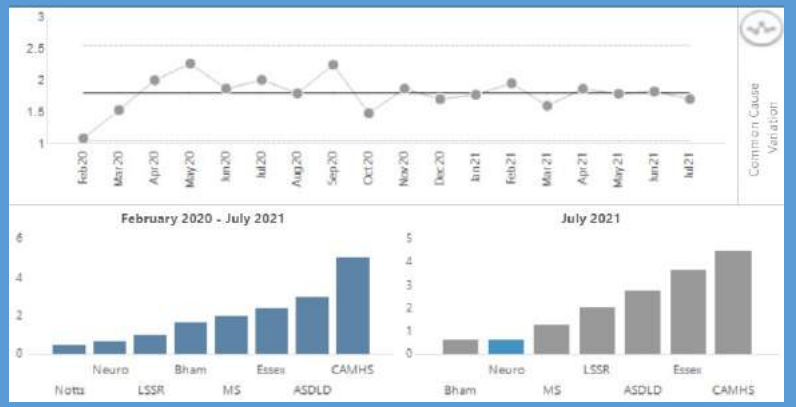
Restraints



Enhanced Support

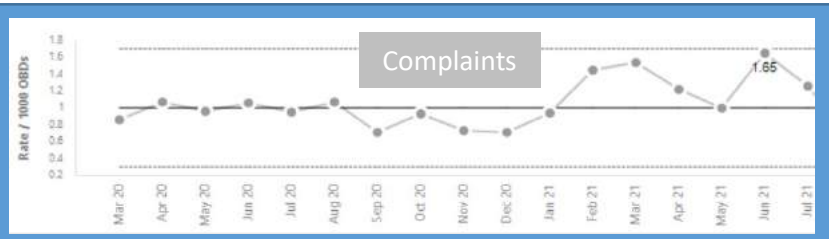
Episodes of enhanced support remain within common cause variation for all divisions and at a Charity level. We have identified a number of patients whose necessity for enhanced support is due the combination of their presentation and a hospital environment, as such our service is not appropriate for them. We are working with IMPACT to secure transition to appropriate services that meet each individual's needs.

LTS episodes



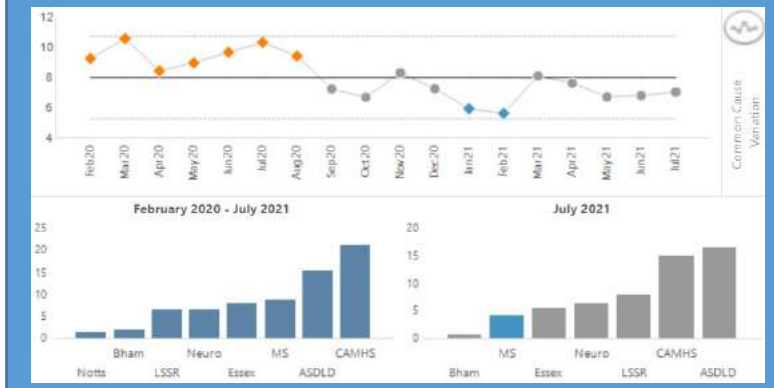
At a Charity level there is no special cause variation with long term segregation episodes. Individually, Neuro have a positive shift with a special cause improvement following seven months below the historical mean.

Patient Feedback



The PREMs roll out continues, with specific focus in Low Secure & Specialist Rehab as part of a wider Continuous Quality Improvement initiative. Additionally, a tailored PREM is being implemented for Community Partnerships. The Patient Engagement team have supported co-production with patients across seven different focus areas, including: Non-Executive appointments and the Advocacy tender – with a new provider now in place. We have received a small number of complaints regarding staffing levels – this correlates with fill rates and absence levels, whilst the rectifications are multifaceted, a review of S17 leave across 17 wards noted <0.1% of leave has been cancelled.

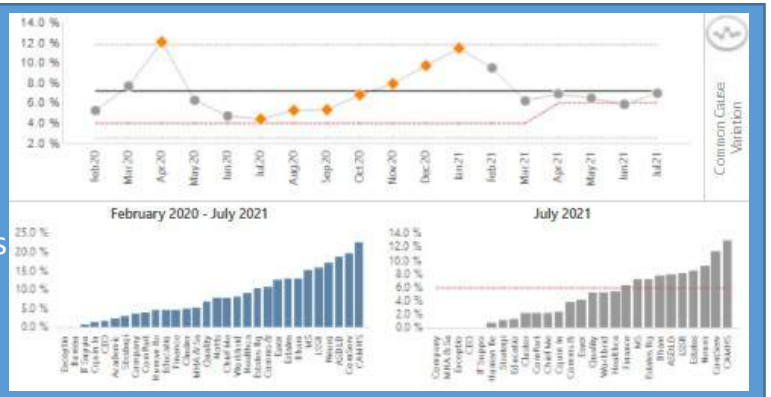
Seclusion events



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, with divisions at 7.9% - continuing the trend for teams with high direct patient contact being above the mean. Other types of absence are increasing. The combined impact of absence is significant for the Charity. Other providers are reporting similar challenges with absence impact.



Remedial actions – summer staffing incentive to combat the short-term impact of absence. Vaccination roll out continuation and booster planning. Self isolation for Healthcare exemption being 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. Benchmarked turnover results are on par with local trusts.

Remedial actions – profession retention reviews for nurses, psychologists and doctors. New engagement session and measurement – enabling greater insight and benchmarking. Supervision and IPDR supporting flight risk minimisation. Career Café. Recovery and restoration programme.

Registered Nurse fill ratio

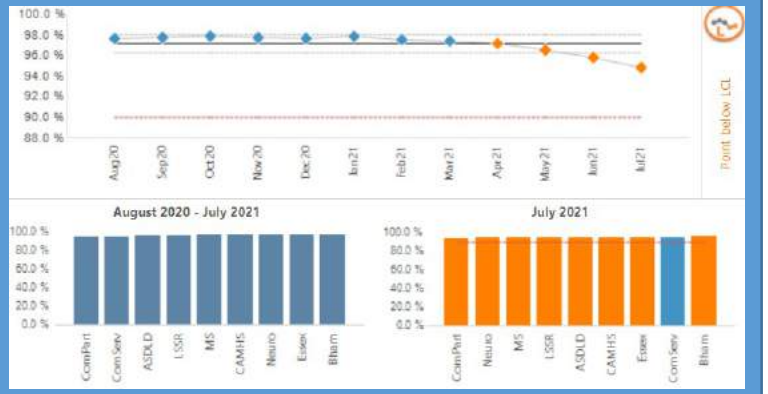
Nurse fill ratio is 80.2%. It is below the lower control limit and below target.

Causal analysis – Metric refreshed in July for latest establishments, the July result is a combination of reduced headcount and increased requirement.

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

Mandatory training

Mandatory training for the full Charity sits at 94.6% well within the 90% target, with all divisions in excess of target. Informal benchmarking insight 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.

St Andrew's Healthcare – Board Performance Report

August 2021

Finance update

	July 2021 MTD			July 2021 YTD		
	July 2021 MTD Actual	Budget	Variance to Budget	July 2021 YTD Actual	Budget	Variance to Budget
Available beds	696	710	(14)	699	693	6
Occupied beds	581	584	(3)	576	579	(3)
Occupancy %	83.5%	82.3%	1.2%	82.4%	83.5%	-1.1%
Total Income (£'000)	**13,531**	**13,947**	**(416)**	**53,769**	**54,282**	**(513)**
Total Direct costs*	(6,546)	(6,696)	150	(27,307)	(27,661)	354
Gross surplus (£'000)	**6,985**	**7,251**	**(266)**	**26,462**	**26,621**	**(159)**
Total Indirect costs**	(3,593)	(3,742)	149	(14,895)	(14,935)	40
Net Contribution (£'000)	**3,392**	**3,509**	**(117)**	**11,567**	**11,686**	**(119)**
Enabling functions (£'000)	(2,475)	(2,488)	13	(10,346)	(10,238)	(108)
Depreciation (£'000)	(1,166)	(1,167)	1	(4,674)	(4,672)	(2)
Operating Surplus/(Deficit) (£'000)	**(249)**	**(146)**	**(103)**	**(3,453)**	**(3,224)**	**(229)**
Non-operating costs (£'000)	(95)	(100)	5	(266)	(329)	63
Exceptional costs (£'000)	(142)	(88)	(54)	(258)	(204)	(54)
Project costs (£'000)	(96)	(87)	(9)	(426)	(494)	68
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)	**(582)**	**(421)**	**(161)**	**(4,403)**	**(4,251)**	**(152)**

* - includes ward nursing and ward funds

** - includes MDT and other divisional costs

Commentary

Operating surplus and Net surplus positions have been impacted by the continuing Covid restrictions on PICU wards significantly slowing admissions and we have started to see the impact of the s31 restrictions on occupancy at the end of July 2021 – this has resulted in July being the first month in the current year to have a material variance in revenue away from the forecast position, a position which will worsen until a resolution is found to both Covid and staffing issues.

As detailed earlier in this report the staffing challenges that the Charity is experiencing has reduced the overall direct costs compared to forecast. The reduction in cost is not directly comparable to the lower staffing levels due to the increased costs of sickness, overtime, agency and incentives that are currently being paid in efforts to maintain staffing levels

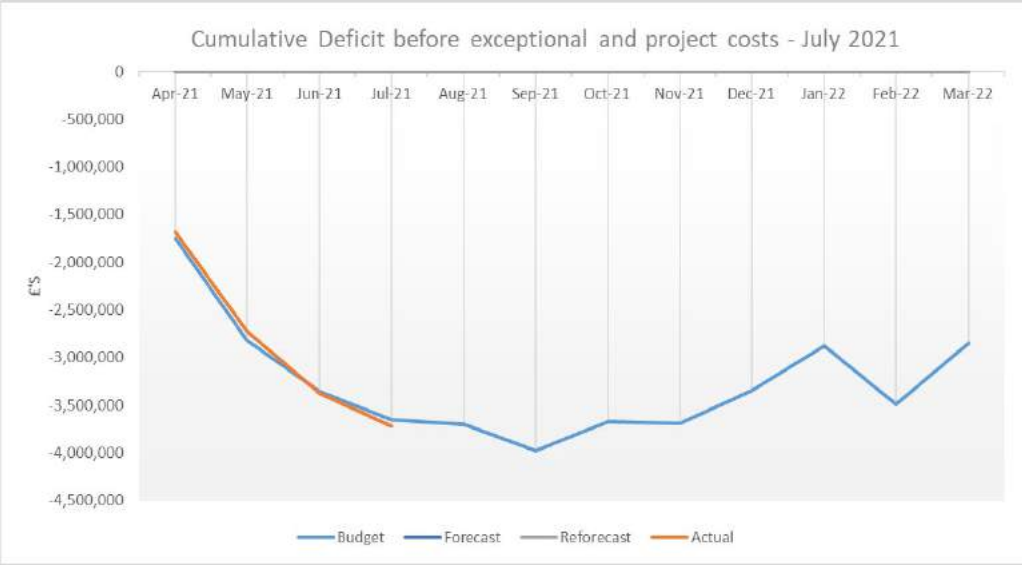
Occupancy has increased over the first 4 month of the financial year as planned but this position will now deteriorate due to the restrictions on admission to wards impacted by the s31 notice, staffing challenges and the quarantining restrictions on the PICU wards effecting occupancy – we are meeting regularly with divisional colleagues to review the occupancy predictions and to support occupancy increases where wards are able to admit.

