CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART TWO

Thursday 28 January 2021 at 10.15 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	Info	Paul Burstow		*2*	*10.15*
Administration						
2.	Declarations of Interest	Info	Paul Burstow		*3*	*10.18*
3.	Minutes from the Part Two Board of Directors Meeting on 26 November 2020	Dec	Paul Burstow	✓	*4-13*	*10.25*
4.	Action Log and Matters Arising	Info & Dec	Paul Burstow	✓	*14-16*	*10.30*
Executive Update						
5.	CEO Report	Info	Katie Fisher	✓	*17-22*	*10.35*
Operations						
6.	Performance Report	Info & Dec	Alastair Clegg	✓	*23-30*	*10.50*
7.	Covid-19 Response	Info & Dec	Alastair Clegg	✓	*31-46*	*11.05*
8.	East Midlands Alliance – Common Board Paper	Info	Jess Lievesley	✓	*47-59*	*11.20*
Break at 11.25 pm						
Patients and Quality						
9.	Divisional Presentation (including patient voice): Willow Ward – Women's Blended Pilot	Info	Alastair Clegg *(Alex Hamilton and Patient)*		*60*	*11.35*
Workforce						
10.	Your Voice update	Info	Martin Kersey *(Tom Bingham)*	✓	*61-68*	*12.00*
Governance and Assurance						
11.	External Governance Review update	Info	Katie Fisher	✓	*69-70*	*12.10*
12.	Interim Governance and Assurance Map Refresh	Info	Duncan Long	✓	*71-74*	*12.15*
13.	**Sub Committee Updates** • People Committee • Quality and Safety Committee • Audit and Risk Committee • Pension Trustees	 Info & Dec Info & Dec Info & Dec Info	 Tansi Harper David Sallah Elena Lokteva Martin Kersey	 ✓ ✓ ✓ ✓	*75* *76* *77-78* *79-80* *81*	*12.20*
Any Other Business						
14.	Questions from the Public for the Board	Info	Paul Burstow		*82*	*12.35*
15.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Info	Paul Burstow		*83*	*12.40*
16.	Date of Next Meeting – 25 March 2021	Info	Paul Burstow		*84*	*12.45*
Meeting Closes at 12.45 pm						

Welcome and Apologies

(Paul Burstow – Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Minutes of the Board of Directors Meeting Part Two on 26 November 2020

(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 26 November 2020 at 10.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Tansi Harper (TH)	Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Paul Parsons (PP)	Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
David Sallah (DS)	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:	
Alastair Clegg (AC)	Chief Operating Officer
John Clarke (JC)	Chief Information Officer
Duncan Long (DL)	Company Secretary
Paul Stankard & Patient (Agenda item 6) (PS)	Clinical Director
Murtz Daud (Agenda item 9)	Head of Business Intelligence
Alison Smith (Minutes)	Committee Secretary

Apologies Received:
No apologies were received.

Agenda Item No		Owner	Deadline
1.	**Welcome** PB welcomed everyone to the second part of the Board of Directors (Board) meeting, the part being presented as a further trial of future meetings in public. PB welcomed AB to St Andrew's and to his first Board meeting as Chief Nurse.		
ADMINISTRATION			
2.	**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.		
3.	**Minutes Of The Board Of Directors Meeting, Part Two, on 24 September 2020** The minutes captured at the meeting of the Board on 24 September 2020 were reviewed and agreed as an accurate and true record of the discussions.	**Decision**	

4.	**Meeting Part Two - Action Log & Matters Arising** There were no actions or matters arising to record. 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**
EXECUTIVE UPDATE			
5.	**CEO Report** KF presented the report which was taken as read. KF then updated the Board on a recent serious incident that occurred on of a ward. KF advised that the serious incident investigation process had been immediately instigated and the external 24 and 72 hour notifications had been submitted and executive level independent investigators have been commissioned to lead this process. A senior health and safety colleague was also conducting a simultaneous H&S investigation into the incident and the Charity was working closely with colleagues in Northamptonshire Police who are conducting a criminal investigation. She was unable to comment further on any immediate conclusions of the investigations as the process was ongoing. Once the investigations were concluded, a deep dive review would be undertaken by QSAC prior to reporting back to the Board. KF reassured that Board that colleagues within Trauma, Occupational Therapy and experts within the multi-disciplinary team were supporting staff and colleagues involved in the incident, as well as those who weren't present but who have also been affected. KF advised she was happy to take questions about the incident as well as other items within the report. EL asked when QSAC would receive the 24 / 72 hour reports as well as the root cause analysis. KF advised of the 60 day requirement for the process to be completed and to be submitted externally. This timeframe is the limit rather than a target but the Charity wants to ensure a comprehensive investigation has been carried out, with conversations had and statements made by all those present and affected. This will obviously be driven by their availability depending on how well they are and their recovery. AB advised there are strict timescales internally, we set 45 days to get the report to us for quality assurance and executive sign off, the deadline for this being 20th January 2021. The deadline for submitting the final report to the commissioners is 4th February 2021. If we could do it quicker we would however this will be a complex investigation. AB reiterated KF's comments that this was being handled as a joint serious incident and HSE investigation in order to minimise the number of staff interviews required, as HSE will have an interest. AB confirmed that Terms of Reference had been signed off this week as the investigations has started and he was confident the timescales could be met and KF assured the Board that root cause analysis would be used. SK assured the Board that immediate and short term management had been overseen by senior clinicians, so risk plans for this ward were being implemented effectively. The Board noted the position on the incident and the investigation. TH sought clarification on when and who led the CQC thematic review in terms of the report and advised it would be useful for the outcomes of the CQC Charity-wide engagement meeting to be shared with the Board. KF advised that Ash Roychowdhury was the Deputy Medical Director and Executive lead in terms of responding to the thematic review, as he heads up the reducing restrictive practices programme, which is overseen in the formal clinical governance oversight group that he chairs. The group reports into the		

	CEC and this was the formal governance mechanism. KF advised that the charity wide engagement meeting was a regular meeting during which KF, AB, AC, SK met with relationship managers from the CQC to review progress and to develop more productive relationships. TH asked whether the Well-Led action plans submitted to the CQC during the May Board meeting had been accepted. JL advised that the Well-Led action plans drawn up following the October 2019 inspection of the Charity had been submitted to the CQ, that all of the actions had been endorsed, with no further follow up placed on us by the CQC. TH felt that, as employers, the Board were committed to the voice of the Charity's staff, of the patient and the carers and therefore the impact of COVID on staff, and the lessons learned from what they have gone through, should be reflected on and responded to by Board. KF advised that based on feedback received from staff, work had been done around better clinical supervision and enhanced support. Staff reward schemes are considered more broadly not just financially. PB commented that, whilst the point about lessons learned was well made, the lessons were still evolving as we are still in the middle of the crisis and he felt it would be useful for MK to provide feedback through the People's Committee on the work he is undertaking and for the Board to keep this under review. AC confirmed that those lessons learned during the first wave had been implemented into second wave. A lesson now captured was not being sufficiently close to NHSE colleagues who could provide us with advice and a steer for the second wave. We now have an infection prevention and control lead contact within NHSE who attends our meetings and who has really helped with a more robust response. We are far more automated so when an outbreak happens AC, AB and SK email a check list to colleagues of actions to be taken and feedback from staff so they feel more secure. PB commented that from other health organisations he works in, the thing most palpable was the level of tiredness and anxiety and that would not be any different to St Andrew's. Those outside of the organisation looking in, need to bear in mind the nature of the pressures faced by this and other health care organisations. SN sought clarification of the wording on page 18 of the report relating to staff training within the eating disorder environment. KF advised that the ward in question was not an eating disorder unit, but a unit for people with personality disorder that happen to present with disordered eating, so whilst those staff had all received training around support for people presenting with disordered eating there was an extra layer of specialism around personality disorder and disordered eating. Training to meet this specialism had been commissioned and the implementation of a roll out programme planned, but postponed due the first wave of lock down. SK assured the Board that all staff have now received this additional training. KF advised that the detailed implementation plan sits with QSAC, where it was being reviewed, and she was happy to provide an additional timeline or implementation plan to the Board. The Board agreed with PB's statement that the Charity's committees should be used to provide line of sight to the Board as necessary PB asked a question regarding the uptake of the Flu Vaccine campaign, MK updated the Board that 37% of staff had taken up the vaccine. PB acknowledged this was better than in previous years and it was agreed that a campaign wash-up would be undertaken by the People's Committee for reflection on lessons learned.		

PATIENTS AND QUALITY			
6.	**Divisional Presentation: Mansfield – Lessons Learned** AC provided verbal background to the presentation and advised the Board that the closure was led by PS and his team. The feedback received from NHSE of how the closure was managed, including staff engagement, was exceptional. PS provided the Board with an overview of the timeline associated with the closure of the site, including reflections on the lessons learned and what should be done in the future. He was joined by a Mansfield patient (C) who provided insight into living in a place that was closing. PS outlined that the most significant concern in this process was finding suitable accommodation in the community and the team enlisted the help of a national expert who works for NHSE in sourcing and adapting accommodation in the community. Where possible the team tried to get patients back to their own home area. PS highlighted that over the course of 2020 and through supporting staff and patients through the difficult time, they were able to reduce the number of restraints and seclusions. The number of incidents also went down, as well as violence overall across the three wards in Mansfield. C provided the Board with an outline of their observations of the move, and stated that the move wasn't welcome. They didn't want to move and didn't like the idea of having to start their progress all over again with a new psychologist who may not be happy with the handover and who would want to start the process again under their terms. It was also a stressful time for the regular health care assistants, who'd worked there for many years, whose attitudes changed because they just wanted to leave and claim redundancy and this wasn't hidden from patients. C was aware that there wasn't an autism service in their own area and commissioners failed on time to find somewhere else. As they receive a lot of family support they didn't want to move to Northampton so the whole process throughout was really stressful. This applied to a lot of patients who didn't know what was going to happen to them and who didn't know until two weeks before closure where they were going and although serious incidents reduced, it didn't take away from the mental stress for patients and staff. They advised that it was irritating to learn that the closure date wasn't delayed as a result of Covid, yet all leave and treatments were cancelled which delayed patient progress and this seemed unfair. After the move to Fitzroy the patients found it was extremely slow to get things actioned, for example getting off the ward could take a long time and whilst improvements had been made, patients were repeatedly bringing issues that weren't being dealt with. At PB's request the patient provided details of incidents that had been reported but not addressed. AC apologised for the delay in these issues being investigated and advised he would address these with the ward following today's meeting. When asked how it could be made easier to stay in touch with families who live further away the patient suggested easier access to video calls. They believed an iPad was available but patients haven't been told what options were available for family contact. Also, greater clarity was needed when there was a lock down or procedure changes. At the end of October and during the current lockdown, the patients asked nursing staff how this would change family visits and they received mixed messages. It was important for management to quickly come to a decision and communicate this as clearly and as quickly as possible to all patients in the service and be as reasonable as possible with family contact. JC advised these issues had been the subject of discussions this week and that key changes were happening over the coming weeks which would result in better services for patients including a Wi-Fi for patients to connect their own devices and have conversations where this was deemed appropriate. JC will discuss access to iPads and Teams with the clinical teams about the processes. C was very pleased to hear this good news.	**JC**	**28/01/21**

	SN asked if there transferable lessons to be learned into the everyday operations and not just in the context of a closure or move? PS advised that in terms of Mansfield, both patient and staff stress levels were very high and this was identified very early. The overall data in terms of a reduction in restrictive practices is almost the antithesis of this so a deeper dive into why that was, what we did, how we supported patients and addressed their stress levels was necessary, certainly in Northampton. PS remains concerned about these types of interventions so this remains high on his agenda. AC highlighted that Mansfield had hung onto trusted staff as long as they could so although there was a shrinking staff team, the overall quality of staff was high and the lesson is, it's not about numbers but about quality and trust. C noted that stress impacts people in different ways. Staff carry out mental health assessments on patients before they are allowed to go on leave or leave the ward. Where a patient is deemed stressed or unsettled they are not allowed to go out, however this appears to be an identical test for every patient, even though in every other aspect of hospital life patients are assessed on an individual basis, so it made no rational or logical sense to the patient when they are assessed individually for every other aspect but not when it comes to a mental health assessment before going to an event. Patients may be stressed but it doesn't necessarily mean they will cause an incident. C also noted that the Board refers to the amount of seclusions as a measure, whereas in the patient's (non-expert) opinion it was almost completely random whether seclusions were applied by nursing staff or not. They felt it more logical to measure the statistics on incidents and amounts of violence rather than seclusions as the numbers weren't an accurate measure of how settled or unsettled a particular ward was. C agreed that experienced staff were helpful however, it was extremely important to keep up staff numbers because five inexperienced staff were better than one experienced staff as this leads to a number of problems and they didn't want the Board to feel that less and experienced was better. PB thanked PS and C whose input and candid comments were appreciated. PB was keen to hear that the follow-up had happened with the issues raised in the meeting.	**AC**	**28/01/21**
7.	**Non-Executive and Executive Visibility Reports** AC presented the report which was taken as read. SN commented that even though visits via Teams may not work as well, he would still welcome this opportunity. KF advised of examples of where this had worked and had been successful but a Plan B was needed for when this wasn't possible. PB commented that, based on discussions with other providers, it was clear they were using video meetings. They all acknowledge that it's less satisfactory for all involved so we need to investigate other routes. AB advised that he takes a very cautious line on this subject. Whilst he appreciated the value of ward visits, he stressed that we are in a pandemic and the visits will spread the infection as more people visit in clinical areas. AB asked, if the visits are going ahead, what is the training for non-executive directors (NEDS) in terms of PPE? In AB's view there are alternatives, albeit flawed, but we should use those alternatives as much as we can.	**AC**	**28.01.21**
8.	**Quality Account** AB presented the report which was taken as read DS joined the meeting TH asked for clearer accuracy of reporting as she wasn't convinced by the commentary other than clinical commentary. AB supported TH's comments and advised that going forward this should be a factual report on what we have achieved backed up with evidence.		