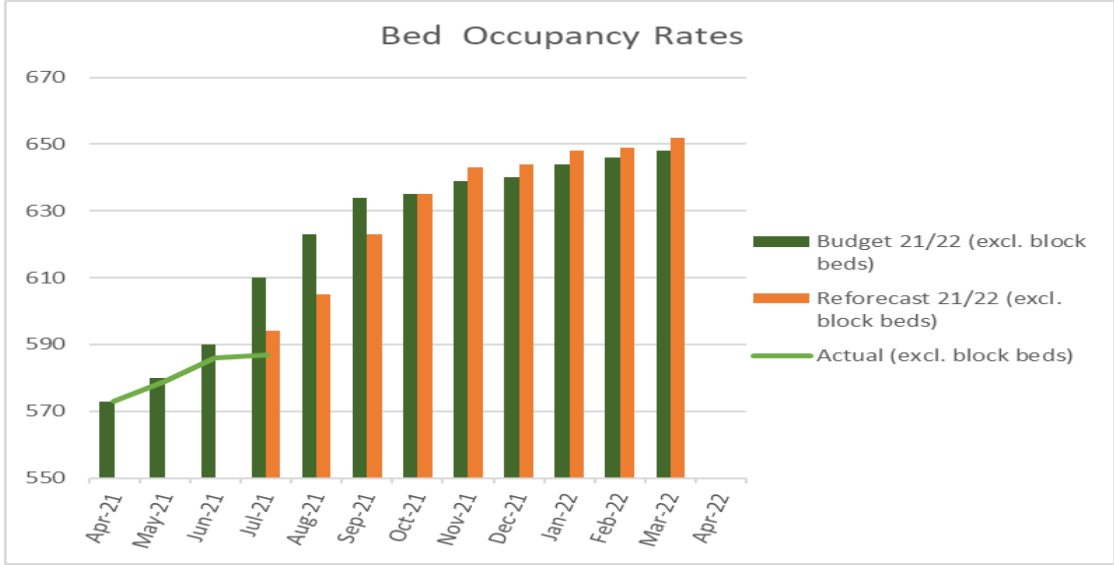
The planned cost savings across the enabling functions has been met across the first 4 months of the financial year – we have accelerated some plans as a result of the current occupancy challenges and the increase in exceptional costs in the month of July is as a result of bring forward certain cost saving plans within a number of enabling function departments

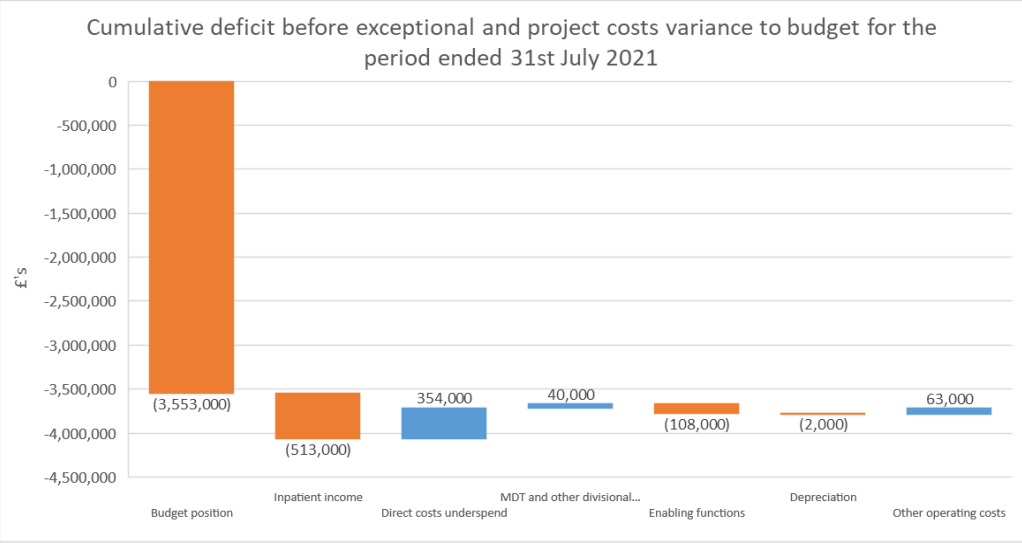
St Andrew's Healthcare – Board Performance Report

August 2021

Finance snapshot







Cashflow summary to July 2021	(£'m)
Opening net debt at 1/4/2021 *	(18.0)
YTD Capex expenditure	(1.4)
YTD Cashflows from operations and working capital movements	(7.1)
YTD Depreciation	4.7
Closing net debt at 31/07/2021*	(21.8)
Planned Capex	(4.1)
Forecast cashflows from operations and working capital movements	(1.5)
Forecast depreciation	9.1
Forecast closing net debt at 31/03/2022*	(18.3)

**-* excludes Stock Market investments*

Paper for Board of Directors	
Topic	Staffing Action Plan
Date of Meeting	Tuesday, 24 August 2021
Agenda Item	**9**
Author	Andy Brogan
Responsible Executive	Andy Brogan
Discussed at Previous Board Meeting	Verbal updates provided at previous Board meetings.
Patient and Carer Involvement	No patient and carers have been involved at this stage. On reviewing establishments in the future, we will develop a process for engaging patients.
Staff Involvement	Ward Managers have been involved in the data collection, and will be involved in discussions on setting individual establishments going forward.
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 ☐
Considered at Committee Meetings	QSC

Report Summary and Key Points to Note

Provides an update on plans to implement an e-Rostering system across the Charity to support the implementation of Right Staff, Right Place, Right time.

Update on introduction of the MHOST.

Assurance on project implementation for e-Rostering and establishment setting.

Proposal for reporting to Board and Quality and Safety Committee.

Appendices

Right Staff, Right Place, Right Time

Introduction
It has been recognised for some time that the current staffing model adopted by the Charity is not fit for purpose. The model adopted is a variation of the original Hurst guidance, which has been further adapted to provide two levels of staffing, Optimum and Safe. This does not provide an objective measure to assess our planned staffing levels on each shift, which has resulted in dissatisfaction amongst our nursing workforce. It has become a matter of custom and practice that Optimum levels are the de facto safe numbers and by implication, anything less unsafe. To compound this our regulators are judging our staffing against these Optimum levels and making assumptions in line with staff views that staffing is unsafe. These levels have not been reviewed since 2018.

Establishment Setting
In NHS Trusts it is a requirement that establishment setting is undertaking annually, with a mid-year review, and takes account of:

- Patient acuity and dependency using an evidence-based tool.
- Activity levels.
- Seasonal variation in demand.
- Service developments.
- Contract commissioning.
- Service changes.
- Staff supply and experience issues.
- Where temporary staff have been required above the set planned establishment.
- Patient and staff outcome measures.

Good practice indicates that establishments are determined locally at ward level and approved by the Board. In addition to utilising an evidence tool, guidance proposes this is supplemented by patient safety and quality outcomes and the professional judgment of the ward clinical staff, led by the ward manager.

Staffing Projects
In response to this we have explored the most suitable evidence tools to provide a robust evidence base for setting establishments. We have settled on the MHOST tool which is used in the majority of Mental Health organisations and has provided benchmark information across over 350 individual wards in mental health settings.

Data collection commenced across all our wards in the month of July and this is being analysed, alongside the other components of establishment setting, outcomes and professional judgement. Further work has been undertaken to benchmark with similar services and examine specific roles, including safety nurse and response. This will be factored into our revised establishments. Once completed we will be a position to make a recommendation to the September Board.

Earlier this year we started to explore the introduction of an e-rostering tool, Allocate, which is used in 95% of NHS trusts and appears to offer us the best solution. It is not without its complications and there have been challenges in its interoperability with Kronos and SAP. It is anticipated that we will have started to implement e-rostering in a phased approach across the Charity in August.

Both these quality initiatives are being managed as major projects, with appropriate governance and support, and reporting into SPOG.

Board Reporting and Governance

As part of the NHS England's `Hard Truths` guidance, NHS Trusts were required to present a monthly update report to their public Boards, containing a summary of planned and actual staffing on each ward. It is proposed to adopt this process to St Andrew's from the October Board.

Safer staffing levels, competencies and skill mix are essential elements of providing safe and high quality care for our patients. It is therefore important that the Board has oversight of our staffing, alongside rationale for any changes to base establishments, in order to assure itself that our wards have sufficient skilled staff to operate safely. Demonstrating sufficient staffing is one of the essential standards that all healthcare providers must meet in order to also be compliant with CQC requirements.

Guidance available to support the reviewing of staffing establishments and reporting on staffing include:

- Hard Truths. April 2014.
- Shape of Caring review. March 2015.
- Safe sustainable and productive staffing. NQB 2016.
- Developing workforce safeguards. Supporting providers to deliver high quality care through safe and effective staffing. October 2018.

This guidance provides a range of tools for us to set staffing establishment, report on the effectiveness and efficiency of our staffing models, and provide metrics for the Board to assess against the principle of Right Staff, Right Place, Right Time.

The Right Staff in the Right Place at the Right Time principles are key to providing high quality and safe services. A safer staffing assurance group has been established, Chaired by the Chief Nurse, which will receive reports on staffing fill rates, incidents and patient outcomes. This will provide assurance to the Quality and Safety Committee.

Reporting on this provides transparency to the Board, our staff and wider stakeholders. It is proposed to provide the Open Board with a monthly report that will include staffing fill rates against planned and actual, the percentage of harm free care and assure Board members of any actions taken to address staffing challenges.

It is recommended that we commence this reporting to the Board from October.