	PP concurred with TH's comments; we need to look as analytically and carefully as possible to ensure that statements made are as accurate as possible. He also asked if going forward are we looking at averages that don't tell us anything. SK advised it was important to recognise that there were two ways to evaluate this particular data; one was in comparison with our own historical data and the other was a comparison of our services with similar services provided by other organisations and an exercise was being undertake to benchmark against similar services. We need to identify the comparable services, one was with the NHS Benchmarking or the other piece of work was to see whether we could benchmark our secure services in particular within the impact region, the theory being if we are all providing similar services to similar groups of patients then the comparisons become more meaningful. SK was having conversations with Impact to see if this was possible but the NHS benchmarking programme was also being explored. AB advised that material changes weren't included in the report. We did report to the date in March on what the position was in terms of CQC. AB gave assurance to the Board that the subsequent CQC ratings were for public record and that we were required to publish them both internally and externally. Even though there wasn't a material requirement for us to report on changes at a point in time, we want to give assurances that the changes were reported on, but not within the Quality Account. PB confirmed it was important to have clarification of the purpose of the report however, it was heavily circumscribed in what was required by guidelines and statutory requirements. In terms of auditing of the report going forward, PB asked whether we wanted to reflect on the process for next year's Quality Account where we add different things to the process for looking at it. DL advised a prescribed internal audit of the Quality Account is included in the audit plan approved by the Audit and Risk Committee and undertaken every year pre submission. The account is also reviewed and endorsed by the Quality and Safety Assurance Committee. PB will review this in the New Year with EL, DS and DL. DS advised that as the report was reflecting back, when many members of the current Board weren't in place, it was difficult to pass comment however, going forward, the Board could be assured of clear processes being in place to ensure that QSC receives the reports in good time, in draft and makes the necessary adjustments / corrections prior to coming to Board. DS asked for more NED colleagues to join QSAC and this request was noted. JL confirmed that the report was a true reflection of a point in time rather than it being a contemporary representation of a performance at the end of a new reporting period. PB concurred with this statement and felt it was important to bear this in mind for the strategy day. The Board formally APPROVED the Quality Account.	**PB/EL/DS/ DL** **Decision**	**25.03.21**
OPERATIONS			
9.	**Integrated Performance Report - Overview and Presentation** The report, presented by AC, SK and MD was taken as read. An interactive presentation of the IPR was also provided. AC acknowledged that all credit for the report should go to MD and JC for pulling the project together. KF confirmed that, in the spirit of transparency, NEDS had been given access to the source data should they chose to access it in their own time but there wasn't an expectation that NEDS would use the tool. SK provided an overview of how the IPR is used and how he sees it being used and added that NEDs can now access it in real time as well, if they required to. SK added that the Board could discuss how the IPR could be developed further to provide the type of data and information that it wished to see. Subcommittee		

	reporting will need to have qualitative information for us to form a judgement on whether this data is important or not and it depends not just on the information on the charts but also what our patients and staff are telling us and what we are observing. SK confirmed this was another operational tool that provided information to help run our services and improve our decision making. A lot of data exists but it was only over the last year or so that we had absolute confidence in the type and quality of data being produced. There was also enormous research potential in terms of correlating different parameters. SK advised that we were struggling with finding comparable data within the UK in terms of benchmarking; even NHS benchmarking didn't provide the context of what the services were. Looking abroad, there were different regulatory environments which cause difficulties, e.g. what the USA considered to be seclusion differed to the UK, similarly with restraint and medication. This wasn't insurmountable but these were issues that needed managing and SK questioned whether we had capacity to do this but it should be built into our strategy and would therefore form a strategy strand that benchmarks our services externally for comparing ourselves against other organisations. SK advised that many of the sub sets matched the CQC data levels however they didn't grade our service levels instead they placed emphasis on what staff, patients and carers said to them or what they observed. It was the triangulation that was important. It helped to target our actions but if we base all our interventions on data we would hit the target but miss the point. AL made the observation that, in order to gain real efficiencies, the system should reduce the amount of reports required. EL asked whether it was possible to consider pairing with other NHS trusts, within the provider Collaboratives, within ICS, to improve the services and outcomes for our patients to see this reflected in external benchmarking. She commented that the CQC focusses its efforts on obtaining direct information from staff and patients and EL asked that this be included in all the reports we receive. DS advised NED colleagues to view the data as a quality and safety performance report. Its purpose was not to benchmark, but to provide an overview of what was happening within the Charity. MD agreed that we needed to review what the Charity's peers were doing. Currently we engage with NHS digital to explore how we could use NHSDS, a data led submission which all mental health organisations have to submit monthly. We also work with NHS Benchmarking to ensure the data is suitable to be mapped against our own, but we were also using the collaborative network to look at their data. Networking points have been established with other mental health organisations to see how we can share data. This was currently in the feasibility stage to ensure comparisons against the right patient mix but the goal was to reach a point where a benchmarking point could be added to the charts. PB highlighted the importance of extracting the insights in terms of actions and in providing the Board with assurance, which is where the triangulation point came in. He highlighted the visibility of exceptions, and also articulating what the Boards' areas of focus were. Efficacy of mitigation was interesting to explore and the relationships between the different types of data was helpful. PB felt there was need to build on the work previously undertaken by AC and he would consider the possibility of holding a workshop around this in the future to identify the requirements for reporting as a Board.		

GOVERNANCE AND ASSURANCE			
10.	**External Governance Review – Terms of Reference** The report, presented by PB, was taken as read. PB outlined the recommendations of the paper for work to be commissioned around the Charity's governance. He advised that one of the origins was the Well-Led inspection however, following discussions with Board colleagues, PB had reached the conclusion that a broader view was needed to take the Charity forward rather than looking back to last October's Well-Led inspection. PB proposed a review be undertaken as set out in the paper, to which the Board AGREED. The Board also AGREED to procure an external supplier to undertake the review.	**DECISION** **DECISION**	
11.	**Sub Committee Updates** **Quality and Assurance Committee** The Paper, presented by DS, was taken as read. DS highlighted that the key challenges for the Board to note were safeguarding, infection prevention and control and physical healthcare delivery. Other key issues highlighted were COVID-19, lessons learned from the Quality and Safety Group report, Integrated Performance Report, the report of the Mental Health Law Steering Group and the Quality Improvement Plan. Following a discussion around the problems experienced with recruiting Infection Prevention & Control (IPC) staff, AC updated the meeting that Director of IPC James Severs (JS) had now been in post for six months, the new Head of IPC had been in post for three weeks, with three experienced IPC practitioners reporting into this post also newly appointed. AB has also been able to provide an administrator to support the IPC team and AC was pleased to confirm that the team was now at full strength. The Board AGREED to the formally rename the QSAC Committee to Quality and Safety Committee (QSC) and AGREED to the changes in the associated Committee Terms of Reference (ToR). **People Committee** The paper, presented by TH, was taken as read. TH outlined that the key issues for the Board to note, were the poor response rate and declining scores for the patient survey, the review and update of the risk register template by January 2021 and the update of the Patient Involvement Strategy by March 2021. TH advised that the committee was a diverse representation of all areas across the Charity with the exception of clinical. However, this tied in with work led by SK around patient reported experience measures which would systematically evaluate the impact of our care on patients' well-being and satisfaction survey. This was an ongoing programme to measure and monitor at CEC and Board level. A proposal was being drafted regarding investment and HR requirements which SK hoped to have implemented by the fourth quarter of this year. TH welcomes the proposal. TH advised that the annual patient survey had been received, the results of which made uncomfortable reading so a deep dive would be carried out in the Divisions around commitment to the patient voice and action plans for addressing the issues. An extraordinary meeting of the People Committee is being held in January to focus on this, the outcomes of which would be brought to the Board. KF apologised to TH and NED colleagues for not being in a position of being able to answer the Committee's questions and concerns and she acknowledged that was an error on the CEC's part. KF assured TH that the	**DECISION**	

	work required for the January 2021 meeting would be completed well in advance. **Pensions Committee** The paper, presented by MK, was taken as read. MK outlined the key issues for the Board to note as being the fiduciary management update, Guaranteed Minimum Pension reconciliation (GMP) and cancellation of the Pensioner's AGM. SRW asked if the GMP increased the liabilities for the pension fund however MK confirmed it wouldn't because this was already built in to the assumptions. AO also confirmed this. **Research Committee** The paper, presented by SK, was taken as read. SK had nothing to add to paper other than asking the Board to note that the refreshed Research strategy would come back to a future Board meeting for formal approval.		
ANY OTHER BUSINESS			
12.	**Questions from the Public for the Board** No questions were received for the Board.		
13.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** JL updated the meeting that a volunteer NED lead would be sought to work alongside Executive Chief Nurse AB for Mental Health Act Managers oversight. The role played into the assurance required as part of the CQC feedback about the connection between Mental Health Act Manages and the Board and also the interface with the Court of Governors, who would be updated next week that this was the intended direction. This was pending notice from the Chair and the NEDS as to who this would be. PB AGREED this would be resolved at the January Board meeting. PB confirmed that addressing information flow between committees would be picked up in the Governance Review.	**JL/AB/PB**	**28.01.21**
14.	**Date of Next Meeting : Thursday 28 January 2020**		

Approved – 28 January 2021

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Paul Burstow
Chair

Action Log & Matters Arising

(Paul Burstow)

St Andrew's Healthcare Board of Directors Part Two 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	**26/11:** Further discussions are needed as part of the Governance Review to agree the Board development programme content and then schedule appropriately throughout the year. **28/01:** Remains in line with November update
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	
26.11.20 **02**	**Patient access to technology** JC will discuss access to iPads and Teams with the clinical teams about the processes that will result in better services for patients, including a Wi-Fi for patients to connect their own devices and have conversations where this was deemed appropriate.	JC	28.01.21	Open	**28/01:** Access to the Wi-Fi for connecting patient's devices has started with pilots in Malcolm Arnold House. As soon as this is deemed successful it will be rolled out to other units. Each ward has specific devices for providing access to applications such as Skype for communications with patient families. Where this is insufficient wards are requesting new additional devices funded from their ward budgets.

26.11.20 **03**	**Divisional Presentation – Mansfield Lessons Learned** Patient C raised a number of issues and recommendations during his presentation and discussion with the Board, including: Delays in getting issues addressed on the ward Access to technology (addressed in 26.11.20 02) Personalised leave assessments Reporting number of incidents and levels of violence versus number of seclusion events PB was keen to hear that the follow-up had happened with the issues raised in the meeting.	AC	28.01.21	Open	**28/01:** Paul Stankard, the Clinical Director for ASD/LD has confirmed that each of these actions has been addressed and that Patient C is content. The relationship between violent incidents and restrictive practice (including but not limited to seclusion) is on the agenda for the Division as a whole.
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	Open	**28/01:** Under normal circumstances we can and will accommodate virtual ward visits via Microsoft Teams and can set up meetings with the MDT and with patients. Given notice of an on-site visit, we will ensure an IPC Super-Trainer is available before a NED visits a ward. PPE will be available. However, given the pressures on staffing at the moment, facilitating either a virtual or onsite visit will be particularly challenging.
26.11.20 **05**	**Quality Account** PB confirmed it was important to have clarification of the purpose of the report however, it was heavily circumscribed in what was required by guidelines and statutory requirements. In terms of auditing of the report going forward, PB asked whether we wanted to reflect on the process for next year's Quality Account where we add different things to the process for looking at it. PB will review this in the New Year with EL, DS and DL.	PB/EL/DS/ DL	25.03.21	Open	
26.11.20 **06**	**Mental Health Act Managers** JL updated the meeting that a volunteer NED lead would be sought to work alongside Executive Chief Nurse AB for Mental Health Act Managers oversight. This was pending notice from the Chair and the NEDS as to who this would be. PB agreed this would be resolved at the January Board meeting.	JL/AB/PB	28.01.21	Open	**28/01:** DS confirmed that at PB's request this is now a discussion topic on the QSC agenda on 19th January.

Paper for Board of Directors	
Topic	CEO Board Report
Date of meeting	Thursday, 28 January 2021
Agenda item	**05**
Author	Katie Fisher, Chief Executive
Responsible Executive	Katie Fisher, Chief Executive
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 or staff.
Staff involvement	A number of these items would have been discussed with patients, carers or 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	Updates have been discussed at the weekly Charity Executive Committee meetings.

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

None.

CEO Report

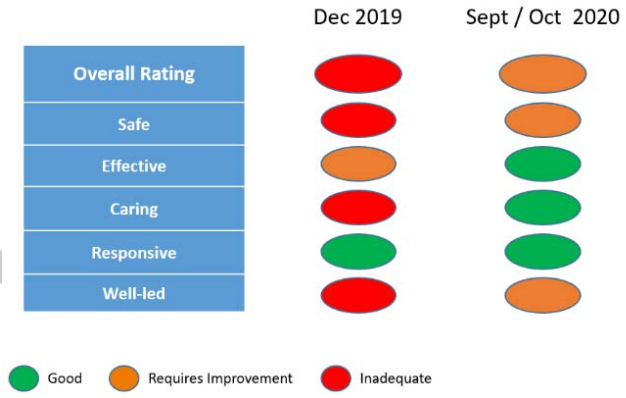
This is the CEO report to the Board of Directors to provide information and assurance on the key areas of focus for the Charity Executive Committee over the last reporting period that are not dealt with under other agenda items for the Board.

1. CQC update

CAMHS

The CQC CAMHS latest report was published on the 18 December. Following the re-inspection by the Care Quality Commission (CQC) of the CAMHS service in September and October, the service have now been lifted out of special measures.

The table below demonstrates that the CQC rated the service 'good' in the majority of categories, including effective, caring and responsive, and 'requires improvement' in the safe and well-led areas, which means the overall rating was lifted from 'inadequate' to 'requires improvement'.



These results are testament to CAMHS colleagues who have worked incredibly hard to improve and develop the service, including supporting young patients with a move from Fitzroy House to Smyth House, and doing so in the middle of global pandemic.

The CQC recognised there had been a culture change in the service since their visit last December 2019.

They praised staff for treating children and young people with kindness, dignity and respect, and in several cases they recognised that staff had gone the "extra mile" to support the young people.

The carers they interviewed also spoke positively about the service, describing staff as "lovely", "supportive", "encouraging", "professional", "fabulous" and "fantastic".

There was one particular area however, where the CQC highlighted there were issues in compliance with PPE with some staff not wearing masks correctly. This contributed to receiving “a requires improvement” rating in the safe domain.

The Charity have already responded to the CQQ’s ‘must do’ actions and have a clear plan to take the service forward and continue the tremendous work already done to improve the quality of care offered to young people admitted to the service.

Women’s Service – preparation is underway to prepare the wards that constituted the Women’s service for a further inspection, due to have taken place six months after the publication of a report in line with the CQCs guidance on special measures. However with the current transitional inspection arrangements that the CQC are working to, the CQC have given notice of prioritising a review of the wards that were in the men’s service first in January 2021 (see below). It is likely the re-inspection of the Women’s wards will now take place in Spring 2021 and allow the CQC to follow up on the Spencer South inspection at the same time.

Spencer South Focused Inspection- the final report was published on the 24 September. This responsive inspection was triggered by complaints and concerns from patients direct to the CQC. The deadline for compliance with the requirements of the warning notice is 3 March 2021. An action plan has been submitted and implementation is well underway.

Men’s Service
The CQC gave notice in early December that they wished to review information and interview some key stakeholders as part of their new transitional approach to monitoring the quality of services (TMA). They identified the wards that were part of the men’s service at the Northampton site as the subject of their review.

Having suspended their routine inspection programme the CQC have adopted a new Transitional Regulatory Approach (TRA), specifically using the Transitional Monitoring App (TMA). The TMA uses intelligence and Key lines of Enquiry (KLOE) questions to assist them in gaining an understanding on the risk level at a location and if any regulatory action is required. This is an interim methodology and can be repeated if required dependent on risk.

The evidence requested by the CQC was submitted with a meeting planned to review it with them on the 21 January. It is anticipated that there may be some follow up activity which could include site visits. Wards are preparing to host CQC colleagues at some point over the next few weeks.

There have been no further CQC inspections in this month.

Mental Health Act Reviews - the CQC have not carried out any new remote Mental Health Act reviews in November or December.

Registration – There continue to be delays in the registration of services in Northampton in line with the new divisional structure. The Registered Managers will be the Heads of Nursing and recent changes have meant we have not completed one application. The new post holder is aware and has been offered support to complete their registration.

We have had some positive conversations with the CQC around removing all current conditions from our registered services. This will allow a clean start for the new registrations to go ahead and an application to remove conditions has been submitted.

Throughout December the Charity was in regular communication with the CQC to update them on acuity on all sites and staffing challenges. This followed a decision at the last engagement meeting to prioritise getting the CQC information about any incidents and risks to service as early as possible. It is hoped that by being more pro-active the CQC will become more assured about the effectiveness of our systems of internal governance.

2. Ofsted update

Ofsted completed the material change inspection of the new college in Smyth on 24th November 2020. The inspector concluded that the college is likely to meet all of the Independent School Standards and that the Health and Safety components of the college were all in order. This report was published in early December 2020 and official approval from the Secretary of State for Education for the college to be opened followed in mid-December 2020.

The college is still overdue a full Ofsted inspection, the last being undertaken in December 2016, as part of a three year cycle. The current situation with Covid-19 means that Ofsted are not currently conducting any face to face visits unless there is a direct safeguarding concern or a material change that requires urgent action.

All regular and routine Ofsted inspections are set to resume in April 2021 however this is still dependent upon the trajectory of the pandemic. There will be a large backlog of overdue inspections at this point and there could be a further delay for the college being inspected as a result.

3. Quality improvement

Across the Charity, in keeping with leading NHS and Healthcare providers, a program of Continuous Quality Improvement has been established. With an emphasis on providing teams and colleagues with the support, tools and techniques to embrace a culture of empowerment that will drive incremental improvements in the delivery of care.

Much of this work has been led internally, however over the last three months additional support was offered from NHSE/I who have supported the training of three cohorts of STAH colleagues, using the CQI approach to support improvements in infection prevention and control systems and practice.

Given the commitment that the Charity has made in the area of CQI it was excellent to see this referenced as one of a number of highlights within the recent CAMHS CQC inspection report.

Although curtailed because of Covid face to face training restrictions, the next phase in the CQI programme will see the Charity formally partner with neighbouring, Outstanding rated Northamptonshire Mental Health NHS Foundation Trust (NHFT) to commence accredited training for colleagues across the Charity.

4. Communications update

Your Voice survey
Understanding how staff feel about working at St Andrew's is hugely important. The annual staff survey, Your Voice, was open for two weeks during November-December. The Charity's employee engagement score dropped by 11 points to 57% (it was 68% in 2019). While no formal external benchmarking is available, anecdotal feedback from a number of suppliers suggests that the impact of COVID on engagement scores in companies most impacted by the pandemic is a negative 3-4% points.

Although St Andrew's engagement score went down overall, 11 wards and 10 enabling function teams achieved an engagement score as good as or even better than the previous Charity-wide score of 68%.

In the coming weeks, managers will share and discuss team results in order to agree the actions that need to be made locally. A number of cross-team listening sessions will also be taking place, as different areas create their action plans.

Launch of new Charity intranet
This month St Andrew's is launching a new intranet, named The Hub. Part of the Charity's move to SharePoint Online, The Hub will feature news from across the Charity, as well as the regular Covid-19 updates, policies and procedures and information on different departments and teams. The Hub will be the go-to place for everything St Andrew's, replacing the current staff intranet which is less reliable and secure.

Media update

CAMHS media coverage
HSJ: Troubled children's service taken out of special measures
BBC: Teen mental health unit in Northampton has 'shown improvements'
Chronicle and Echo: Northamptonshire children's mental health service taken out of special measures but inspectors still have concerns

The news that St Andrew's CAMHS unit had been lifted out of special measures was covered by the HSJ, BBC news online, the Chronicle and Echo and ITV Anglia news, who did a short 20 second news in brief. Both the HSJ and BBC news online covered the positives from the report, while the Chronicle took a more negative approach, leading with some of the critical points from the report, before coming onto the positives.

Chronicle and Echo: 'I survived days I didn't think I would': Northampton woman speaks out about mental health recovery after attempted suicide
Megan, who was recently discharged from St Andrew's, has shared her story with the Chronicle and Echo. In the feature, Megan praised staff for helping her to get better. She is quoted as saying: "The therapists at the hospital are some of the smartest and nicest I've met."

The Pharmaceutical journal: Outstanding work of 12 female pharmacy professionals celebrated in Women to Watch 2020 list
Lisa Green, Pharmacy Operations Manager has been listed as one of 12 'Women to Watch' on The Pharmaceutical Journal's 2020 list. The list celebrates brilliant, under-

recognised female pharmacy professionals who are accomplishing great things across the sector. Lisa was praised by the judges for being a driven and influential member of the profession, who is pioneering the way in veterinary medicine and mental health.

Chronicle and Echo: St Andrew's unveils memorial garden for those who lost their lives during the coronavirus pandemic in Northampton
Featuring a video and quote from Katie Fisher, the Chronicle and Echo piece highlighted the opening of a memorial garden at St Andrew's in Northampton.

Let's Talk About…
St Andrew's has now released all four films in the Let's Talk About series, which explored dementia, BPD, schizophrenia and PTSD. The series received thousands of views online and praise for speaking about conditions which aren't explored that much in the mainstream media. The series is available to view here. A follow up series is in the pipeline, focussing on bi-polar, Huntington's Disease and body image.
https://ontheward.stah.org/553780/6613738-s2-ep3-off-the-ward

On The Ward podcast
St Andrew's award-winning podcast has released two more episodes. In a special edition, On the Ward went Off the Ward, and spoke to those working and accessing mental health treatment in the criminal justice system. During the episode listeners hear from a service user in the probation service, who explains how he's battled with drug and alcohol addiction for most of his life. He has now received CBT through St Andrew's Community Partnerships Team, and is now on the road to recovery thanks to the therapy he received. You can listen to the episode here.

In a second episode, a newly discharged patient called Megan, mentioned above, and her mum talk about her recovery, hope, and inspiration. Listen here.

Yahoo! News
St Andrew's psychotherapist, Liz Ritchie, has featured in several articles including 'the surprising health benefits of 2020', 'how to cope with grief over the festive season', and 'how to stay motivated with social distancing'.

5. Legal update

The government published its white paper on the Reform of the Mental Health Act on 13 January 2021. The Mental Health Law Steering Group is coordinating a response to this consultation.

Paper for Board of Directors	
Topic	Performance Report
Date of meeting	Thursday, 28 January 2021
Agenda item	**06**
Author	Alastair Clegg, Chief Operating Officer
Responsible Executive	Alastair Clegg, Chief Operating Officer
Discussed at previous Board meeting	Not 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.
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

The attached paper provides a high-level overview of the Charity's performance across four key areas: safety, patient experience, workforce and finance. In each area, the paper summarises performance against four or five key performance indicators, all of which are considered in greater detail by the relevant Board sub-Committee. The report is deliberately high-level so as to give the Board an overview of performance without duplicating the work of those Committees.

The data making up the report is sourced from the Integrated Performance Reporting tool presented to the Board at the last meeting. That tool is still under development, and for the next meeting will be able to provide an overview of Divisional performance against a range of metrics, and that overview will be included in future Board Performance Packs.

The 2021/22 budget assumptions preparation has not been completed due to the 3 month delay by NHSE/I in their financial and operational planning process which includes the agreement of the fee uplift percentage. The Board

is requested to approve delegating the normal review and agreement of these assumptions to the Finance Committee when the information becomes available.

The Board are invited to review and provide feedback on performance, and to provide a steer on whether the report provides the right balance and gives enough of a strategic overview.

Appendices

None.

St Andrew's Healthcare – Board Performance Report

January 2021

Summary overview

Safety

There has been an overall rise in incidents. This rise is driven by an increased number of the least severe incidents. Severity is reducing with improvements across: Serious Incidents, Incidents of Violence and Safeguarding. Incident levels in CAMHS has risen with new admissions and consequently Safeguarding levels remain high.

Patient Experience

We are working to introduce PREOMS to improve our actionable insight. Enhanced Support continues as a significant focus area as we strive for continual improvements in least restrictive practice. Whilst overall episodes of enhanced support are static we are actively challenging ourselves to reduce the per person ratios, in particular in ASD/LD. With the dual benefit of improved patient experience and reduced staffing demand.

Workforce

Sickness levels have risen, active monitoring and management is needed to ensure well-being is preserved and potential impacts to ward based staffing level are mitigated. Turnover has increased as people seek more balance and/or more remuneration. Fill ratio continues to be challenging in an increasing employee driven market.

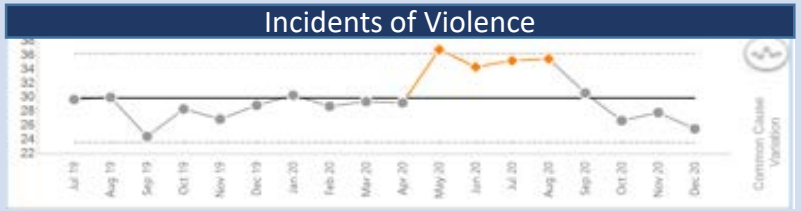
Finance

Financial performance is in line with reforecast for the 9 months to December 2020, Net deficit position of £214k better than expected at this point in the financial year. COVID associated impacts currently being mitigated. Year end preparations shared with ARC. Budget planning progress hampered by NHSE/I rate delays.

St Andrew's Healthcare – Board Performance Report

January 2021

Safety

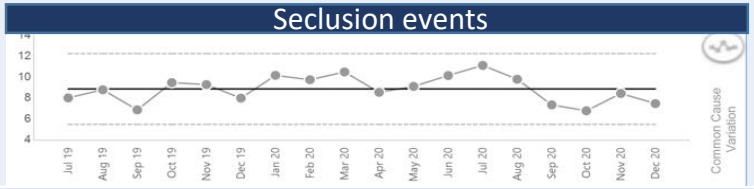
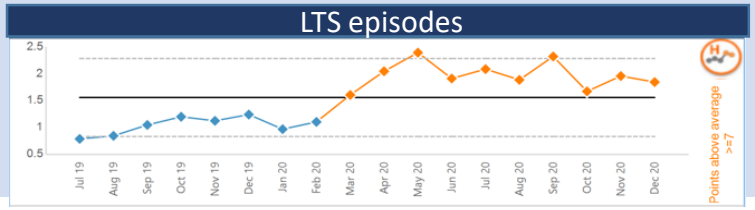
Indicator (all per 1,000 occupied bed days)	Commentary
Incidents 	The increase in incidents is driven by above typical levels across CAMHS, LSSR and Neuro. CAMHS are the chief driver, being above their upper control limit for two of their three wards. The increase was most notable for Stowe – where recent admissions have resulted in increased incident levels. Overall, whilst it is undoubtedly concerning to see incident level increase, it is an increase in the volume of the least severe incidents that is behind the rise.
Serious Incidents 	For the majority of 2020, Serious incidents have been at or below the mean, with the overall downward trend continuing into December. There are no divisional outliers. We are working to improve our classification of Serious Incidents.
Incidents of Violence 	Overall, incidents of violence have been at or below the mean since September 2020, with the positive trend continuing into December. Neuro is the only division above their typical levels – the current acuity on Tallis is the source of the increase. A mitigation plan is in place with new clinical model being finalised, to which a new staffing model is integral. The Tallis team have presented their plans for the ward to CEC.
Safeguarding 	December has seen a return to the trend of a positive reduction in safeguarding incidents as seen across the last half of 2020. CAMHS and LSSR are above their upper control limits with the remaining divisions at or close to their mean. For CAMHS the December safeguarding reports concern: sexualised behaviour between patients, self harm and staff behaviour. Where appropriate, investigations have LADO oversight – LADO has not deemed it necessary to oversee all investigations, an indication of the improving relationship. LSSR main theme being self harm whilst being observed, should investigations indicate omission appropriate action and learning will be secured.