Paper for Board of Directors	
Topic	Annual Mortality Report (Learning from Deaths)
Date of Meeting	Tuesday, 24 August 2021
Agenda Item	**10**
Author	AyeMa Lwin, Lead for End of Life Care
Responsible Executive	Sanjith Kamath
Discussed at Previous Board Meeting	Mortality Surveillance Group reports are brought to each Quality and Safety Group and the Annual Mortality Report is brought to the Quality and Safety Committee prior to submission to the Board of Directors.
Patient and Carer Involvement	It would not be appropriate to involve patients and carers in the preparation of this report.
Staff Involvement	Numerous staff who have been involved directly and indirectly with the mortality reviews and investigation as well as in various governance groups will have discussed elements of this report.
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	Quality and Safety Committee – 8 June 2021

Report Summary and Key Points to Note

The report providers assurance of the efficacy of the Learning from Deaths (LFD) process, in line with the National Quality Board (NQB) guidance on learning from deaths (March 2017). The expectation from the NQB guidance is for the Charity to collection and publish information on deaths to generate learning. This report considers the data from 1 April 2020 to 31 March 2021 inclusive.

There have been a total of 27 deaths within the Charity during this period in comparison to 18 deaths in the previous year. 2020 was an unusual year in many respects due to the Coronavirus pandemic but specifically in terms of the increase in the numbers of deaths across the country. 18 of the deaths in the Charity have Covid-19 as

an associated factor recorded on the death certificate and as such will have been included in the national statistics of Covid related deaths. Many of the patients who died from Covid related illnesses were on an End of Life Care pathway.

The report has been presented to and approved by the Charity's Quality and Safety Committee.

Appendices

Report for the Board of Directors
Annual Mortality Report (Learning from Deaths) April 2020 - March 2021

This report considers the data from 1 April 2020 to 31 March 2021 inclusive. There have been a total of 27 deaths within the Charity during this period in comparison to 18 deaths in the previous year.

2020 was an unusual year in many respects due to the Coronavirus pandemic but specifically in terms of the increase in the numbers of deaths across the country. 18 of the deaths in the Charity have Covid-19 as an associated factor recorded on the death certificate and as such will have been included in the national statistics of Covid related deaths. Many of the patients who died from Covid related illnesses were on an End of Life Care pathway

Introduction

This document is presented to the Board of Directors, to provide assurance regarding the efficacy of the Learning from Deaths (LFD) process, in line with the National Quality Board (NQB) guidance on learning from deaths (March 2017). The expectation from the NQB guidance is for the Charity to collect and publish information on deaths to generate learning.

.

All expected deaths were subject to the mortality review process, using a structured judgement review tool. Serious Incident (SI) investigations, using root cause analysis methodology, were undertaken where the death was unexpected or where it was felt that it was possible to gain more in depth organisational learning. As per policy and procedure, the CQC and relevant commissioning bodies are notified in the case of all deaths. The summary figures are as follows:

Table 1: Total deaths review process 2020/2021

Total Deaths	Deaths associated with Covid 19	Deaths investigated only through the SI process	Deaths reviewed only through the mortality review process	Deaths reviewed through both the mortality review & SI process
27	18	3	11	13

Covid related deaths:

There were 18 patients who died within 28 days of a positive Covid test. 13 patients died during the first wave of the Covid pandemic from March to June 2020 and 5 patients died in the second wave which began in September 2020. These include patients who were on End of Life care pathways as well as patients who died unexpectedly following a Covid infection. To support organisational learning, 13 of the Covid related deaths were subject to the Serious Incident investigation process. All mortality reviews for Covid related deaths were undertaken by clinicians independent to the treating team and these were presented to the Mortality Surveillance Group which reports into the Quality and Safety Group.

In addition, all 13 deaths in the first wave were the subject of a commissioned thematic review which was presented to the Board and commissioners. The findings from the review helped the Charity improve its preparedness for the eventual second wave. The actions from the review, along with a number of other plans focused on increasing the robustness of the Charity's Infection Prevention and Control (IPC) measures, supported the effective management of the second wave of the pandemic. Although the second wave was more prolonged, it resulted in fewer deaths (5) in the Charity compared to the first wave. Identified recommendations and actions from the thematic review focused on the following areas:

- Improvements in the assessment and management of the deteriorating patient
- implementation of the National Early Warning Score (NEWS2) tool
- recommendations to strengthen the advance care planning process
- the consistent and objective assessment of frailty

Table 2: Covid related deaths

Patient number	Age	Ward	Gender	Covid pandemic wave	Mortality Review / SI process	Date of death
1	65	Cranford	M	First Wave	MR and SI	5 April 2020
2	62	Cranford	M	First Wave	MR and SI	8 April 2020
3	59	Cranford	M	First Wave	MR and SI	9 April 2020
4	66	Cranford	M	First Wave	MR and SI	12 Apr 2020
5	63	Cranford	M	First Wave	MR and SI	12 Apr 2020
6	67	O'Connell	M	First Wave	MR	16 Apr 2020
7	55	Elgar	F	First Wave	MR and SI	17 Apr 2020
8	80	Cranford	M	First Wave	MR and SI	21 Apr 2020
9	67	Allitsen	M	First Wave	MR	26 Apr 2020
10	90	O'Connell	M	First Wave	MR	7 May 2020
11	71	Compton	M	First Wave	MR	10 May 2020
12	76	Harper	F	First Wave	MR and SI	11 May 2020
13	67	O'Connell	M	First Wave	MR	12 May 2020
14	58	Lifford	M	Second Wave	MR and SI	18 Nov 2020
15	66	Fairbairn	M	Second Wave	MR and SI	14 Dec 2020
16	43	Tallis	M	Second Wave	MR and SI	10 Jan 2021
17	32	Ashby	F	Second Wave	MR and SI	19 Feb 2021
18	71	Cranford	M	Second Wave	MR and SI	25 Mar 2021

The average age at death from Covid related illnesses in the Charity was 64.3 and the median age was 66 years. 14 patients were on wards for older adults with mental disorders and progressive neurological conditions, like Dementia.

Non Covid related Deaths

There were 9 deaths in the Charity that were not related to Covid and these are detailed below

Table 4: Non-Covid deaths summarised

Patient	Age	Gender	Ward	Date of death	End of life care plan	Resuscitation status at the time of death	Diagnosis	Mortality review or SI process
1	67	M	O'Connell	17 April 2020	Yes	Not for resuscitation	Pick's Disease(severe Dementia) Frailty Repeated pneumonia	MR
2	70	M	Moor Green	28 May 2020	Yes	Not for resuscitation	Frailty Hypothyroidism Diabetes Hypertension Bowel Ca. (in remission)	MR
3	70	M	Cranford	22 July 2020	Yes	Not for resuscitation	Chronic kidney disease End stage renal failure Cardiac failure Hypertension Anaemia	MR
4	41	M	Tavener	2 September 2020	No	For resuscitation	Cause of death: Cardiac arrhythmia Left ventricular hypertrophy	SI
5	62	M	Cranford	23 September 2020	No	For resuscitation	Pulmonary embolism Pneumonia	SI – joint investigation with Northampton General Hospital
6	79	M	Redwood	9 November 2020	Yes	Not for resuscitation	Vascular Dementia Type II Diabetes Hypertension	MR
7	66	F	Elgar	13 February 2021	No	For resuscitation	?Aspiration pneumonia	SI ongoing
8	66	F	Cherry	20 February 2020	Yes	Not for resuscitation	Progressive supranuclear palsy(Dementia) Somatoform Disorder	MR
9	81	M	Redwood	21 March 2021	Yes	Not for resuscitation	Alzheimer Dementia Diabetes Hypertension Cardiac conduct disorder	MR

Summary of Findings

Overall Findings

- The majority of deaths in the last year were related to Covid--19 as the principal or contributory cause of death. Nearly all patients affected had multiple physical health co-morbidities that placed them at a higher risk of a serious adverse outcome as a result of Covid infection.
- None of the deaths subjected to mortality reviews were judged to be more likely than not, to have been due to problems in the care provided in the patient.
- There was good evidence of integrated care and active relationships with external experts including the Palliative Care Team.
- There was evidence of supportive relationships with families, supported by positive feedback.
- In contrast to the previous year, where all deaths occurred within the Neuropsychiatry Division, most deaths occurred in other divisions with 8 deaths on Cranford ward, the older men's forensic service.

Case specific findings

- Patient 4 - general recommendations identified for the Charity, regarding delayed discharges, no smoking policy and detail recorded whilst enhanced observations are recorded. The investigation also found that an expedition of the requested cardiology appointment may have been considered.
- Patient 5 - suboptimal prioritisation of an unwell patient following a handover that the patient's behaviour was due to medication withdrawal, rather than physical deterioration. This has been addressed through an action plan.

Improvement Opportunities

Table 5: Learning and actions taken

Learning Theme	Action Taken	Assurance process
VTE assessments to be completed for all patients	Refreshed VTE procedure published and communicated to all medical staff	Charitywide audit on compliance initiated
Lack of Advance care planning, particularly in clinical areas outside of the Neuropsychiatry division	A Working Group led by the Clinical Director for Neuropsychiatry has been set up, in order to embed and improve advance care planning practices across the Charity	Assurance processes will be agreed by this group and included in the organisational wide governance process.
Improvement in the delivery of end of life care in divisions outside of Neuropsychiatry	Appropriate support and escalation sort through the divisional leadership team	Mortality review process in place using the standardised judgement tool
Consideration and recording of Spiritual needs at any point in the patients journey **and not only when end of life care needs have been identified**	All patients to have a holistic assessment of their needs	Review of patient and carer feedback Audit of care plans to review if spiritual needs to be considered

Improved physical health monitoring across all patient groups	Updated training and review of the interface between physical health care practitioners and mental health teams	Assurance processes aligned to the overall organisational governance process.
Single point of contact for families of patients on an end of life care plan.	End of life policy to be updated and communicated to all MDTs	Mortality review process in place using the standardised judgement tool

Summary of report

There were 27 deaths in the year between 1 April 2020 to 31 March 2021, compared to 18 deaths the previous year. Covid 19 infection was a cause or contributory factor in 18 of deaths across the year.

All deaths were subject to a mortality review or a serious investigation process or both. Key learning was related to improved physical health monitoring, advance care planning, holistic care planning to include spiritual needs and ease of contact for family members. Actions related to these have been completed or initiated with review and monitoring processes put in place to provide ongoing assurance. Areas of good practice of note related to integrated care, communication and liaison with external agencies.

Recommendation
The Board of Directors is asked to consider and approve this report.

Paper for People Committee	
Topic	Armed Forces Covenant
Date of Meeting	Tuesday, 24 August 2021
Agenda Item	**11**
Author	Cat Vichare
Responsible Executive	Jess Lievesley
Discussed at Previous Board Meeting	May 2021
Patient and Carer Involvement	Patients and carers not directly involved in preparation of paper. However, our collaborative work with other areas of NHS Armed Forces ensures patients and carers are aware of our partnership working alongside organisations that have adopted the AFC.
Staff Involvement	Developed in collaboration with Veterans CTS Lead and Community Partnerships Staff.
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	

Report Summary and Key Points to Note

The Armed Forces Covenant is a national responsibility involving government, businesses, local authorities, charities and the public. Businesses and charitable organisations who wish to demonstrate their support for the Armed Forces community can sign the Covenant. The charity can adapt the attached templates to create a pledge that works for our staff and service users.