*data is based on the 7 live divisions

St Andrew's Healthcare – Board Performance Report

January 2021

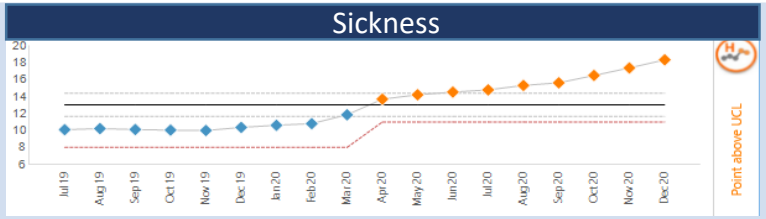
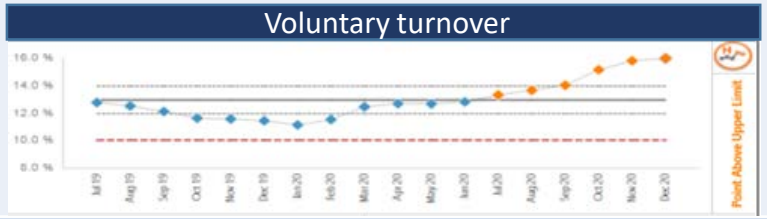
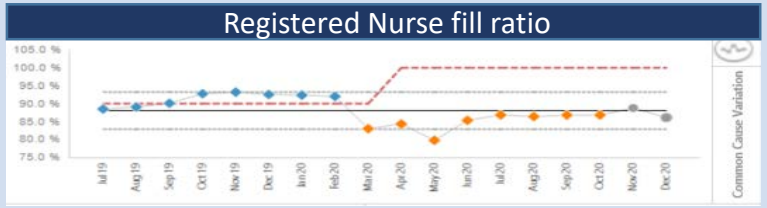
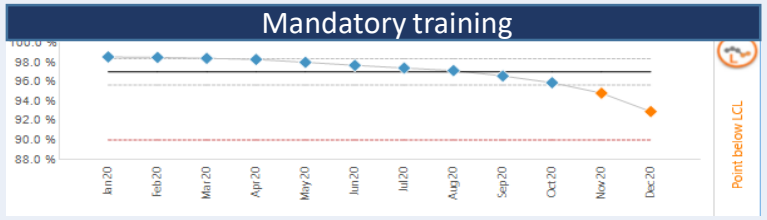
Patient Experience

Indicator (all per 1,000 occupied bed days)	Commentary
Complaints 	Overall complaints remain below the mean with no outlying divisions. The two top complaint areas are restrictive practices (31%) and clinical treatment (23%). We are actively working on increasing our feedback from patients with the development of the PREOMS. An overview of plans has been shared with the People Committee for their reflections.
Enhanced Support 	The number of episodes of patients being placed on enhanced support is at the mean for December 2020 – an improvement since the prior month and in line with the overall position for 2020. As part of our REDUCE programme we are continuing to strive to minimise enhance support, ensuring it is only used where there are no other means to manage clinical risk. We recognise the impact enhance support has on our patients and are actively challenging ourselves to reduce the current enhanced support level.
Restraint 	Restraint levels increased in December – with LSSR and Neuro above their upper control limits. For LSSR the restraint levels are due to intervention to prevent or minimise self injurious behaviour and for NG feeding. For Neuro, Tallis represents 49% of their restraints, with the majority of these being due to personal care interventions for one patient. Overall, prone restraint continues the positive decreasing trend and is currently at the lower control limit.
Seclusion events 	Seclusion events remain below the historical mean. Hours of seclusion have risen slightly in December, however remain in line with historical mean. All divisions, with the exception of Neuro, are within their control limits. The Neuro position correlates with the increased incidents of violence on Tallis ward – with the adapted clinical and staffing model mitigations underway.
LTS episodes 	Episodes of long term segregation have reduced slightly this month but remain above the historical mean. No divisions have breached their control limits.

St Andrew's Healthcare – Board Performance Report

January 2021

Workforce

Indicator	Commentary
	Absence Charity wide for December is 17 days/9%. There has been a significant monthly increase since September, where absence was 15 days/5.22% (16 days for divisions). Both absence measures are significantly above the 11 day/4% Charity target. There has been a significant increase in long term absence cases contributing to the above figure with 174 cases, 21% relating to Covid and 18% to anxiety, stress and depression. Refreshed absence management plans will be discussed with the People Committee.
	Voluntary turnover Charity wide stands at 14.2% (10% tolerance). With overall turnover at 23.7% equating to 766 leavers in the last 12 months. This takes account of the Nottingham closure. Voluntary and overall turnover has increased in recent months. Worklife balance is the top reason for leaving (40%), indicative of the challenges in our sector at present. Better package and promotion follow (27%), the Charity has struggled to keep up with competitor salary offers and the roll out of the NHS 3 year pay deal, it also highlights that even during a pandemic the healthcare sector is very competitive and people are actively looking for new roles.
	The registered nurse fill ratio demonstrates a slight decrease to 86% although it did increase in June and then has stayed relatively static. We are actively recruiting and continue to develop in house, however this registered recruitment market continues to be extremely competitive. We are marginally over established once we combine Healthcare Assistants – our current absence rates however impact the volume of staff available for work. We have twice daily staffing command calls in order to ensure staffing is sufficient and balanced.
	Mandatory training has decreased due to prioritisation of ward based shifts and the induction of new staff. We have extended refresher dates in line with external expectations. We continue to focus on training that is essential to safety. Whilst there is a reducing trend, we remain above the 90% target.

St Andrew's Healthcare – Board Performance Report

January 2021

Finance update

	Dec 2020 MTD			Dec 2020 YTD		
	Dec 2020 MTD Actual	Re-forecast	Variance to Re-forecast	Dec 2020 YTD Actual	Re-forecast	Variance to Re-forecast
Available beds	721	731	(10)	774	775	(1)
Occupied beds	588	589	(1)	629	629	0
Occupancy %	81.6%	80.6%	1.0%	81.3%	81.2%	0.1%
Total Income (£'000)	**13,823**	**13,505**	**318**	**126,478**	**125,498**	**980**
Total Direct costs*	(7,133)	(6,760)	(373)	(66,568)	(65,424)	(1,144)
Gross surplus (£'000)	**6,690**	**6,745**	**(55)**	**59,910**	**60,074**	**(164)**
Total Indirect costs**	(2,873)	(2,992)	119	(26,382)	(26,636)	254
Net Contribution (£'000)	**3,817**	**3,753**	**64**	**33,528**	**33,438**	**90**
Enabling functions (£'000)	(3,543)	(3,600)	57	(31,464)	(31,666)	202
Depreciation (£'000)	(1,165)	(1,184)	19	(2,149)	(2,204)	55
Exceptional costs (£'000)	(6)	(52)	46	(832)	(837)	5
Project costs (£'000)	(504)	(405)	(99)	(5,076)	(4,935)	(141)
Operating Surplus/(Deficit) (£'000)	**(1,401)**	**(1,488)**	**87**	**(5,993)**	**(6,204)**	**211**
Non-operating costs (£'000)	(103)	(159)	56	(1,426)	(1,429)	3
Unrealised Movement on investments (£'000)	0	0	0	1,549	1,549	0
Net Surplus/(Deficit) (£'000)	**(1,504)**	**(1,647)**	**143**	**(5,870)**	**(6,084)**	**214**

* - includes ward nursing and ward funds
** - includes MDT and other divisional costs

Commentary

Financial performance in line with reforecast for the 9 months to December 2020, Net deficit position £214k better than expected at this point in the financial year

Current level of Covid infections in both staff and patients is having a impact on the ability of the Charity to achieve the capacity creation plan and associated ward moves and enabling function savings. Financial impact of these delays has been mitigated to date and ongoing impact will be discussed as part of the wider meeting

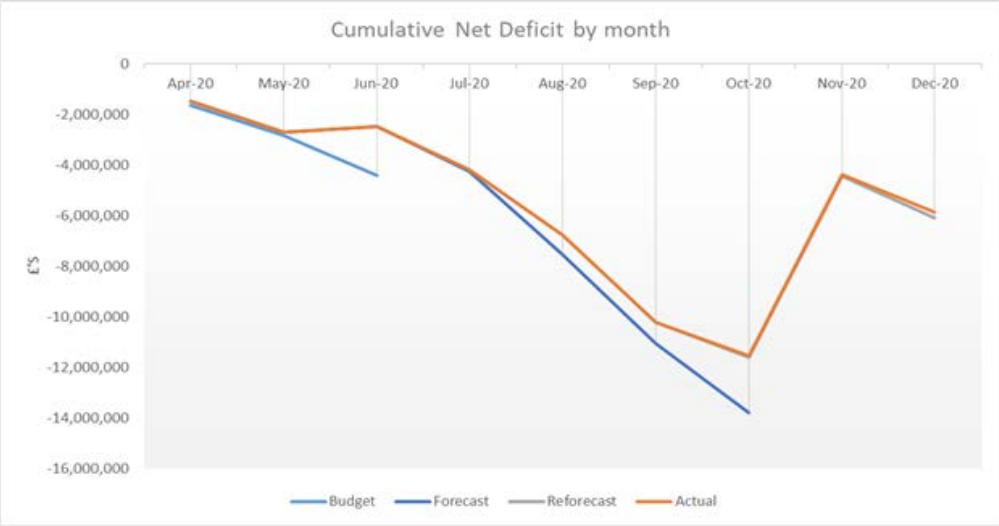
2020/21 year end planning is ongoing with initial areas of external auditors focus and fee proposal presented to the ARC in their January meeting, interim audit to commence remotely in February 2021

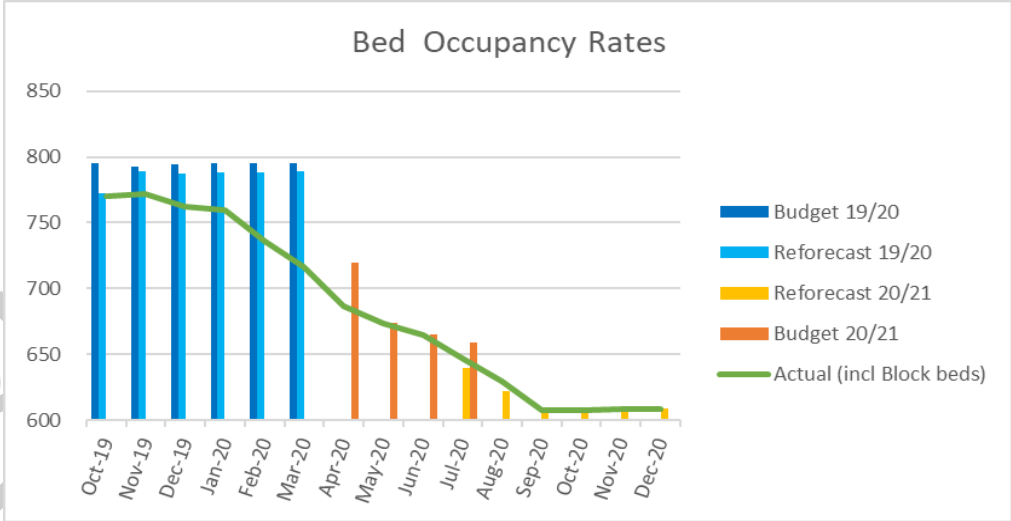
2021/22 budget assumptions preparation has not been completed due to the 3 month delay by NHSE/I in their financial and operational planning process which includes the agreement of the fee uplift percentage. I would ask for the Boards agreement to delegate the normal review and agreement of these assumptions to the Finance Committee when the information becomes available.

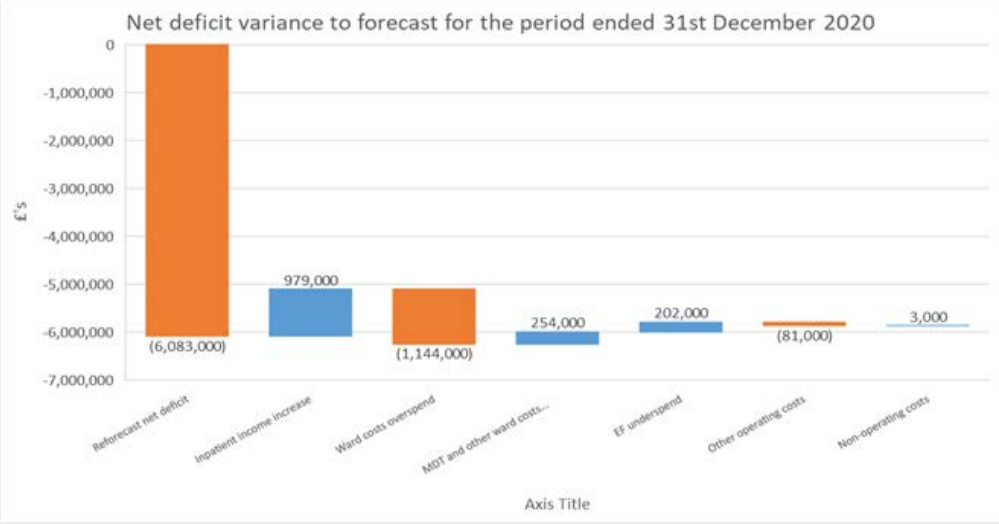
St Andrew's Healthcare – Board Performance Report

January 2021

Finance snapshot







Cashflow summary to December 2020	Dec 2020 (£'m)
Opening net debt at 1/4/2020 *	(32)
YTD Net Capex and project movement	19
YTD Net cash flows from operations and balance sheet movements	(1)
Closing net debt at 31/12/2020*	(14)
Planned Capex and project spend	(2)
Forecast net cashflows from operations and balance sheet movements	(4)
Forecast/Actual closing net debts at 31/03/2021*	(20)
* - *excludes Stock Market investments*	

Paper for Board of Directors

Topic	Covid-19 Response
Date of meeting	Thursday, 28 January 2021
Agenda item	**07**
Author	Alastair Clegg, Chief Operating Officer
Responsible Executive	Alastair Clegg, Chief Operating Officer
Discussed at previous Board meeting	The Charity's response to Covid has been discussed at all Board meetings in 2020
Patient and carer involvement	Patient feedback is sought at community meetings on the impact of Covid and Covid-related restrictions on patients. This is escalated to CPAC.
Staff involvement	Daily communications sent to all staff - staff feedback on these. Weekly Teams calls allow for further staff comment, questions and feedback.
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	Covid BAF: submitted to and approved by QSC. Risk management: discussed by both ARC and QSC.

Report summary and key points to note

The report outlines the Charity's ongoing response to the Covid pandemic. The Board is asked to consider and approve the Board Assurance Framework document within Appendix B. This framework has been approved for submission to the Board by the Quality and Safety Committee.

Appendices

A Trend data for positive Covid cases
B Covid Board Assurance Framework
C Covid Material risk
D Covid risk control measures

Board of Directors Covid-19 Update – Jan 21

Summary

This paper provides an update on the Charity's response to and management of the impact of the Covid-19-19 pandemic. It provides a summary of the current and cumulative to-date position in relation to patient cases and staff absences, together with our current outbreaks and wards in isolation, an assurance framework for our management of Covid-19, progress on PPE supplies, lateral flow testing and vaccinations, and a summary of the governance arrangements in place to manage the pandemic.

The Board is invited to review and comment on the arrangements set out in the paper, and to approve the Board Assurance Framework document at Appendix B.

Patient data

As at close of play on Wednesday 20 January, the position is relation to patient infection rates was:

Current positive	**19**
Current symptomatic	6

The cumulative position since the beginning of the pandemic is:

Total positive	**225**
Wave 1 (Feb-May)	114 (101 recovered, 13 passed away)
Wave 2 (Sept+)	111 (87 recovered, 3 passed away)

At Appendix A are charts showing a seven-day rolling average of positive cases, showing the impact of the pandemic on each of our three sites over time, and providing a comparison with the local data (although local data is only available from the end of April).

Staff data

Staff data is more difficult to track over time as testing was not available to staff during the early months of the pandemic. The management of staffing data therefore focuses on absence from work, as this impacts the Charity's ability to safely staff wards.

The position at close of play on Wednesday 20 January is summarised in Table 1.

Table 1: STAH staff COVID-19 and sickness absence as at 20 January 2021

	Covid-19-related absence	Other sickness	Total
Operations	252	240	492
Estates	34	18	52
Enabling functions	35	31	66
TOTAL	**321**	**289**	**610**

Isolation and Outbreaks

In line with Public Health England (PHE) and NHSE/I guidance, we place a ward in isolation when a patient becomes symptomatic. Staff on outbreak wards wear scrubs and do not move to other wards, visitors to the wards are not permitted. As at 21 January, 23 wards were isolation.

Again, in line with PHE and NHSE/I guidance, an Outbreak is declared when two or more positive cases are recorded that can be linked by time and place. Outbreak wards and areas require daily returns to NHSE/I together with regular detailed management. As at 21 January, 13 wards and one central services team area were being managed as outbreaks.

The figures for both isolations and outbreaks are at a relatively high point, reflective of the increased infection rates nationally and locally. They are broadly in line with rates seen in comparable NHS Mental Health Trusts.

Lateral Flow Testing

3,400 Lateral Flow Tests were distributed to staff shortly before Christmas. Approximately 50% of the kits have been registered, although we know that more have been taken home by staff. 5,500 test results have been received to date, with a positive test rate of 0.89%. All of these figures are in line with feedback received about LFT take-up and positive result rates in other healthcare organisations, where (a) take-up rates are higher in outbreak areas or areas with greater risk, (b) staff tend to register results only when they test positive, and (c) testing rates drop off over time as the testing process is seen as unpleasant.

Although the Charity is not an outlier, there is a continuing push for improved testing rates and for colleagues to register their results.

Covid-19 Board Assurance Framework

Attached at Appendix B is the Board Assurance Framework document, which sets out levels of assurance against a range of areas relating to the Charity's management of the response to the Covid-19 pandemic. The document has been discussed and approved at the QSC meeting on 19 January. The format and content of the Framework were mandated by NHSE in 2020, and the Framework benefitted from input from NHSE/I colleagues who have commented helpfully on earlier drafts.

The Board is asked to provide feedback on the Framework document.

A further assurance framework will be submitted to the next Board meeting.

Covid-19 Risk Management

The Charity's approach to risk management in relation to Covid-19 has been considered and approved by both the Audit and Risk Committee and QSC at their January meetings.

The Material Risk (Appendix C) relating to the Covid-19 pandemic as well as the specific Covid-19 Risk Register continue to be reviewed and developed by the Risk function in conjunction with the CEC and individual risk owners to take into account and reflect the on-going activities required to maintain the necessary controls and mitigating actions.

The CEC review and comment on the risk controls and actions on a monthly basis, with update and amendments being made as required during the period. Following the latest review, the material risk has been reviewed by the risk owner and the executive committee.

Following this, the residual risk assessment of the COVID-19 material risk has been increased in likelihood to 'likely', (previously 'possible') while the impact remains at 'medium' increasing the residual score to '27' (previously 23), still with an 'amber' residual rating. This assessment is in light of the increase in Covid-19 infections of individuals, an increase in ward isolations due to Covid-19 positive patients and/or symptomatic and the increase of management arrangements taking place to mitigate the impacts of Covid-19

11 new risks have been identified and added to the supporting COVID-19 Risk Register.

This reflects the increase in Covid-19 activities and risk awareness of other possible internal and external risks to consider:

- R1400 Insufficient Testing for FFP3 Masks
- R1404 Impacts of the Combination of C-19 & Flu Season/ Second Wave Resurgence
- R1405 Deterioration of Mental Health Wellbeing & Morale of Staff
- R1433 Deterioration of Mental Health Wellbeing & Morale of Patients
- R1437 Failure to Manage Outbreaks
- R1453 Disruption Due to Vaccine Programme
- R1436 Significant Number of Staff Not Taking the Vaccination
- R1439 Failure to Follow IPC Procedures
- R1397 Unable to Access Testing in a Timely Manner
- R1396 Potential Economic Crisis & Brexit Impacts
- R1447 Lateral Flow Testing

The CEC have reviewed the material risk in detail in December 2020 and an assessment made of the effectiveness of the design and performance of the stated material controls (Appendix D), along with updates to on-going actions and activities.

PPE Supplies

The NHSE/I "pallet push" continues to deliver supplies of key PPE items on a weekly basis. Al the Charity's requests for PPE items continue to be met and the target of 50 days' internal supply of all items has been met for several months. As things stand, there are therefore no concerns about the supply of PPE.

Vaccinations

The Charity has received confirmation that the Northampton site has been registered as a mass vaccination site, for the vaccination of St Andrew's patients and staff. Detailed preparations have been put in place to ensure we have vaccinators trained (a challenge given strict requirements around the amount of training needed, and the requirement that only registered staff may vaccinate), and that we have the facilities and systems in place to manage the vaccination process. As at 21 January, however, there was no confirmation as to when vaccines would be received. This is beginning to cause some anxiety among staff who are aware that those working in care homes and local NHS Trusts are starting to receive the vaccine. 100 slots a day were made available at very

short notice at Northampton General Hospital over the weekends of 9/10 and 16/17 January and these were used to vaccinate staff, with priority given to:

- those who are clinically vulnerable and currently shielding at home,
- those assisting with the vaccination programme, and
- BAME staff, given the evidence to suggest that Covid-19 presents a higher risk to these staff.

Staff in the Charity's Birmingham and Essex hospitals are being given access to vaccinations via local mass vaccination centres.

Governance arrangements

Six key governance processes continue to be utilised to manage the Charity's response to the pandemic:

- Nursing staffing levels are managed at Silver Command level with twice-daily (8.30am and 2pm) meetings seven days a week to ensure staffing is at safe levels across all three hospitals.
- A daily 10am meeting at Gold Command, chaired by the Chief Operating Officer (or the duty Gold Commander at weekends) reviews:
    - patient data
    - staffing data (including any issues escalated from Silver Command)
    - isolation and outbreak wards and areas
    - progress with lateral flow testing
    - PPE availability
    - Housekeeping team numbers
    - Environmental audit data and plans, and plans for deep cleaning of wards
    - Progress with the fit-testing programme for FFP3 masks
    - PPE and IPC compliance data, and
    - Action plans
- A daily Outbreak Meeting, at 4pm, chaired by the Chief Nurse in his role as DIPC, which reviews in more detail patient, staffing and IPC compliance data relating to each of the outbreaks. This meeting is attended by, *inter alia*, the Nurse Manager and RC for each outbreak ward.
- The Charity's Clinical Professional Advisory Committee (CPAC), chaired by the Executive Medical Director or his Deputy, meets as required (but at least weekly) to provide clinical guidance on every aspect of the management of the pandemic, ranging from the interpretation of government, PHE and NHSE/I instructions to individual requests from patients and wards.
- The CEC meets weekly and discusses reports from Gold Command and CPAC. CEC looks in particular at whether risks are being managed (in particular those relating to staffing) and whether further Charity-wide interventions are needed.

- A closure meeting is held for each outbreak, again chaired by the Chief Nurse, 28 days after the last positive test result, at which lessons learned are shared for wider circulation. A number of such meetings are scheduled for the end of January and beginning of February and a summary of lessons learned will be submitted to the next QSC and ARC meetings and to the Board.

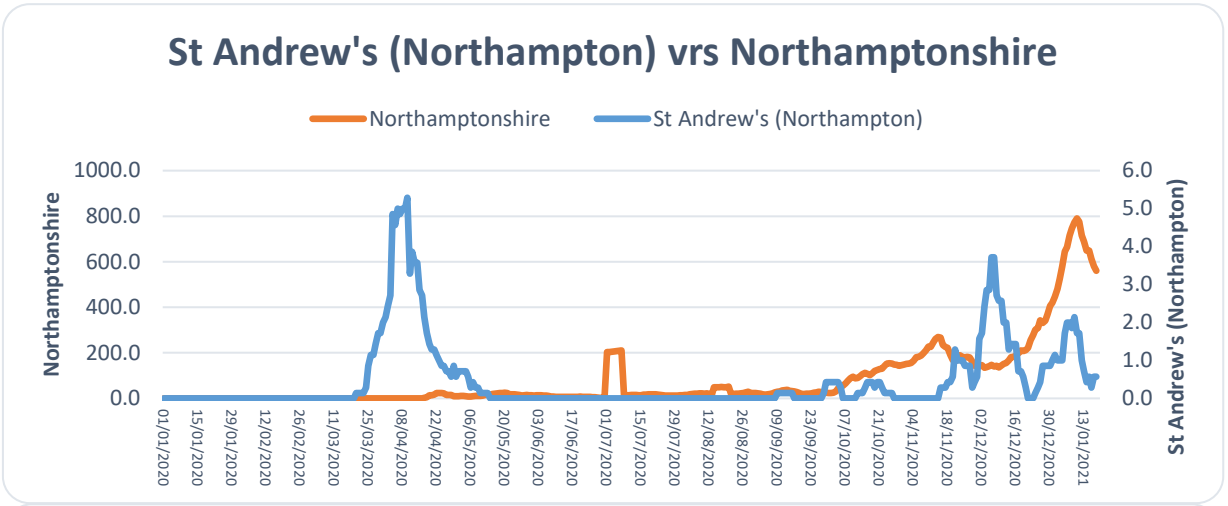
Alastair Clegg

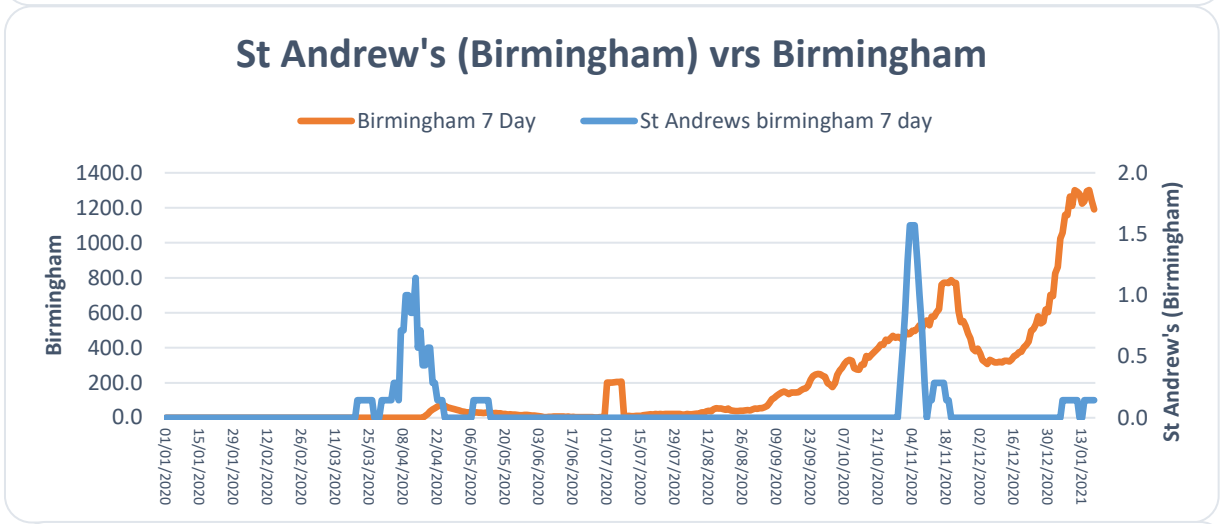
Chief Operating Officer

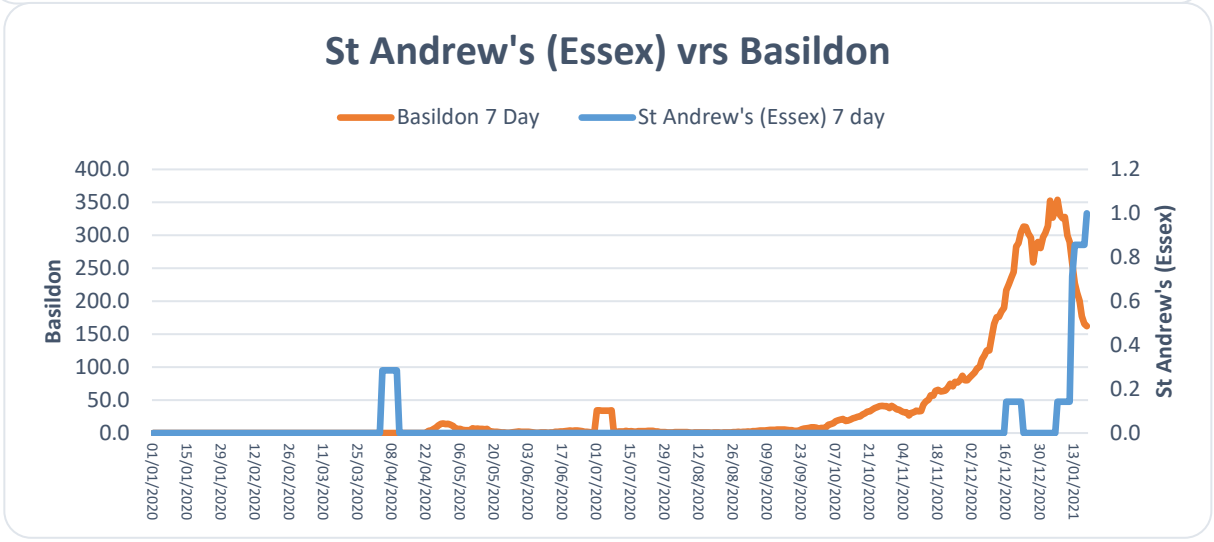
January 2021

Appendix A

Seven day rolling averages of positive patient cases, compared with positive cases in the local population