Current NHS contracts include a condition that requires services that are commissioned to carry out work on behalf of the NHS uphold the principles of the AFC.

There are some clinical and staffing considerations involved with pledging the AFC, and these are detailed in the main report.

Currently AFC is a promise or commitment, rather than a requirement. However, in December 2020 the Government announced their intention to legislate around the AFC.

The pledge outlined in the appendices is aligned to AFC Pledges undertaken by Northamptonshire Healthcare NHS Trust, Nottinghamshire Healthcare NHS Trust and Birmingham and Solihull Mental Health Foundation Trust.

A decision is required as to whether St Andrews Healthcare agree to sign the AFC pledge.

Appendices

AFC Pledge for St Andrews Healthcare

Background

The Government is committed to supporting the armed forces community by working with a range of partners who have signed the covenant. The covenant is a national responsibility involving government, businesses, local authorities, charities and the public.

Businesses and charitable organisations who wish to demonstrate their support for the Armed Forces community can sign the Covenant. Organisations can make a range of written and publicised promises to set out their support to members of the Armed Forces community who work in their business or access their products and services.

The level of support will depend on the size and nature of the organisation, but typically includes policies that: encourage reserve service; support employment of veterans and service spouses/partners; give the Armed Forces community a fair deal on commercial products and services. More than 800 businesses and charities have signed an Armed Forces Covenant, and that number continues to grow.

The current NHS in-patient contract includes the following condition "the parties must ensure that, in accordance with the Armed Forces Covenant, those in the armed forces, reservists, veterans and their families are not disadvantaged in accessing the Services", so as an organisation working with the NHS we are already committed to uphold some of the principles of the AFC pledge.

Process

Appendix 1 shows the AFC that we are asking the board to approve.

This is the pledge that has been signed by our significant partners at Northamptonshire Healthcare NHS Trust, Nottinghamshire Healthcare NHS Trust and Birmingham and Solihull Mental Health Foundation Trust.

The Covenant would be signed by someone in authority within the charity. Once the pledge document is signed a copy is sent to the Covenant Team (AFCovenant@rfca.mod.uk), so they can register the commitment and provide a letter giving permission for use of their logo for the next five years.

If we were to pledge the AFC, we would need to ensure that both our staff and patients systems were able to record if an individual is a veteran, in order to provide data/assurance that the commitments given are being followed.

Considerations

Signing of the AFC would apply to the charity as a whole, and there may be some implications for other areas of the charity.

Clinical Care

- Consideration of priority of admissions if bed capacity was an issue.
- There may be implications for the prioritisation of physical/therapeutic interventions in inpatient service
- *However, it is based on clinical judgment of need and so these decisions (about whether someone should be prioritised for admission or intervention) remains with clinicians.*

Recruitment

- Offer guaranteed interviews to veterans, young and old, if they meet the selection criteria laid out in a job advert.
- Support the employment, where appropriate, of wounded, injured or sick veterans, perhaps by working with the Career Transition Partnership (CTP Assist) or through a guaranteed interview scheme.
- Recognise military skills and qualifications when interviewing for new positions.
- Hold briefing days specifically for those leaving the Armed Forces, as a way to raise awareness of the opportunities for employment in the charity.

Employee Relations

- Look sympathetically on requests for holidays before, during or after a partner's overseas deployment, when the service person has leave to spend time with their family.
- Consider whether special paid leave is appropriate for employees who are bereaved or whose loved ones are injured.
- Accommodate your reservists' training commitments wherever possible.
- Accommodate mobilisation of your reservists if they are required to deploy.
- Encourage any reservists in the charity to participate in Reserves Day.

Currently AFC is a promise or commitment, rather than a requirement. However, in December 2020 the Government announced their intention to legislate around the AFC. There is no further information in regards to this, although government statements indicate that is likely to become a legal duty for specified public bodies, including local authorities and healthcare, to have due regard to the principles of the Covenant.

Future Considerations

Defence Employer Recognition Scheme (ERS)

The Defence Employer Recognition Scheme (ERS) encourages employers to support defence and inspire others to do the same. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant. Employers can sign themselves up for awards once they have signed the Armed Forces Covenant.

The ERS is designed primarily to recognise private sector support although public sector organisations such as the emergency services, local authorities, NHS trusts and executive agencies are also eligible to be recognised.

Veterans Covenant Healthcare Alliance

The Veterans Covenant Healthcare Alliance (VCHA) is a group of more than 50 providers aiming to improve the healthcare veterans receive from the NHS. The Alliance seeks to showcase high quality veterans' healthcare and support NHS trusts to learn from each other by sharing what works. This includes committing to the Armed Forces Covenant, raising awareness among staff of veterans' healthcare needs, and establishing clear links with service charities and local support providers. 58 trusts have already demonstrated they are delivering these standards and have been accredited as 'Veteran Aware'.

Recommendation

It is recommended that the Board agree to the signing of the recommended pledge as noted in appendix 1.

Further discussions with regards to ERS and VCHA will continue, for future application once the AFC is adopted.

Further Reading:

The Armed Forces Covenant (publishing.service.gov.uk)

Armed Forces Covenant Guidance Notes (publishing.service.gov.uk)

Appendix 1 – AFC Pledge

St Andrews Healthcare

We, the undersigned, commit to honour the Armed Forces Covenant and support the Armed Forces Community. We recognise the value Serving Personnel, both Regular and Reservists, Veterans and military families contribute to our business and our country.

Signed on behalf of:

St Andrews Healthcare

Signed: _____

Name: _____

Position: _____

Date: _____

Add company logo

The Armed Forces Covenant

An Enduring Covenant Between

The People of the United Kingdom
Her Majesty's Government

– and –

All those who serve or have served in the Armed Forces of the Crown

And their Families

The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

Section 1: Principles of The Armed Forces Covenant

1.1 We **St Andrews Healthcare** will endeavour in our business dealings to uphold the key principles of the Armed Forces Covenant, which are:

- *no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen*

- *in some circumstances special treatment may be appropriate especially for the injured or bereaved.*

Section 2: Demonstrating our Commitment

2.1 We recognise the value serving personnel, reservists, veterans and military families bring to our business and to our country. We will seek to uphold the principles of the Armed Forces Covenant, by:

- Promoting the fact that we are an Armed Forces-friendly organisation, to our staff, customers, suppliers, contractors and wider public.

- Supporting the employment of veterans

- Supporting the employment of Service spouses and partners

- Endeavouring to offer a degree of flexibility in granting leave for Service Spouses and partners before, during and after a partner's deployment

- Seeking to support our employees who choose to be members of the reserve forces, including accommodating training and deployment where possible.

- Seeking to support our employees who choose to be volunteer leaders in military cadet organisations

- Supporting Armed Forces Day, Reserves Day, the Poppy Appeal Day and Remembrance activities;

2.2 We will publicise these commitments through our literature and/or on our website, setting out how we will seek to honour them and inviting feedback from the Service community and our customers on how we are doing.

Paper for Board of Directors	
Topic	Responsible Officer Regulations
Date of Meeting	Tuesday, 24 August 2021
Agenda Item	**12**
Author	Shubhinder Shergill, Medical Appraisal Lead
Responsible Executive	Sanjith Kamath
Discussed at Previous Board Meeting	Annual report – last discussed July 2020
Patient and Carer Involvement	It would not be appropriate to involve patients and carers in the preparation of this report.
Staff Involvement	This is a statutory report that collates information regarding appraisal and revalidation and as such does not require staff involvement.
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	The report would usually be presented to the People Committee prior being taken to the Board, however due to a change in meeting timings and the deadline to report to NHS England and NHE Improvement by the end of September, the report will be presented to the People Committee in September.

Report Summary and Key Points to Note

The annual report on Appraisal and Revalidation is submitted in a prescribed format introduced by NHS England and NHS Improvement (NHSE/I) in 2019 and updated in 2021. The report would usually be presented to the People Committee prior being taken to the Board, however due to a change in meeting timings and the deadline to report to NHSE/I by end September, the report will be now presented to the People Committee in September.

In the 2020-2021 appraisal cycle, despite the challenges presented by the Covid pandemic, it was possible to continue to appraise all doctors effectively. A number of revalidations have also been completed well

in advance of the deferred date provided by the GMC which is further evidence of an effective system. Doctors have been able to continue to pursue CPD activities remotely, both externally and internally through an effective weekly CPD programme and the availability of online modules and conferences provided by the Royal College of Psychiatrists and other organisations.

Two cycles of the peer review process have now been completed with actions identified for individual doctors to follow-up on.

No doctors have been referred to the GMC.

The Board are asked to consider the report and for the Chief Executive or Chair to sign the Statement of Compliance at Section 7. This will then be submitted to NHSE/I prior to their deadline of 30 September 2021.

Appendices

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the Designated Body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level Responsible Officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement of Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Board of St Andrew's Healthcare can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a Responsible Officer. Dr Sanjith Kamath was appointed Responsible Officer (RO) on 1 May 2018.

Action from last year: nil
Comments: nothing further to add
Action for next year: no current actions

2. The Designated Body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No~~ [delete as applicable]
Action from last year: nil
Comments: nothing further to add
Action for next year: no current actions

3. An accurate record of all licensed medical practitioners with a prescribed connection to the Designated Body is always maintained.

Action from last year: nil
Comments: all new starters continue to be added to GMC Connect and a local database is also maintained
Action for next year: no current actions

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: the Medical Appraisal and Revalidation policy and the Responding to Concerns policy currently being updated following an update on the MAG (Medical Appraisal Guide) triggered by the pandemic

Comments: this is due for completion by the end of September 2021

Action for next year: no further actions at this time

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: to review progress in completing a benchmarking exercise with Northampton General Hospital (NGH) subject to the challenges of the pandemic

Comments: an audit meeting was held on 18 June 2021, to review appraiser standards by benchmarking these against those for the NGH doctors. Two appraisers from St Andrew's were selected. Results compare favourably with those for NGH.

Action for next year: consider repeating the audit subject to capacity of NGH staff.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: nil

Comments: all locum and fixed term contract doctors continue to be able to access the weekly CPD and case presentation programmes. Locum doctors continue to be provided with supporting information if requested for their own appraisals, which are organised through external locum agencies.