Appendix B

Infection Prevention and Control (COVID-19) - Board Assurance Framework (NHS IPC BAF v1.3)

November 2020

Key to levels of assurance:

No gaps in assurance
Gaps in assurance but a plan to mitigate
Gaps in assurance and no clear plan to mitigate

	Key Lines of Enquiry	Evidence	Gaps in assurance	Level of assurance and mitigating actions
1	**Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**			
	Systems and processes are in place to ensure:			
1.1	Infection risk is assessed at the front door and this is documented in patient notes	A full physical heath check is completed on admission and recorded on RiO. As inpatient mental health hospitals, we place all new arrivals in quarantine in their bedrooms for six days, test each patient on day 1 and day 6, and only end the quarantine period following a negative test and the conclusion of the six-day period, symptom-free. Where it is not possible to quarantine patients in their bedrooms because of intellectual impairment or challenging behaviour, more restrictive interventions are considered, such as Extra Care suites. All of this is captured in our RiO patient notes. **Assurance:** Quarantine status, compliance with quarantine, and test results are reported on and monitored daily as part of COVID command. This allows CEC-level support and intervention if the quarantine is proving challenging. **Evidence to 10 November 20 is that quarantine compliance is close to 100% and that instances of non-compliance are addressed promptly.**	None	None - we are confident this measure is met and that we have appropriate assurance measures in place.
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Patients with ceiling of care for active treatment are transferred to an acute hospital if required, and decision-making is logged on RiO. High risk patients are identified through a specific Covid care plan. **Assurance:** The status of all symptomatic and positive patients is reviewed daily as part of COVID Command. **No patients have been moved unless essential.**	None	None - we are confident this measure is met and that we have appropriate assurance measures in place.
1.3	Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Before any patient is moved to another provider (including to the community), the patient is tested. A symptomatic or positive patient would only be moved if (a) moving was in line with national guidance, (b) we are able to transfer the patient safely, (c) the receiving provider was able to admit the patient safely, and (d) it was in the best interests of the patient. **Assurance:** The decision to transfer patients requiring overnight transitions and extended leave must be authorised by our Clinical Professional Advisory Group (CPAC), chaired by our Executive Medical Director, and including our DIPC, and would be fully documented. **All transfers to date have been compliant with national guidelines.**	None	None - we are confident this measure is met
1.4	All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting	Online donning and doffing training is available for all ward staff as part of IPC training, and completion of the course is recorded. Posters are also up on every ward and in every clinical area. Following feedback from staff on wards in isolation in the second wave of COVID, we now provide refresher training for staff on wards as they go into isolation. NHSE Super-IPC Trainer training has commenced. **Assurance 1:** Specialist Nurses and Heads of Nursing check for compliance as part of regular visits to wards. **Assurance 2:** We record and review compliance with IPC training. **Compliance currently exceeds 90% across all Divisions.**	We do not review course completion rates sufficiently frequently to identify if a ward is slipping and intervene We do not formally record results of checks on donning and doffing compliance	We will commence review of training completion rates every week, and results of checks from 1 December. These results will be reviewed by the COVID Command meeting and reported to the Charity Executive Committee (CEC)
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC guidance is checked every day by the DIPC, brought to CPAC, and communicated to staff as part of the CPAC decision-making process **Assurance:** Specialist Nurses and Heads of Nursing check for compliance as part of regular visits to wards.	Results of spot-checks are not escalating to COVID Command, and from there to the CEC and Board.	As above
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	All CPAC decisions are ratified by the Charity Executive Committee, and any risks and mitigations are brought to CEC's notice by the Executive Medical Director. Changes are also communicated to the IPC and Health and Safety at Work Committee. **Assurance 1:** CPAC and CEC minutes. **Assurance 2:** A dedicated COVID risk register is reviewed monthly by CEC	None	None - we are confident this measure is met

	Key Lines of Enquiry	Evidence	Gaps in assurance	Level of assurance and mitigating actions
1.7	Risks are reflected in risk registers and the board assurance framework where appropriate	Risks are recorded in the Charity's IPC Risk Register, COVID risk register, or overall risk register, as appropriate. All three risk registers are regularly reviewed and updated and reported to QSAC, and from there to the Board. **Assurance:** compliance is reported to overseen monthly by the IPC Group and issues reported up to CEC.	None	None - we are confident this measure is met
1.8	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	At a Charity level, a robust COVID risk register is in place, is regularly reviewed, and feeds into the Charity Risk Register, which is reviewed monthly by the CEC. Local risk assessment processes and practices are in place, and are documented. However, the capacity of the IPC function to ensure these are all up-to-date and sufficiently robust has been limited due to an historic under-investment in the function, which is now being addressed with the recruitment of a head of IPC and two IPC advisor roles.	As detailed, insufficient IPC resource, an under-developed Link Nurse programme and lack of focus on this area historically meant that IPC risk assessment and practice was inadequate.	Recruitment of a new IPC team is in progress. The Link Nurse system is being redeveloped and relaunched and will be more robust with extensive training for Link Nurses.
2	**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**			
	Systems and processes are in place to ensure:			
2.1	designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Patients who become symptomatic and/or test positive are placed into isolation on their wards, and the ward is placed in isolation. The nature of our patient groups means that, in general, it would not be safe or appropriate to cohort all COVID patients in a single area. We do, however, make use of a dedicated isolation area for those dementia/HD patients who are symptomatic and who are unable to self isolate safely. These patients are looked after by dedicated Dementia/HD nurses. All staff in clinical areas have IPC training. **Assurance:** Daily COVID Command meetings review the care provided for each patient in isolation. Any breaches would be reported to CEC and would trigger an intervention. There have been no breaches to date.	None	None - we are confident this measure is met
2.2	designated cleaning teams with appropriate training in required techniques and use of personal protective equipment (PPE), are assigned to COVID-19 isolation or cohort areas.	We do not have specific cohort areas (for reasons set out elsewhere). There is a full training programme for all housekeeping staff that includes cleaning in high-IPC risk areas. **Assurance 1:** cleaning records are held on all wards. **Assurance 2:** We conduct monthly environmental checks of wards using the industry-standard Auditor housekeeping-based audit tool and these are reviewed and action-planned. Ward managers, Specialist Nurses and Heads of Nurses are responsible for spot-checks.	We do not have adequate systems of assurance for training levels and practice of housekeeping staff	Assurance to be in place by 1 December, and training levels regularly reviewed thereafter.
2.3	decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	See answer 2.1. Cleaning occurs twice daily on all wards in isolation, including two-hourly cleaning of high-touch points.	None	None - we are confident this measure is met
2.4	increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Bedrooms of patients in isolation are cleaned twice daily utilising chlor-clean. **Assurance 1:** Cleaning schedules. **Assurance 2:** Nurse Managers of wards in isolation confirm twice daily cleaning has taken place **Assurance 3:** Twice weekly audit of cleaning standards of wards in isolation undertaken by Housekeeping Team Leader.	None	None - we are confident this measure is met
2.5	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	Chlor-clean and Clinell wipes are used in all clinical areas. **Assurance 1:** Cleaning schedules **Assurance 2:** Twice weekly audit of cleaning standards of wards in isolation undertaken by Housekeeping Team Leader. Manufacturer's guidance is adhered to.	None	None - we are confident this measure is met
2.6	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products.	Housekeeping staff are provided with Covid cleaning guidance which includes manufacturer's guidance. **Assurance 1:** Twice weekly audit of cleaning standards of wards in isolation undertaken by Housekeeping Team Leader. **Assurance 2:** We conduct monthly environmental checks of wards using the industry-standard Auditor housekeeping-based audit tool and these are reviewed and action-planned. Ward managers, Specialist Nurses and Heads of Nurses are responsible for spot-checks.	None	None - we are confident this measure is met
2.7	As per national guidance:			
2.7.1	'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	A number of high-touch areas (such as reception areas) are cleaned more than twice a day. **Assurance 1:**	The frequent cleaning approach is not extended to high touch areas on every ward as it should be, nor does the Charity have adequate measures of monitoring and assurance	A frequent cleaning schedule and monitoring system will be established and implemented by 23 October.
2.7.2	electronic equipment e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned a minimum of twice daily	Ward and office staff are instructed to clean electronic items after use, and at least twice daily	We have not implemented systems of assurance that this is being done regularly in every area	A frequent cleaning schedule and monitoring system will be established and implemented by end November.

	Key Lines of Enquiry	Evidence	Gaps in assurance	Level of assurance and mitigating actions
2.7.3	rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	PPE donning and doffing applies only to our wards in isolation. These wards and donning and doffing areas are cleaned twice daily.	The second clean does not happen after PPE is doffed by the day shift leaving at 7.45pm.	An evening clean for isolated wards will be instituted by 23 October
2.8	linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	The red bag linen management system is in place and checked. Non-compliance is identified by the laundry team and addressed with wards as appropriate	None	None - we are confident this measure is met
2.9	single use items are used where possible and according to single use policy	All single-use items are used once. A four-hour rule is in place for masks.	None	None - we are confident this measure is met
2.10	reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Reusable equipment is decontaminated using Universal Green Clinell Wipes. **Assurance 1:** "I Am Clean" stickers - use of these is audited in Quality Assistant visits and reviewed in Operational Quality Meetings **Assurance 2:** Auditor environmental audits will include checks of "I AM Clean" stickers from 1 December		Second line assurance will be in place from 1 December.
2.11	ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air	Air dilution is handled mechanically in our newer, secure buildings (in many secure standards mean windows cannot be opened). In our older buildings, windows are opened wherever possible and appropriate. **Assurance:** Head of Nursing and Specialist Nurses spot-checks will assess ventilation levels, and any issues will be reported weekly to COVID command meetings	None	None - we are confident this measure is met
3	**Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**			
	As per national guidance:			
3.1	arrangements around antimicrobial stewardship are maintained	Antimicrobial stewardship arrangements are maintained and overseen by the IPC team. **Assurance 1:** IPC Group meetings will review and report on antimicrobial arrangements. **Assurance 2:** We conduct an annual antimicrobial audit which is reviewed by the IPC Committee and forms part of the annual IPC report	Arrangements for Birmingham and Essex need to be formalised and monitored	The IPC Team will need to establish formal monitoring and assurance processes, and report on these to the IPC Group.
3.2	mandatory reporting requirements are adhered to and boards continue to maintain oversight	**Assurance 1:** IPC Group meetings will review and report on antimicrobial arrangements. **Assurance 2:** We conduct an annual antimicrobial audit which is reviewed by the IPC Committee and forms part of the annual IPC report	None	None - we are confident this measure is met
4	**Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion**			
	Systems and processes are in place to ensure:			
4.1	implementation of national guidance on visiting patients in a care setting	CPAC reviews all relevant national guidance and issues internal guidance on implementation to ensure appropriate arrangements are in place for visits. **Assurance:** CPAC decisions and guidance are minuted, and its decisions are ratified by the Charity Executive Committee (CEC)	None	None - we are confident this measure is met
4.2	areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Any ward with a symptomatic or positive patient(s) is placed into isolation, with appropriate signage. Wards do not come out of isolation unless authorised by the DIPC, Deputy DIPC, EMD or DD Nursing. As and when patients are required to go into isolation, nursing teams will work with that patient to explain the isolation requirements. Carers and family members are informed. **Assurance:** Daily COVID Command meetings receive a verbal report on compliance with isolation requirements, and this is an agenda item for Outbreak control meetings. The isolation procedure is well-understood by staff.	None	None - we are confident this measure is met
4.3	information and guidance on COVID-19 is available on all trust websites with easy read versions	**Assurance**: STAH website includes a statement on procedures and requirements for visitors.	None	None - we are confident this measure is met
4.4	infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Before any patient is moved to another provider, the patient is tested, the infection status is communicated to the receiving organisations and this information is captured in RiO notes for each patient. For emergency transfers, the receiving hospital will be informed of the status of the patient and the ward. **Assurance:** CPAC are notified of all proposed, planned transfers during COVID, and check to ensure appropriate communication. To date all transfers have been appropriately communicated.	None	None - we are confident this measure is met
5	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**			
	Systems and processes are in place to ensure:			