Action for next year: continue current processes

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model,

there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: to ensure that all appraisals are completed for the 2020–21 cycle after there were six agreed missed approved appraisals for the 2019-20 cycle Comments: there were three approved missed appraisals in the 2020-21 cycle (one doctor was on maternity leave, one doctor transferred from general practice (GP) to psychiatry towards the end of the year and GP appraisals had been suspended due to Covid, one doctor had completed their 2019-20 appraisal late (November 2020) and therefore did not undertake a 2020-21 appraisal due to timescales). Appraisers, including those newly trained have been updated on the need to focus on the impact of the pandemic and to reduce the bureaucratic requirements. Action for next year: to maintain no further missed appraisals in the upcoming appraisal cycle

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a Comments: n/a Action for next year: Nn/a

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: to update the Medical Appraisal and Revalidation policy Comments: this policy along with the Responding to Concerns policy is currently being updated with the planned deadline of September 2021 Action for next year: to maintain these relevant policies as current in line with any further changes

4. The Designated Body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: to maintain appraiser numbers

Comments: three new appraisers were trained during the year, however five appraisers left the organisation during the same period

Action for next year: to increase appraiser numbers

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: to maintain quarterly appraiser network and collection of feedback

Comments: the quarterly appraiser network has continued remotely and most recently has included a reflective session on the impact of the Covid pandemic on the appraisal process from the point of view of appraisers. The wider impact for appraisees is also currently being explored. Appraisal feedback continues to be collected from appraisers and appraisees via the Clarity appraisal toolkit and is reported as appropriate.

Action for next year: to maintain the current appraiser network meetings and feedback collation and to consider the wider impact of the pandemic on appraisees

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: to maintain the annual reporting process to the Quality and Safety Committee Comments: this practice has been maintained but from September 2021 will report into the organisation's People Committee Action for next year: to continue to report to the Board on an annual basis through the relevant process

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: St Andrew's Healthcare	
Total number of doctors with a prescribed connection as at 31 March 2021	**60**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021 (this includes appraisals for doctors who had left the organisation prior to 31 March 2021)	**64**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**3**
Total number of agreed exceptions	**3**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and Responsible Officer protocol.

Action from last year: nil as no recommendations were made to the GMC Comments: concerns with the practice of any doctors continue to be monitored as per the policy, which prescribes the intervention of a Decision

Making Group (DMG) chaired by the Medical Appraisal Lead and discussion between the RO and the Employer Liaison Advisor (ELA) as necessary

Action for next year: to continue to make any recommendations to the GMC as appropriate

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: nil

Comments: doctors continue to be notified promptly by the RO when a recommendation is made

Action for next year: continue to notify doctors promptly of revalidation recommendations

Section 4 – Medical Governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: nil

Comments: the organisation continues to operate a ward to board clinical governance framework, led on by doctors on individual wards which is reported up through the divisional structures via the Clinical Director and Deputy Medical Director

Action for next year: to continue current reporting processes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: nil

Comments: in addition to the processes of last year, the Medical Appraisal Lead also monitors any complaints received about doctors and will organise a DMG as appropriate in order to determine any further necessary actions to maintain patient safety

Action for next year: to continue current process of issuing line manager statements, monitoring complaints and soft intelligence on doctors' conduct and performance which are also presented at the appraisal meeting

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: updating the Responding to Concerns policy

Comments: current process involves monitoring any concerns about doctors' conduct and performance on an ongoing basis and where required, using a decision-making group to review incidents of concern and determine any further action necessary. The Responding to Concerns policy is currently being updated and has a deadline of September 2021 for completion.

Action for next year: to continue to use current processes and update relevant policies as necessary with any new guidance or information that comes to light.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: nil

Comments: relevant information is now presented to the People Committee which meets on a bi-monthly basis and will next be presented in September 2021

Action for next year: to continue current reporting processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: nil Comments: current process involves requesting a Medical Practice Information Transfer (MPiT) form from a doctor's previous employer as soon as their prescribed connection to our Designated Body is in place. This form allows transfer of relevant information from one RO to another RO and to act on any relevant concerns in a prompt fashion Action for next year: to continue current process

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: nil Comments: the current process involves informing a doctor of any allegation or complaint at the earliest opportunity and offering them the opportunity to bring a representative with them to any HR meetings if they wished. The DMG includes representatives from clinical and non-clinical fields aimed at ensuring the greatest possible degree of impartiality Action for next year: to continue current process

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: nil Comments: all checks are undertaken prior to employment and for locum doctors involves checks completed by their agency. Action for next year: to continue current process

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

There has been an opportunity to carry out an audit with Northampton General Hospital to benchmark the performance of St Andrew's appraisers compared to those at NGH. This shows a favourable comparison in the two cases that were selected. The organisation has managed to complete all appraisals for the 2020-2021 cycle with meetings that were held remotely and complete new appraiser training.

Actions still outstanding

Updating of the Medical Appraisal and Revalidation and Responding to Concerns policies, which are on course to be completed by the end of September 2021.

Investigation training will continue to be explored as we emerge through the pandemic

Current Issues

Maintaining current levels of appraisal and revalidation practice, whilst remote meetings continue to be held. There is a need to continue to reflect on the full impact of the pandemic as it draws to a close and return to greater face-to-face working.

New Actions:

Updating of the Medical Appraisal and Revalidation and Responding to Concerns policies, which are on course to be completed by the end of September 2021.

Reporting to the People Committee on behalf the Board

Overall conclusion:

In the 2020-2021 appraisal cycle, despite the challenges presented by the Covid pandemic, it was possible to continue to appraise all doctors effectively. A number of revalidations have also been completed well in advance of the deferred date provided by the GMC which is further evidence of an effective system. This has also included the delayed process of Section 12 renewal after the organisation was able to hold its own training event in February 2021. Doctors have been able to continue to pursue CPD activities remotely, both externally and internally through an effective

weekly CPD programme and the availability of online modules and conferences provided by the Royal College of Psychiatrists and other organisations.

Two cycles of the peer review process have now been completed with actions identified for individual doctors to follow-up on.

Lead doctors have, or are already currently being recruited in the areas of: quality improvement, safeguarding and as postgraduate medical lead. This is in addition to the recruitment of new appraisers to replace those who have left the organisation.

No doctors have been referred to the GMC.

Section 7 – Statement of Compliance:

The Board of Directors of St Andrew's Healthcare has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the Designated Body

Chief Executive or Chairman

Official name of Designated Body: St Andrew's Healthcare

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Paper for Board of Directors	
Topic	Caldicott Guardian & Senior Information Risk Owner Annual Report
Date of Meeting	Tuesday, 24 August 2021
Agenda Item	**13**
Author	John Clarke, Chief Information Officer
Responsible Executive	John Clarke / Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	N/A
Patient and Carer Involvement	No patient or carer involvement has been required in the preparation of the submission.
Staff Involvement	Key staff have been involved through the Information Governance Group.
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 ☒
Considered at Committee Meetings	The individual items have been through the Information Governance Group and the paper through ARC.

Report Summary and Key Points to Note

We have met the requirements of The NHS Data Security and Protection Toolkit's yearly submission, which is self-assessed, to providing assurance that we are undertaking appropriate actions on data security and information governance.

We have maintained our externally assured accreditation (ISO 27001:2013 certification) as a key part of our assurance and is a noted best practice recommendation from the NHS. We have also (July 2021) achieved the NHS Wales Cyber Essentials accreditation, again assured by external organisation.

In line with other healthcare organisations, this year has been challenging to achieve the training component due to the impact of Covid-19 on staffing. However, nationally there has been a delay on the submission from March to June 2021, which allowed us to move back up to the 95% yearly training requirement.

The recommendation is that we will provide our submission in June 2021 and state we are “Standards Met”.

Our key risk is the physical security and storage of paper records. We have a clear plan in place for removing this in 2021/22 by the destruction of physical records.

Whilst having self-referred items to the ICO these, for this period, are all now closed with no action against St Andrew’s.

The role of SIRO has now passed to Sanjith Kamath, thus ensuring we have separation of duties, as John Clarke has line management of the DPO.

Appendices

Information Governance Annual Report 2020-2021

Introduction

The purpose of this annual report is to provide assurance to the committee of activity undertaken across the organisation for the reporting period 1 April 2020 - 31 March 2021, in relation to the Charity's requirements to demonstrate compliance with relevant Information Governance standards and laws including the Data Protection Act and responsibilities relation to the role of the Caldicott Guardian.

Compliance with the NHS Data Security & Protection Toolkit

All NHS providers need to provide information security and protection assurances to the NHS on an annual basis. These assurances are provided through completion of an online assessment tool, the NHS Data Security and Protection Toolkit. As part of the Charity's contract with NHS England, the Charity is required to meet a 'Standards Met' compliance status. The Charity met this requirement in June 2021 including the 15 additional requirements that were added in June 2020. The timetable was moved from March to June by the NHS as part of their Covid-19 response.

A notable outcome of the process this year was the need to improve completion of the mandatory Data Security Awareness training. An improvement plan is being created for 2021/22 which considers the differing needs of staff groups rather than providing a single training resource.

Requirements for the NHS toolkit change annually to ensure that the toolkit is up to date with information related legislation. and the DPO is performing a gap analysis against the new requirements. The 2021/22 submission will be overseen by the Charity's Information Governance Group.

Compliance with the Data Protection Act

The organisation processes large amounts of personal and sensitive data about our patients and our staff, and also about carers, volunteers, and others. This means that we are obliged to ensure that we uphold the privacy rights of individuals, and that we make sure we collect, handle and store personal data in accordance with Data Protection law.

The Charity has updated privacy notices for patients, staff, carers and volunteers and an updated policy and procedure set has been published and communicated to staff. Other documentation such as the personal data register and breach register have also been updated. ARC was kept updated of the detail work to achieve compliance through the CIO/DPO's report in January 2021.

Assurance

We continue to work with Internal and External Audit to provide assurance on our approach and eservices.

We continue to hold the ISO27001 accreditation. We achieved full recertification in December 2020 as part of our three-year plan. We have achieved the Standards met criteria for the NHS and we have just received (July 2021) the cyber essential accreditation as required by NHS Wales.

Complaints to the Information Commissioner's Office

The ICO is the UK's independent body set up to uphold information rights in the public interest. Under the Data Protection Act, individuals are entitled to raise a concern or complaint with the Information Commissioner's Office (ICO) if they are unhappy with how an organisation has managed their personal data or addressed their data protection rights.

For the period that this report covers, the organisation has not received any complaints from the ICO.

Subject Access Requests

Under data protection legislation, individuals have the right to find out if an organisation is using or storing their personal data and to request copies of that information. The Charity receives a large number of requests, which tend to come from patients and or their representatives. The Charity also has to deal with a number of third-party requests under the law (mainly regarding patients) from other third parties such as Solicitors, the Police, and other government agencies.

On average we dealt with 75 information requests per month during the period

Under GDPR subjects are entitled to compensation where harm has been caused, even where this is intangible (e.g. embarrassment, loss of reputation). We have seen a small number of these civil claims to date, but we should be conscious that these may increase as data subject awareness of their rights is raised.

Information Governance Breaches

As part of complying with the NHS toolkit and Data Protection law, the Charity is required to have a process for identifying and managing information governance and data protection breaches. This is manged through Datix with any items marked for a potential breach going straight to the IG for triage.

The published guidelines for when data protection breaches become reportable to the ICO are vague and open to interpretation. This leaves us open to challenge in a situation where we have assessed an incident as non-reportable that later ends up as a complaint to the ICO.

In order to support our judgements, we have developed a qualitative severity assessment that gives us a 'default' decision to report or not.

This does not replace the ICO reporting requirements. It is a tool to help consider more complex cases to consider how the contributory factors affect the overall severity of an incident. If there is any doubt, advice should be sought from the DPO, SIRO and Caldicott

Guardian. It is based on a Data Breach Severity Methodology by European Union Agency for Cybersecurity (ENISA). It has been simplified and made relevant to the St Andrews Healthcare environment.

Where we believe that a decision to report to the ICO is borderline but we choose not to report we would now record our internal assessment of the incident using this methodology in case our decision is ever challenged.

We have referred several items to the ICO. All of which are now closed with no action taken against St Andrew's. Any noted learning is then brought to the Information Governance Group for discussion and dissemination.

Resources

We continue to keep Information Governance as a key priority for Board Directors and we are maintaining the mandatory roles:

- The Caldicott Guardian, which is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing, was Lisa Cairns, Chief Nurse. This has now moved to Andy Brogan as the new Chief nurse

- The Senior Information Risk Owner (SIRO), which is a senior person who acts as an advocate for information risk on the Board, was John Clarke, Chief Information Officer. As per the previously communicated plan this role has moved from the CIO to the Executive Medical Director (Sanjith Kamath) during 2020/21 to ensure clear separation of management duties.

The substantive Data Protection Officer (DPO) was on maternity leave during much of the period of this report During this time the DPO role was assigned to an external contractor on a 40% basis. We have recruited to a full-time support role for the DPO, and this is now in place

Data Protection Risks

Part of the role of the DPO is to identify, assess and support the organisation with managing data protection risks. Risks are now formally being taken to the Charity's Information Governance Group for oversight and recorded in the Charity risk register. These risks are reviewed regularly and will be reviewed again as a whole in 2021/22 as part of the move to the new RISK system.

As previously noted, a key risk for us it the retention of historic, mainly paper but not exclusively, records. These pose a risk due to both their physical security and that they are now beyond the record retention dates. However, due to an on-going police investigation, for which some of these records were in potential scope, the board took a decision to not destroy them.

However, time has moved on and we have written to the enquiry team to inform them that we will be destroying them in line with our policies but giving them suitable time to request any additional items.

National Data Opt-OUT

The NHS national data opt-out is a new right for NHS patients to opt out of their confidential patient information being used for anything other than the direct provision of their care. The requirement was extended to include independent providers from 1st September 2020. This date was delayed until the September 2021. We will be able to meet the requirements of this in September 2021.

Impact of Covid-19

The key impact of Covid-19 within this arena was the move to more working from home. The need to enable more people to work remotely accelerated the roll out of IT plans for adopting Office 365 and Teams.

Some risks were accepted in this 'emergency' response which involved changing the security setup to enable people to access files and folders outside of our secure network from non-corporate controlled devices. This has now been removed from the vast majority of users with only a few very senior individuals left who have auditable access in this way

The longer term, more considered adoption of the new 'cloud based' tools, and specifically the design of appropriate technical and procedural security measures has proved difficult to achieve due to cost pressures, but this is key priority of 2021/22.

Key Plans for 2021/22

- The Charity to achieve "standards met" compliance with the updated NHS Data Security and Protection Toolkit in March 2022.
- Rationalisation and restructuring of the policies and procedures that relate to Information Security and Information Governance to reduce contradictions and ease maintenance.
- Resolve the approach to Data Security and Awareness mandatory training to meet 95% compliance.
- To destroy historic paper records that meet the requirement for destruction under the record retention policy
- To enforce the record retention schedule, and to investigate and apply to historic electronic records that we have stored.
- To ensure that the new strategy, such as focus on research, is underpinned by excellent approaches to information governance
- To create a dashboard of IG issues to improve visibility and awareness.
- To ensure smooth, easy but secure access to cloud-based systems and services for all staff.
- St Andrew's is in the process of joining the NHS secure email solution which will make it easier for us to securely work with partners.
- To undertake work with internal and external audit, as appropriate, to provide assurance on our assertions.

Recommendations

The committee are asked to note the content of this report and progress made in 2020/21 and to comment on whether further assurance for 2020/21 is required and or changes to the plans set out above for 2021/22.

Sanjith Kamath	**Andy Brogan**	**John Clarke**
SIRO (2021/22)	**Caldicott Guardian**	**SIRO (2020/21)**

Paper for Board of Directors	
Topic	Modern Slavery Statement
Date of Meeting	Tuesday, 24 August 2021
Agenda Item	**14**
Author	Rachel Brown, Head of Commercial Legal
Responsible Executive	Martin Kersey, Executive HR Director
Discussed at Previous Board Meeting	Annual Modern Slavery Statement approved at Board Meeting last Sept 2020
Patient and Carer Involvement	Patients and Carers have not been involved
Staff Involvement	Staff have not been involved
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	None

Report Summary and Key Points to Note

We are required to publish a Modern Slavery Statement on or website every year, the Modern Slavery Statement has been refreshed with current staff numbers and an update on purchasing actions and is submitted for approved by Board.

Appendices

Modern Slavery and Human Trafficking Statement

This statement is made pursuant to s54(1) of the Modern Slavery Act 2015 and sets out St Andrew's Healthcare's modern slavery and human trafficking statement in relation to actions and activities for the financial year ending 31 March 2021.

We are committed to preventing slavery and human trafficking in our business activities and to ensuring that our supply chains are free from slavery and human trafficking.

Organisational Structure
We are a charity and a unique and influential pioneer in mental health, with a reputation grown over 180 years. We have sites in Northampton, Birmingham, Essex and Nottinghamshire employing over 4,200 people, providing specialist and secure care and treatment in mental health and neuropsychiatry.

We have adopted the following practices, policies and approaches to help us address any potential slavery or human trafficking risks:

People
- We have robust procedures in place for recruiting our workforce. We ensure that all applicants are legally entitled to work in the UK. All staff undergo a full DBS (Disclosure & Barring Service) check.
- We pay all staff above the National Minimum Wage.
- Our directors are checked against the Fit and Proper Person Regulations to ensure they are compliant with these Regulations before they take up their position.
- Our Staff Code of Conduct helps promote a culture where transparency, honesty and fairness are the norm. Our Code forms part of our contractual terms with our staff.
- Staff training (including Director training) is continually reviewed and updated to ensure every person has awareness of our regulatory compliance responsibilities including modern slavery, safeguarding and anti-bribery. Such training is mandatory and completion is actively monitored.

Freedom to Speak Up (Whistleblowing)
- Our workforce and service users, as well as anyone we do business with, are encouraged to report and expose unethical or inappropriate activities, procedures or behaviour within our business and supply chain.
- Our Freedom to Speak Up and Whistleblowing Procedure is intended to make it easy for disclosures to be made without fear of consequence. The policy encourages people to raise concerns directly with their line manager, HR, any senior executive or through the Charity's appointed Freedom to Speak Up Guardians. There is also free access to an independent service through which to report any concerns.
- Any modern slavery or fraud concerns raised are thoroughly investigated by us and actioned appropriately in accordance with our robust procedures and standards and outcomes reported through our Board of Directors and, where relevant, our Audit & Risk Committee.

Diversity and Equality
We are fully committed to proactively promote diversity, equality of opportunity and human rights for all and to creating a culture of inclusivity for the people who provide and use our services. The Charity's Board reviews the Charity's Diversity and Inclusion report and approves the Diversity and Inclusion Strategy annually.

Procurement & Supply Chain
The Charity is committed to ensuring that its suppliers and supply chain adhere to the highest standards of ethics and integrity. We achieve this through our relationships and contractual requirements:
- Our procurement guidance for staff ensures that all new suppliers are appointed in conjunction with our Procurement Team so appropriate checks can be taken.
- Our procurement process includes (within our pre-qualification questionnaire) questions regarding the Modern Slavery Act. Any supplier unable to declare their compliance with the Act will be excluded from the procurement process.
- Our standard procurement contracts contain a requirement for the supplier to ensure ongoing compliance with the Modern Slavery Act and allow us to terminate the relationship, should compliance not be maintained.
- We have a Supplier Code of Conduct which includes a specific requirement to comply with Act.

Review of Effectiveness
Whilst we have had no modern slavery issues reported to date, we are committed to regularly reviewing our procedures and seek to continually improve our practices to prevent modern slavery and human trafficking.

In 2021/22, we will continue to review our safeguarding strategy, policy and procedures and general training plan to ensure that modern slavery and human trafficking are adequately covered.

The Board approved this statement at its meeting on [ ] 2021.

……
Katie Fisher, Chief Executive, St Andrew's Healthcare
[ ] 2021

NHS Providers Board Development Programme

(Katie Fisher – Verbal)

Sub Committee Updates

Quality and Safety Committee
June and August 2021
Professor David Sallah

Pension Trustees
June 2021
Martin Kersey

Audit and Risk Committee
April and August 2021
Elena Lokteva

Research Committee
July 2021
Professor Stanton Newman

People Committee
July 2021
Paul Burstow

Committee Escalation Report to the Board of Directors

Name of Committee:

Quality and Safety Committee (QSC)

Date of Meeting:

08 June 2021

Chair of Meeting:

Professor David Sallah

Significant Risks/Issues for Escalation:

- Staffing number levels and solutions being looked at.
- Quality Account, revisions and approval
- Process of managing SIs. Better control and more assurance is now being seen in this area.

Key issues/matters discussed:

- **ASD & LD deep dive**

  The deep dive was presented by the division and noted. Discussions included, issues relating to maintaining quality within a number of wards; improved leadership within the Women's wards; planned transition of patients into community settings and improvements in governance oversight.

- **Executive Medical Director report**

  The committee noted the EMD report and that there had been an increase in staff within Safeguarding, increasing the Charity's capacity in this area.

- **Chief Nurse report**

  The committee noted the Chief Nurse report

- **Safer Staffing**

  The committee was presented with an update report on work progressing around Safe Staffing, including an update on the new M-Host rostering tool and benchmarking data from NHS Trusts.