	Key Lines of Enquiry	Evidence	Gaps in assurance	Level of assurance and mitigating actions
5.1	front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non-COVID-19 cases to minimise the risk of cross-infection as per national guidance	As inpatient mental health hospitals, we place all new arrivals in quarantine for six days, test each patient, and only end the quarantine period following a negative test and the conclusion of the six-day period, symptom-free. **Assurance:** Quarantine status, compliance with quarantine, and test results are reported on and monitored daily as part of COVID command. This allows CEC-level support and intervention if the quarantine is proving challenging. Evidence to 10 November 20 is that quarantine compliance is close to 100% and that instances of non-compliance are addressed promptly.	None	None - we are confident this measure is met
5.2	mask usage is emphasized for suspected individuals.	Mask usage is compulsory for staff, but, given the nature of our patient group, we cannot reasonably require all patients to wear masks. Patients who are symptomatic are isolated, and those who are admitted or transferred from other healthcare providers, or from the community, are placed in quarantine. **Assurance:** Patient isolation and quarantine arrangements are monitored daily, as is detailed elsewhere.	None	None - we are confident this measure is met
5.3	ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	All our reception areas are protected by screens. Patients displaying symptoms are identified immediately and contact tracing is commenced.	None	None - we are confident this measure is met
5.4	for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Actions and decisions are documented on RiO. **Assurance:** The status of all symptomatic patients is reviewed daily by COVID Command. Contact tracing information is required as soon as a positive result is received.	We have had instances on contact tracing not commencing immediately at weekends.	We have extended our COVID Command meetings to cover weekends, and monitors the provision of contact tracing data.
5.5	patients with suspected COVID-19 are tested promptly	Patients displaying symptoms are identified immediately and testing is booked. All symptomatic patients, test dates, results etc are recorded centrally and reviewed daily. **Assurance:** Covid Command meetings review symptomatic patients daily. Where a patient refuses a test (and has capacity to do so), the patient is placed into isolation in any event and monitored accordingly. Where a patient is non-compliant with isolation, CPAC are informed and more restrictive interventions are considered.	None	None - we are confident this measure is met
5.6	patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Patients displaying symptoms are identified immediately and testing is booked. All symptomatic patients, test dates, results etc are recorded centrally and reviewed daily. **Assurance:** Covid Command meetings review symptomatic patients daily. Where a patient refuses a test (and has capacity to do so), the patient is placed into isolation in any event and monitored accordingly. Where a patient is non-compliant with isolation, CPAC are informed and more restrictive interventions are considered.	None	None - we are confident this measure is met
5.7	patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Not applicable: as a mental health inpatient hospital, we do not have patients who attend for routine appointments.	None	Not applicable
6	**Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**			
	Systems and processes are in place to ensure:			
6.1	All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Our mandatory training includes modules on IPC (for all staff working in clinical environments) and (for all staff) Health and Safety at Work. **Assurance 1**: Training compliance records are held for all staff and reviewed monthly as part of Clinical Governance. Compliance is consistently above 90% **Assurance 2:** During the pandemic, training compliance is also monitored weekly by COVID Command. Any wards below 90% are identified, prioritised for improvement, and performance managed.	None	None - we are confident this measure is met
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	This is included in the in the IPC eLearning. Specific face-to-face training was given on all wards at the beginning of the pandemic and guidance videos were made available on our Intranet All staff training is recorded and records are reviewed as part of Clinical Governance and Operational management.	We don't have a testing regime in place for ensuring staff are donning and doffing properly	We will set up a system of assurance by 1 November
6.3	A record of staff training is maintained	**Assurance 1:** Training compliance records are held for all staff and reviewed monthly as part of Clinical Governance. Compliance is consistently above 90% **Assurance 2:** During the pandemic, training compliance is also monitored weekly by COVID Command. Any wards below 90% are identified, prioritised for improvement, and performance managed.	None	None - we are confident this measure is met
6.4	Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	We do not authorise the re-use of any PPE, and any re-use would need to be sanctioned by the DIPC	We do not have systems in place to monitor and provide assurance that PPE is not being re-used.	As part of regular IPC checks on wards we will audit compliance with PHE national guidance on PPE use, and in particular check to see if there is any evidence of PPE re-use. This will be in place by 31 October.

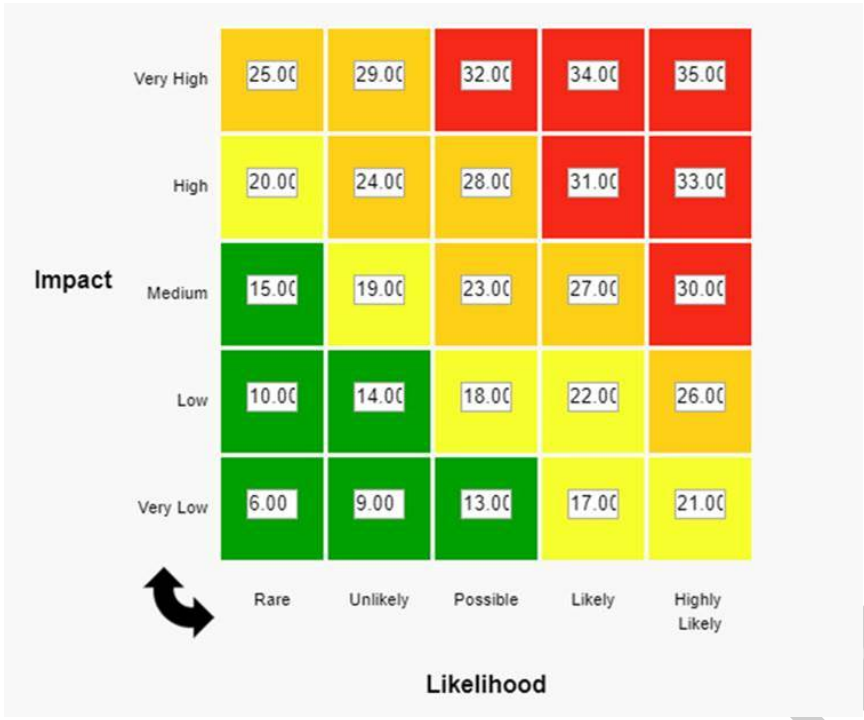
	Key Lines of Enquiry	Evidence	Gaps in assurance	Level of assurance and mitigating actions
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	As above	As above	As above
6.6	Adherence to PHE national guidance on the use of PPE is regularly audited	Considerable effort has been put into improving adherence to PHE guidance on the use of PPE, and compliance has improved significantly, particularly in relation to Bare Below the Elbow and mask use. Compliance has improved significantly, but is still short of 100%.	As above	As above
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	**Assurance**: spot-checks are carried out by Heads of Nursing and Specialist Nurses and breaches addressed. A report is made to Covid Command weekly on compliance rates. Practice has improved significantly since March, with regular updates and bulletins, posters on wards and checks. **Assurance:** spot-checks are carried out by Heads of Nursing and Specialist Nurses and breaches addressed. A report is made to Covid Command weekly on compliance rates.	We do not yet have a formalised system of recording the results of compliance checks	We will set up a system of assurance by 1 November
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	**Assurance:** We do not have hand driers in clinical areas (or other areas). All toilets and bathrooms use soft, absorbent, disposable paper towels which are located high enough from sinks to reduce splash risk	None	None - we are confident this measure is met
6.9	Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	**Assurance:** Hand hygiene guidance is on display in every public toilet and staff areas and is regularly checked and replaced if necessary.	None	None - we are confident this measure is met
6.10	Staff understand the requirements for uniform laundering where this is not provided for on site	Those staff who currently wear uniform (Physical Healthcare Team, and those working on Dementia and HD wards) demonstrate a clear understanding of laundering requirements. Staff working on wards in isolation are required to wear hospital provided and laundered scrubs. We do **not** have assurance that staff are laundering their own clothes in line with best IPC practice and so are introducing uniforms for nursing staff.	We are moving to uniforms for other ward-based staff, beginning with a pilot in November 2020 but do not yet have in place laundering arrangements	Part of the pilot will be to establish proper laundering instructions and ensuring they are reasonable and complied with.
6.11	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	Staff are reminded daily by email of the symptoms and appropriate action to take. **Assurance:** all staff absence is routed through a trained Central Absence Team (CAT) who talk through with staff the symptoms and requirements. Absence rates are monitored daily.	None.	None - we are confident this measure is met
7	**Provide or secure adequate isolation facilities**			
	Systems and processes are in place to ensure:			
7.1	Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Patients who become symptomatic and/or test positive are placed into isolation on their wards, and the ward is placed in isolation. The nature of our patient groups means that, in general, it would not be safe or appropriate to cohort all COVID patients in a single area.	None	None - we are confident this measure is met
7.2	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	**Need to outline approach to risk assessment** See 7.1, above. We do not have cohort areas as a rule.	None	None - we are confident this measure is met
7.3	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement			
8	**Secure adequate access to laboratory support as appropriate**			
	Systems and processes are in place to ensure:			
8.1	Testing is undertaken by competent and trained individuals	Testing of patients is only carried out by our Physical Healthcare Team who are competent and trained	None	None - we are confident this measure is met
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patients are tested as soon as they become symptomatic. Staff are not tested onsite, but are encouraged to book tests as soon as they are symptomatic, or advised to test by the T&T system. The dates when patients become symptomatic, when they are tested, and the details of test results are all logged centrally and reviewed daily. **Assurance:** all staff absence is routed through a trained Central Absence Team (CAT) who talk through with staff the symptoms and requirements. Absence rates are monitored daily.	None	None - we are confident this measure is met
8.3	Screening for other potential infections takes place	Patients have physical health checks completed on admission, and then at least annually (variable according to patient type) and these are recorded in Rio. Physical health observations are monitored regularly at a frequency determined appropriate for individual patients by their clinical teams and any deterioration is escalated to the physical healthcare team. **Assurance:** completion rates of physical healthcare reviews are included in the ward, Division and Hospital clinical governance process.	None	None - we are confident this measure is met

	Key Lines of Enquiry	Evidence	Gaps in assurance	Level of assurance and mitigating actions
9	**Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections**			
	Systems and processes are in place to ensure:			
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	All staff receive Health and Safety at Work training, and clinical staff receive IPC Training. The Charity has an IPC policy and procedures, signed off by CEC. Posters and guidance are displayed across all three sites. Guidance is available on the Intranet. **Assurance:** IPC spot-checks are carried out, including checks on staff's understanding of IPC policies. Results are fed back to COVID Command.	Our IPC Procedures and Manual are not best in class	We are revising our IPC Manual in line with that used in NHS Scotland, which has been recommended for adoption by NHSE/I colleagues. This new manual will be up and running from 1 December
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	IPC guidance is checked every day by the DIPC, brought to CPAC, and communicated to staff as part of the CPAC decision-making process Clinical waste is handled in line with national guidelines.	None	None - we are confident this measure is met
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	**Assurance:** Checks are carried out by the Health and Safety Team. There have been examples of poor practice, and these have been escalated.	None	The Charity has established a working group from Ops, Estates and H&S which is examining all areas of clinical waste handling
9.4	PPE stock is appropriately stored and accessible to staff who require it	PPE stock is stored centrally in Northampton Stores and is distributed as required by Estates staff, and a reserve supply is held by security teams for out of hours access on each site. **Assurance:** PPE stock levels and the efficacy of the distribution process is monitored daily by COVID Command. There have been instances of stock levels running low, particularly in Birmingham, and processes for monitoring stock levels and ensuring resupply have been improved.	None	None - we are confident this measure is met
10	**Have a system in place to manage the occupational health needs and obligations of staff in relation to infection**			
	Systems and processes are in place to ensure:			
10.1	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	All staff have been asked to undertake a COVID risk-assessment. Staff in at-risk groups shielded for the duration of the Government's initial shielding period. All were given support from Occupational health support to manage their return to work, and were placed in COVID-secure areas where appropriate. Those who still need to shield are continuing to do so.	None	None - we are confident this measure is met
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Our policies are aligned to Resus Council Guidelines regarding AGPs and chest compressions	We do not have a comprehensive programme of Fit Testing in place for FFP3 masks	We are in the process of commissioning a Fit testing programme so staff will have access to the right equipment when managing AGPs.
10.3	Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Staffing of wards is in line with our infection control and pandemic preparedness policies, so staff working on isolated wards are not able to work on other wards until their ward comes out of isolation. (This approach was adapted at the height of the first wave, as, with 900 staff absent, it became unsafe to prevent staff from working across different wards. We therefore allowed staff to work on a different ward the following day. Movement between isolated and non-isolated wards on the same day was not allowed) **Assurance:** staffing levels are monitored and reported on daily, and any shortages are addressed on a hospital-wide basis by management teams.	None	None - we are confident this measure is met
10.4	All staff should adhere to national guidance on social distancing (two metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Mask-wearing and the two-metre rule is in force across all three hospitals. **Assurance:** COVID-Secure areas have been established, and these are monitored regularly by the Health and Safety team. Where appropriate, COVID secure status has been revoked (Birmingham) or procedures adapted (WWH 2nd Floor).	Despite repeated reminding, compliance with social distancing and mask wearing is still not at 100%, particularly at night. Regular checks are carried out and disciplinary action is now being taken against those not complying.	A more formal system of assurance checks will be established and implemented by 24 October.
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	Staff breaks are staggered on each ward to ensure safe staffing throughout the day. Further staggering (between wards) has been considered but is not possible. Staff Rooms and onsite cafes have been closed in order to reduce the risk of staff density.	None	None - we are confident this measure is met
10.6	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff absence is managed through a dedicated Central Absence Team who work closely with the Occupational Health team and local management to ensure staff are supported. **Assurance:** Absence rates are reviewed daily by COVID Command. Trigger points, at which absence rates trigger increased support for each ward have been established.	None	None - we are confident this measure is met
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	The Occupational Health Team and HR Business partners work with all staff who test positive, and provide information and support to them and to their line manager. Return to work is planned jointly by the individual, their manager, OH and HR.	We do not routinely seek feedback from staff who have tested positive about the experience of returning to work.	A system of seeking feedback will be in place by 1 November