- **Quality Improvement Plan**

  The quality Improvement plan was presented and noted. The committee was made aware of improvements in reporting brought about by the new joint performance and quality approach to the plan commencing in June.

- **Serious Incidents**

  The serious incidents in the last period were reviewed. It was noted that the expanded SI team continue to improve the reporting and investigation process for serious incidents.

- **Quality Account**

  The final draft 2020/21 Quality Account was presented to the committee. The committee made a number of recommended amendments and additions. The committee approved the Quality Account ahead of submission to the Board.

- **Quality and Safety Group (QSG)**

  The Quality and Safety Group report was received and noted.

Decisions made by the Committee:

- **St Andrew's Healthcare 2020-21 Quality Account**
  The committee approved the Quality Account ahead of submission to the Board

- **Mortality Surveillance Report**
  The committee approved the report for submission to the Board

- **Complaints Annual Report**
  The committee approved the report for submission to the Board

Implications for the Charity Risk Register or Board Assurance Framework:

- R224 – Integrated Patient Healthcare Management – following a comprehensive deep dive the likelihood has increased from "possible" to "likely", increasing the Residual risk score. Under the new 5x5 scoring matrix used for Material Risk, the residual score is now 16.
- R1011 – Unwarranted Clinical Practice Variation – following a comprehensive deep dive the impact was reduced from "high" to "moderate", decreasing the Residual risk score. Under the new 5x5 scoring matrix used for Material Risk, the residual score is now 12.

Issues/Items for referral to other Committees:

- None

Appendices:

- None

Committee Escalation Report to the Board of Directors

Name of Committee:

Quality and Safety Committee (QSC)

Date of Meeting:

10 August 2021

Chair of Meeting:

Professor David Sallah

Significant Risks/Issues for Escalation:

- Community Partnerships – issues with patient information system and digital solutions that are having a negative impact on delivery of services. Along with the relatively high number of information governance issues seen within the division (12 in 12 months).

- Staffing number levels and solutions remain a key focus. Effective governance and oversight measures are now in place to monitor progress with the on-going developments. QSC confirms that subject to Board approval that it will assume responsibility for governance oversight of safer staffing monitoring, reporting, controls and assurance.

Key issues/matters discussed:

- **Community Partnerships divisional deep dive**

  The deep dive was presented by the division and noted. Discussions included development of RiO for use within Community Partnerships, issues relating to information governance over patient records, CQC Transitional Monitoring Approach appears to have been well received and the division is seeing an increase in demand for its Neurodevelopmental Assessments.

- **ASD & LD deep dive update**

  The deep dive follow-up was report was received and noted including a detailed training needs analysis. Concerns remain within the division over leadership and staffing, The division is seeing the benefit of following the STOMP (Stopping Over Medication of People with learning disabilities and autism, or both) programme with very low levels of rapid tranquilisation.

- **Executive Medical Director report**

  The committee noted the EMD report. The report highlighted the outcome of the recent CQC unannounced inspections of the Men's and Women's services as well as a focussed review on controlled drug errors.

- **Chief Nurse report**

  The committee noted the Chief Nurse report. The report gave an update on the development of an eRostering solution and the work to implement a Safer Staffing Tool.

- **Quality Improvement Plan**

  The quality Improvement plan was presented and noted. A new Single Point Action Plan has been developed as highlighted at the previous QSC to absorb the open actions from the QIP and is based on improved “SMART” methodology.

- **Serious Incidents**

  The serious incidents in the last period were reviewed. It was noted that there were a relatively high number of open investigations that were awaiting closure from the commissioners (although no additional work has been requested at this time). The committee gained assurance that lesson were being learned and monitored.

- **Integrated Performance Report**

  An initial Integrated Performance Report template was presented and noted. Further discussions are required on what information is to be included and how it is presented for the QSC so that it provides clear information and does not duplicate information contained in existing separately provided reports. The report is to represent all areas of Quality environment.

- **Health & Safety Annual Report**

  The committee noted the report. The report highlighted the key issues, actions and activities relating to the Health & Safety environment within the Charity.

- **Handover Process update**

  The committee received an update on the development of the Charity-wide Handover process. It was noted that the process remains under review with a number of confirmed actions being measured as part of an agreed approach.

- **Quality and Safety Group (QSG)**

  The Quality and Safety Group report was received and noted.

- **Mental Health Law Steering Group (MHLSG)**

  The MHLSG report was received and noted.

Decisions made by the Committee:

- **St Andrew’s Healthcare Annual Safeguarding Report**
  The committee approved the Annual Safeguarding Report ahead of submission to the Board subject to a number of minor amendments and additions.

- **Nursing Strategy**
  The committee approved the strategy for submission to the Board.

- **Safer Staffing governance oversight and assurance**
  The committee confirms that subject to Board approval that it will assume responsibility for governance oversight of safer staffing monitoring, reporting, controls and assurance.

Implications for the Charity Risk Register or Board Assurance Framework:

- R1271 (now R868 on Datix) – COVID-19 Infection and Pandemic – the overall residual risk rating for the material risk remains consistent and under the new scoring system is 9, with a moderate impact and possible likelihood. The risk is being maintained constant

as a result of the effectiveness of controls already in place and the supplementary controls which are being implemented.

- R264 – Restrictive Patient Interventions – the overall residual risk rating for the material risk remains consistent and under the new scoring system is 9, with a moderate impact and possible likelihood. The risk is being maintained constant as a result of the effectiveness of controls already in place and the supplementary controls which are being implemented. Whilst the risk score remains consistent, the operational significance of the risk is still seen as unacceptable and there remains a constant vigil maintained around the effectiveness of the required controls.

Issues/Items for referral to other Committees:

- None

Appendices:

- None

Committee Update Report to the Board of Directors

Name of Committee:
Meeting of Directors of St Andrew's Pension Trustees Limited

Date of Meeting:
24 June 2021

Chair of Meeting:
Martin Gaskell

Significant Risks/Issues for Escalation:
- None

Key issues/matters discussed:
- GMP reconciliation and equalisation projects
- Scheme funding approaches
- Appointment of new Chair of the pension Trustee Board
- Long-term funding objective

Decisions made by the Committee:
- Agreed to appoint Martin Kersey as Chairman of the pension Trustee Board

Implications for the Charity Risk Register or Board Assurance Framework:
- No Change for Pension Risk on the Risk Register

Issues/Items for referral to other Committees:
- None

Issues Escalated to the Board of Directors for Decision:
- None

Committee Update Report to the Board of Directors

Name of Committee:

Audit and Risk Committee

Date of Meeting:

19 April 2021

Chair of Meeting:

Elena Lokteva

Significant Risks/Issues for Escalation:

Committee remains very conscious that current risk management system can provide the Board with partial assurance only.

At the date of ARC meeting Material Risk Register includes 21 material risks. During the past three months 5 risks were identified as having reduced in their overall rating and 2 increased. The two being:

- achieving positive cultural change, and
- integrated mental & Integrated Patient (physical and mental) healthcare management.

Key issues/matters discussed:

1. External audit plan and strategy

The Committee (ARC) considered the external audit plan and strategy presented by PWC partner Gill Hinks. Having scrutinised these plans, the committee supported the planned scope and timing of the statutory audit of the Charity.

Committee confirmed to PWC that it is not aware of fraud, either actual, suspected or alleged, including those involving management. Committee promised to inform the auditors if anything arises and requested our IA and management to do the same.

2. Annual Report

Committee thanked Alex Owen (AO) for the suggestion how to improve our annual reporting process and make it more economical. It supported proposed decoupling of Annual Report and Financial Statements and asked AO to organise a Page Turning Review of the draft Annual Report and Accounts and invite all Board members to go through the content of the final version ahead of formal approval at the Board on 29 July.

Committee noted that there are no amendments to our accounting policies in FY20/21. Therefore, decision on adoption of the new policies was not needed.

3. Risk

ARC reviewed the risk management and risk register including scrutinising the current program of work to transition to DATIX as our primary risk management and reporting system. This work is due to conclude by the end of June 2021.

There was recognition about the positive impact of the work to date and desire to establish wider organisation's commitment to a culture of active risk management, led from the Board and the wider leadership of the Charity.

The ARC received the review of the Material Risk Register, of the 21 material risks, 5 were identified as having reduced in their overall rating and 2 increased. The two being:

- achieving positive cultural change, and
- integrated mental & Integrated Patient (physical and mental) healthcare management.

With the aim to gain an assurance that current frequency of material risks reviews is adequate and sufficient, ARC asked management to provide a justification for quarterly reviews of the material risks with the score above 25 for July meeting.

4. Internal audit

The committee reviewed the current internal audit work program and requested that the practice of changing actions due dates from their original timescale cease, in favour of maintain the original timescales with an explanatory narrative where there is a slip.

Further analysis was requested by the ARC regarding the 2020/21 partial assurance received in relation to Standards of Ward Cleanliness. In particular, the adequacy of management response and its timing for recommendations implementation.

2021/22 the internal audit plan was agreed with the requested reintroduction of the audit of the Quality Account and the extension of the inclusive recruitment audit to be broadened to encompass career progression.

The committee raised concerns about

- regular and multiple changes in IA plan during the FY20/21
- the fact that there is no full-time leadership role in the Internal Audit function
- the task of performing 20/21 internal audits across the charity was placed on a single full-time resource.

Options regarding the potential to outsource the internal audit function within the Charity were received and considered. The recommendation to maintain an internal audit function within the Charity with more aligned operating model across other aligned functions of the Charity was not supported due to insufficient information being available and as such the ARC will consider this further at its meeting in July.

5. Counter fraud

   ARC received and considered the report relating to potentially fraudulent activity in the previous period along with a work plan for 2021/22. The committee:

   - Approved Counter Fraud Work Plan 2021-22 as a very high-level plan
   - With the aim to gain an assurance that areas selected for proactive coverage are appropriate, committee asked LCFS to conduct an evaluation of our current fraud risk profile and present at the next ARC meeting key fraud and bribery risks which warrant counter fraud coverage in FY21/22

6. Emergency Preparedness Response & Resilience

   Having received the biannual update from the Chief Operating Officer, the committee noted the role Paul Parson's had played historically in supporting our EPRR functions and noted that in his absence the EPPR program would report directly to ARC rather than have a nominated NED aligned. In addition, the committee supported the COO in identifying any subject matter expertise that would result as a consequence of Paul's absence.

7. Quality Account

   ARC noted the required revised timescales relating to the production of the Quality Account as agreed by the Quality & Safety Committee ahead of its presentation to the Board in May 2021.

Decisions made by the Committee:

- Approved planned scope and timing of the statutory audit of the Charity
- Agreed the proposal to simplify and align annual and financial reporting timelines
- Internal audit plan for 2021/22 was agreed, subject to reintroduction of the audit of the Quality Account and the extension of the inclusive recruitment audit to be broadened to encompass career progression
- Approved Counter Fraud Work Plan 2021-22 as a very high-level plan

Implications for the Charity Risk Register or Board Assurance Framework:

For July ARC requested a justification for the current frequency of reviews for material risks with a score greater than 25.

Issues/Items for referral to other Committees:

-

Issues Escalated to the Board of Directors for Decision:

-

Committee Update Report to the Board of Directors

Name of Committee:

Audit and Risk Committee

Date of Meeting:

03 August 2021

Chair of Meeting:

Elena Lokteva

Significant Risks/Issues for Escalation:

- Whilst there has been significant progress with the improvements required over the risk management system, the Committee remains very conscious that current risk management system can provide the Board with partial assurance only.

  The ARC received the latest review of the Material Risk Register, of the 21 material risks, 14 were identified as having changes to their residual ratings, with 3 increased. The three being:
  - Violence and Aggression
  - Health & Safety Management
  - Integrated Patient (physical and mental) Healthcare Management

  Two material risks have been proposed for retirement, with 5 new material risks proposed to be added to the register. Once confirmed the Material Risk Register will contain 24 risks.

No Head of Audit Assurance Opinion was provided within the Internal Audit Annual Report that was presented. The Committee were concerned that no overall opinion had been provided in this instance as the IA & Risk Manager did not feel he was in a position to provide one this year due to him being the third IARM in post during the reporting year and the reduction in the size by of the Internal Audit function by 40% from 1 April 2020. As a result, number of engagements was down from 27 to 15, 7 of which (47%) have no opinion (advisory engagements). Committee noted portfolio of assurance opinions delivered in FY20/21: 5 adequate assurance, 2 partial and 1 limited.

Key issues/matters discussed:

1. St Andrew's Property Management Ltd (SAPML) accounts 31 March 2021

The Committee (ARC) reviewed the proposed SAPML accounts for year ending 31 March 2021. The accounts rely on a letter of comfort from St Andrew's Healthcare and this is subject to the on-going work on the SAH going concern and post balance sheet events. Committee confirmed to postpone the approval and to align the final review with the SAH accounts review and sign off process.

2. St Andrew's Healthcare (SAH) Statutory Accounts 31 March 2021

The Committee reviewed the updated accounts, following the detailed ARC Page Turning

exercise completed on 29 July ahead of the meeting. The Committee was satisfied with the responses to queries raised at the page turning exercise and agreed to the revisions within the accounts' text where applicable.

The Committee discussed the timeline for finalising the SAH accounts and confirmed that they would be approved at the September 30th Board meeting, with an extraordinary ARC being held on 23 September to complete a final review ahead of submission for approval.

3. Price Waterhouse Coopers audit report

The Committee noted the audit report from PwC and agreed that it would be discussed with PwC at the 23 September ARC meeting.

4. Risk

ARC acknowledged that the risk management system had now migrated across to Datix from the previous system, and recognised the significant level of work that this has required by all those involved, along with the positive impact that this will have on St Andrew's. All risks within Datix have undergone a recent review and represent the latest risk assessment by the owners supported by the Risk team.

There was recognition about the positive impact of the work to date and desire to establish wider organisation's commitment to a culture of active risk management, led from the Board and the wider leadership of the Charity.

The ARC received the latest review of the Material Risk Register, of the 21 material risks, 14 were identified as having changes to their residual ratings, with 3 increased. The three being:

- Violence and Aggression
- Health & Safety Management
- Integrated Patient (physical and mental) Healthcare Management

Two material risks have been proposed for retirement, with 5 new material risks proposed to be added to the register. Once confirmed the Material Risk Register will contain 24 risks.

To further enhance the reporting of material risks to the Committee, ARC requested that a roadmap is provided in all future updates that highlights updates on scorings, review process undertaken and trajectory of risks.

5. Internal audit

The Committee reviewed the current internal audit actions dashboard and were pleased to see the reduction in overdue actions, with only one low priority action now overdue for completion, however there were a relatively high number of action due (25) for completion that needed to be addressed.

The Committee also reviewed the latest status of the Internal Audit work program and highlighted the potential capacity issue with the team and whether they could deliver as planned. The Committee was informed of a benchmarking exercise that would be presented at the next meeting that would assist in confirming the capacity position of the IA team.

The Internal Audit Annual Report and Head of Audit Assurance opinion was

presented. The Committee were concerned that no overall opinion had been provided in this instance as the IA & Risk Manager did not feel he was in a position to provide one this year due to him being the third IARM in post during the reporting year and the reduction in the size by of the Internal Audit function by 40% from 1 April 2020. As a result, number of engagements was down from 27 to 15, 7 of which (47%) have no opinion (advisory engagements). Committee noted portfolio of assurance opinions delivered in FY20/21: 5 adequate assurance, 2 partial and 1 limited.

6. Counter fraud

   ARC received and considered the Counter Fraud Annual Report, along with the NHSCFA annual functional standard return, this established that the Charity was adhering to the standards expected within the four main standards areas of “strategic governance”, “inform and involve”, “prevent and deter” and “hold to account”, and that an overall green rating had been achieved.

   The Committee also received and reviewed the latest counter fraud activity update that included information on closed investigations relating to potentially fraudulent activity in the previous period. The committee was comfortable with the apparent anti-fraud culture being maintained within the Charity.

   Following a request at the last ARC meeting, a detailed Charity-wide Fraud Risk Assessment was presented and discussed. This assessment was completed in conjunction with the HR, Finance and Procurement teams and in accordance with the Government Counter Fraud Profession (GCFP) risk assessment methodology and the Charity’s risk management procedures. Thirty fraud specific risks have been identified and the assessment details the current controls in place and management’s self-assessment of the risk rating.

7. Board Assurance Framework (BAF)

   The Committee received an update on the development of the Charity’s BAF. At the stage presented, the Committee was asked to provide feedback on the format and process being developed. The Committee clarified what it expected its role to be in regards to oversight of the BAF and that other Board committees were to be have a formal involvement in the process.

   It was agreed that the BAF would return for further review once the Charity’s strategy for 2021-26 was finalised so that the BAF could be populated with relevant risks and objectives. Further clarity on how the BAF aligns with the Material Risk Register was requested.

   The Committee also requested that a pictorial representation of the BAF and overall Risk Management process be developed that provides clarity on how the levels of assurance are obtained and how each respective element fits together. This is to be brought back to the next ARC meeting.

8. Senior Information Risk Owner and Caldicott Guardian annual report

   ARC noted the report and the assurances that it provided over the information governance and patient confidentiality controls and processes.

9. Approval of appointment of external auditors.

ARC noted the work that had gone into the selection process for external auditors and approved the proposed appointment ahead of approval by the Board and submission to the October AGM.

10. Cyber Incident

    The Committee received a detailed report into the March 2021 Cyber Incident, that highlighted the initial response, how the incident was reported both internally and externally and the lessons learned.

Decisions made by the Committee:

- Approved the appointment of the external auditors ahead of submission to the Board and the October AGM.
- Agreed to defer the approval of the SAPML and SAH accounts in line with the revised reporting and approval timeline

Implications for the Charity Risk Register or Board Assurance Framework:

It was agreed that the BAF would return for further review once the Charity's strategy for 2021-26 was finalised so that the BAF could be populated with relevant risks and objectives. Further clarity on how the BAF aligns with the Material Risk Register was requested.

The Committee also requested that a pictorial representation of the BAF and overall Risk Management process be developed that provides clarity on how the levels of assurance are obtained and how each respective element fits together. This is to be brought back to the next ARC meeting.

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- StAH Internal Audit Annual Report 2020-21

Committee Update Report to the Board of Directors

Name of Committee:

Research Committee

Date of Meeting:

7 July 2021

Chair of Meeting:

Stanton Newman

Significant Risks/Issues for Escalation:

- Plan to get new research strategy to the Board in October

Key issues/matters discussed:

- Two Clinical Secondments, Charlie Staniforth and Inga Stewart, introduced to the Committee and their research areas were presented
- An update of current research projects were presented to the committee (currently 56 projects are live and in write-up)
- The draft Research Strategy was discussed and further comments requested from the members following the meeting

Decisions made by the Committee:

- New draft strategy to be finalised by 25 August and will be presented to the CEC

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- Request for following members to have their terms extended from October 2021 to end October 2022 by which time the Research Strategy will have been agreed:
  Sanjith Kamath
  Bryan Green
  Kieran Breen
  Kevin Browne
- All documentation completed for referral to the Nominations and Remuneration Committee

Issues Escalated to the Board of Directors for Decision:

- None

Committee Update Report to the Board of Directors

Name of Committee:

People Committee

Date of Meeting:

12 July 2021

Chair of Meeting:

Paul Burstow

Significant Risks/Issues for Escalation:

- The staffing concerns in Northampton were discussed in depth. A number of short and long term actions are being taken to improve the position.
- Overall mandatory training levels are above target (90%) at 93% in June. For areas below 90% a clear action plan is in place and the numbers attending training has improved.

Key issues/matters discussed:

- A Health and Safety update was provided by the Chief Information Officer focusing on the actions taken since the previous meeting including Executive and CEC level training being completed, a continued focus on mandatory training completion and confirmation that operational issues, such as Violence and Aggression and RIDDOR reporting were being reported to CEC on a twice weekly basis
- An in depth update was provided by the Chief Operating Officer on the operations staffing status focusing on the Northampton site. Key actions include introducing a new rostering approach, offering shift flexibility, continued absence management and working with local partners such as the Northamptonshire People Board to assess staff shortages and system actions
- The Diversity and Inclusion strategy for employees (2021-24) was reviewed focusing on:

- *fixing the basics*
- *improving male and female representation*
- *mental health in the work place*
- *Tackling and promoting fairness*

- People KPIs update including turnover, absence, nurse fill rate, agency spend and mandatory training
- Updates were provided from the following reporting groups:

- BENNs Group
- Carers Group
- Employee Forum
- Learning & Development Group
- Inclusion Steering Committee

Decisions made by the Committee:

- Diversity and Inclusion Strategy reviewed and approved

Implications for the Charity Risk Register or Board Assurance Framework:

- There are staffing shortages within the Northampton site and this is a key priority for the charity
- Health and Safety and the high number of RIDDORs previously identified is an area for ongoing monitoring
- Mandatory training is 93% overall and training that is below 90% (ILS, BLS and Safeguarding level 3) is showing improvement

Issues/Items for referral to other Committees:

- Prems and patient survey action group updates to proceed to the Quality and Safety Committee

Issues Escalated to the Board of Directors for Decision:

- None

Questions from the Public for the Board

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public – 30 September 2021 9.00am

(Paul Burstow - Verbal)