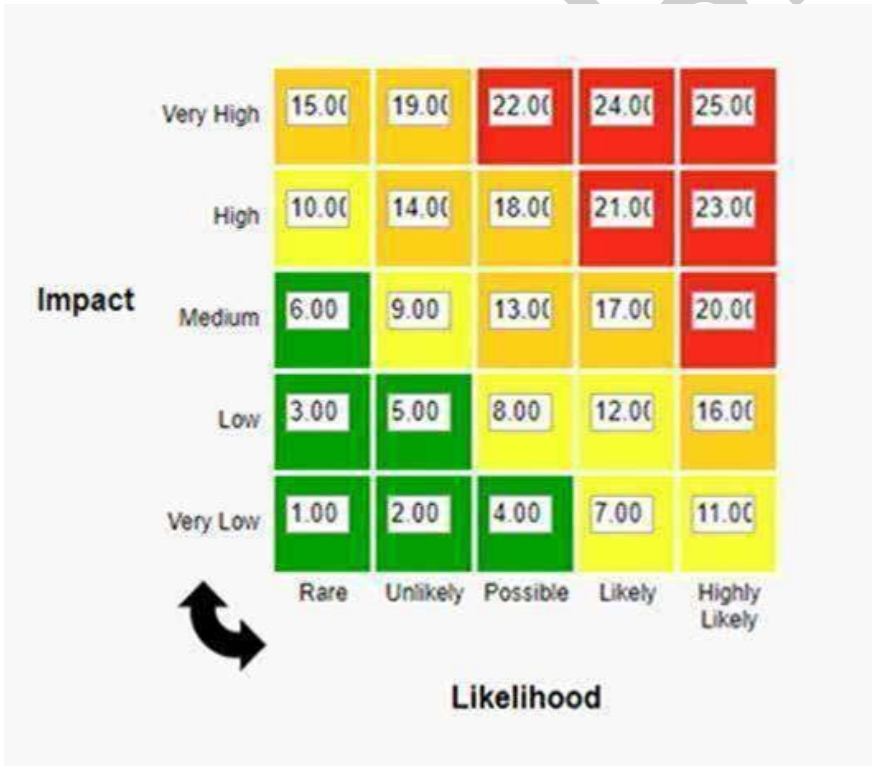
Appendix C

Risk														Actions			
Risk No	Risk Title	Description	Inherent Rating	Inherent Score	Risk Mitigation	Residual Impact	Residual Likelihood	Residual Rating	Residual Score	Residual Score Movement Direction	Next Review Date	Is the Risk Acceptable?	Risk Owner	Mitigating Action Name	Description	Action Owner	Target Completion Date
R1271	COVID-19 Infection & Pandemic	The risks associated with COVID-19 outbreak could impact the Charity's financial position, workforce stability, procurement of resources, patient and staff safety causing widespread service disruptions (impacting patient care) potentially leading to litigation. financial and reputational damage.		35	**Working Arrangements Adaptions** Adapting working arrangements as required to support requirements of self-isolation, working from home and redirecting additional resources to required areas and functions. Active COVID-19 risk assessments in association with the guidance for NHS organisations for working environments across the Charity that re closely monitored. **Identification of Facilities** Identification of facilities on site at Northampton and regional sites to provide options to support an external 'surge' response arrangement. **Clinical & Professional Advisory Committee (CPAC)** CPAC forms daily reviews as part of Charity emergency planning for COVID-19 pandemic, providing advice to clinical teams regarding ethical, clinical and complex decisions. **Insurance Cover Programme** StAH insurance programme covers organisational risks. **Charity-wide Communications** Daily internal COVID-19 updates, weekly Charity-wide Q&A with executive leadership and ongoing open channels for queries and concerns. **Incident Management Process** Incident Command and control procedures for the anticipation and response to unplanned disruptive events and situations, (BCEP02). Incident Command process established with patient evacuation identified as an Incident Command event. **External Guidance for Coronavirus (COVID-19)** External Guidance for Coronavirus (COVID-19) includes Government advice, Public Health England (PHE), NHSE, CQC. **Charity-wide Daily Staffing Reviews** Daily meeting held to review staffing arrangements and requirements by the Contingency Support team led by Chief Operating officer. **Personal Protective Equipment (PPE) Policy & Procedures** StAH is apart of the NHS pool for PPE distribution, and is now on the pallet push programme which supports the Charity with a weekly delivery of PPE. Reviews form part of daily routine for stores and procurement teams, whilst interacting with the COVID-19 dashboard to circulate demand in individual areas. **Pandemic Preparedness Plan** The Pandemic Preparedness Plan (PPP) is to support StAH in organising and delivering a proactive response to a declared pandemic. Providing a framework for command, co-ordination, communication and to support management in anticipating and controlling the wide range of potential impacts. **Infection Control Procedures** Application of infection control procedures to manage hygiene, including hand hygiene ('bare below the elbows' Charity-wide initiative), use of PPE, waste disposal, sharps management, procedures for management of bloods / bodily fluids and removal of used linen, procedures for isolation (IC04).	Medium	Likely		27	↑	04/01/2021	Not Acceptable	Alastair Clegg	CPAC Guidance and Oversight	2x weekly reviews by the Clinical and Professional Advisory Committee (CPAC), forms part of the Charity emergency planning for COVID-19. The CPAC will provide advice to clinical teams regarding ethical, clinical and complex decisions regarding patients are services in the face of challenges presents to StAH by the pandemic. It will report directly to the CEC.	Sanjith Kamath	31/01/2021
														Periodically Review Strategic Targets	Periodically review strategic targets which are delayed due to tactical focus on risks associated with COVID-19 pandemic. Contractual targets reviewed and mitigations agreed with commissioners in the short term. Planning for medium term contractual changes underway to reflect ongoing requirements arising from COVID 19.	Jess Lievesley	31/01/2021
														Revise Pandemic Preparedness Plan	Review and revise Pandemic Preparedness Plan to ensure it reflects actual practices.	Alastair Clegg	30/12/2020

‘Material’ Scoring Scheme for reference:



‘Operational’ Scoring Scheme for reference:



Appendix D

	Control Name	Description	Is Key Control	Design	Performance
☑	Charity-wide Communications	Daily internal COVID-19 updates, weekly Charity-wide Q&A with executive leadership and ongoing open channels for queries and concerns.	☑	Designed to reduce most areas of risk	Control is always applied as intended
☑	Charity-wide Daily Staffing Reviews	Daily meeting held to review staffing arrangements and requirements by the Contingency Support team led by Chief Operating officer.	☑	Designed to reduce some areas of risk	Control is generally applied correctly
☑	Clinical & Professional Advisory Committee (CPAC)	CPAC forms daily reviews as part of Charity emergency planning for COVID-19 pandemic, providing advice to clinical teams regarding ethical, clinical and complex decisions.	☑	Designed to reduce most areas of risk	Control is always applied as intended
☑	External Guidance for Coronavirus (COVID-19)	External Guidance for Coronavirus (COVID-19) includes Government advice, Public Health England (PHE), NHSE, CQC.	☑	Designed to reduce most areas of risk	Control is always applied as intended
☑	Identification of Facilities	Identification of facilities on site at Northampton and regional sites to provide options to support an external 'surge' response arrangement.	☑	Designed to reduce some areas of risk	Control is generally applied correctly
☑	Incident Management Process	Incident Command and control procedures for the anticipation and response to unplanned disruptive events and situations, (BCEP02). Incident Command process established with patient evacuation identified as an Incident Command event.	☑	Designed to reduce some areas of risk	Control is sometimes applied correctly
☑	Infection Control Procedures	Application of infection control procedures to manage hygiene, including hand hygiene ('bare below the elbows' Charity-wide initiative), use of PPE, waste disposal, sharps management, procedures for management of bloods / bodily fluids and removal of used linen, procedures for isolation (IC04).	☑	Designed to reduce some areas of risk	Control is generally applied correctly
☑	Insurance Cover Programme	StAH insurance programme covers organisational risks.	☑	Designed to reduce most areas of risk	Control is always applied as intended
☑	Pandemic Preparedness Plan	The Pandemic Preparedness Plan (PPP) is to support StAH in organising and delivering a proactive response to a declared pandemic. Providing a framework for command, co-ordination, communication and to support management in anticipating and controlling the wide range of potential impacts.	☑	Designed to reduce most areas of risk	Control is generally applied correctly
☑	Personal Protective Equipment (PPE) Policy & Procedures	StAH is apart of the NHS pool for PPE distribution, and is now on the pallet push programme which supports the Charity with a weekly delivery of PPE. Reviews form part of daily routine for stores and procurement teams, whilst interacting with the COVID-19 dashboard to circulate demand in individual areas.	☑	Designed to reduce most areas of risk	Control is always applied as intended
☑	Working Arrangements Adaptions	Adapting working arrangements as required to support requirements of self-isolation, working from home and redirecting additional resources to required areas and functions. Active COVID-19 risk assessments in association with the guidance for NHS organisations for working environments across the Charity that re closely monitored.	☑	Designed to reduce most areas of risk	Control is generally applied correctly

Paper for Board of Directors

Topic	East Midlands Alliance Update & Board Paper in Common
Date of meeting	Thursday, 28 January 2021
Agenda item	**08**
Author	Jess Lievesley, Deputy Chief Executive
Responsible Executive	Katie Fisher, Chief Executive
Discussed at previous Board meeting	Multiple updates through 2019-20.
Patient and carer involvement	Not in relation to this report.
Staff involvement	Not in relation to 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 ☐ (Delivering 50% of services in partnership)
Committee meetings where this item has been considered	Charity Executive Committee, however not specifically in relation to this paper.

Report summary and key points to note

As on previous occasions, this report has been prepared by the East Midlands Mental Health & Learning Disability Alliance, which comprises of the five NHS Foundation Trusts in the region and St Andrew's Healthcare.

The paper provides an update on the continued work of the alliance against a number of work streams and contains feedback from each partner in the alliance following the last board paper in common from the Summer of 2020.

The Alliance represents a significant strategic opportunity for all partners, including our charity to influence and inform the development and delivery of Mental Health and Learning Disability services across the region. The Alliance also presents an opportunity for a collective voice nationally and reflects a way of working that is fully supported by our current strategic direction.

The Board are asked to note this report.

Appendices

None.

East Midlands Alliance for Mental Health and Learning Disabilities

Common private Board paper

Introduction

This common Board paper provides an update on the work of the East Midlands Alliance for Mental Health and Learning Disabilities.

Board feedback

Following a joint Chair and CEO meeting on 5 June a common slide pack was presented to each of the Alliance member provider Boards with a request for feedback. The Board pack summarised the progress made in the first half of 2020, a suggested work programme for the remainder of 2020/21 and proposed lead CEO roles.

The feedback is summarised in Appendix one. The feedback from most of the Boards was consistent and supportive. There were a small number of suggestions to amend the work programme. There was agreement to share key messages with local partners.

The feedback from Nottinghamshire was supportive but raised some questions on potential duplication, pace of change, building in time for Board review, veto powers, risk ambition and the link to provider collaboratives.

Work programme – 2020/21

The presentation made to each member Board in the summer included a draft work programme.

Elements of the work programme have moved forward, summarised later in this paper. Examples include:

- Collaborative learning workshops
- Using technology to address common issues
- Using the collective voice of the Alliance to lobby regional and national leaders
- Development of the demand and capacity model
- Widening the groups of staff brought together under the Alliance – notably the Finance and Operations Directors
- Aligned approach to the Mental Health Investment Standard
- Developing closer links with the AHSN and the Mental Health Clinical Network
- Maintaining the weekly support meetings for CEOs
- Taking the lead locally within STPs on Mental Health and LD programmes
- Improving the quality of services by sharing learning from CQC inspections.
- Agreeing single Provider Collaborative governance and a shared staff hub for the East Midlands

Other aspects of the proposed work programme have yet to move forward and the CEO group have agreed to pause the following for three months while providers work through the second wave of Covid:

- End to end pathway reviews considering the total available resource
- Population Health Management
- Delivering a standard approach to service and quality improvement
- CEO leadership of pathways working with Alliance wide clinical networks
- Bring the Medical leadership and Nursing leadership together

CEOs meeting with Claire Murdoch

The CEO group met with Claire Murdoch, the national director for mental health and learning disabilities, in late July. The group held a wide-ranging discussion on capacity, the mental health equivalent of Nightingale Hospitals, the acute focus of some national and regional discussions, Covid and recovery. The group discussed the importance of pushing other leaders in the NHS to create the bandwidth to discuss and consider mental health properly.

The group discussed the case for wider engagement on mental health, the support from mental health to the acute sector during Covid and the need to the need for effective challenge of token discussion of mental health at the end of wider leadership meetings.

Claire set out work being planned at national level with NHS Providers and other partners to look at a one-step removed mental health support function for NHS staff. The funding offered will enable a pilot in each region.

The group discussed the Mental Health Investment Standard (MHIS). The CEOs raised concerns over the process to sign off the MHIS, their lack of involvement in the audit and the lack of transparency of the spend and audit. Claire noted the plans to take feedback and ideas to strengthen the audit next year. The group discussed the audit company having to get in touch with the lead provider CEO, as an automatic proactive step. The publication of the audit was also discussed.

Claire concluded the discussion with encouragement to the Alliance to develop a population health approach and to consider population level outcomes delivered through provider collaboratives based on members that share the risk and gain. Claire praised the CEOs in the East Midlands for pushing that agenda forward at pace and taking a broad rather than narrow view of the potential benefits of close joint work and collaboration.

Learning Disabilities and Transforming Care workshop

The Alliance held a collaborative learning workshop in August to share best practice and common issues in relation to the provision of Learning Disability services and delivery of the national Transforming Care programme. Some providers have taken a lead with the TCS programme in their STP area with integrated provider and commissioner teams which have proved successful.

The clinicians and managers present shared innovative approaches and reflected on service provision and commissioning gaps in the East Midlands including LD Crisis support, community forensic services, community provision to support ASD and challenging behaviour, and a lack of

Autism specific support services. The group agreed to recommend a common Alliance approach to training for mental health staff that care for service users with Learning Disabilities and Autism.

BAME risk assessment theme workshop

The Alliance held a collaborative learning workshop in August to share the themes from the BAME risk assessment process and to discuss learning from the different approaches taken to this task. The main themes from the workshop focused on the need to work with existing BAME networks, the need to support managers, the importance of clarity on the respective roles of HR, line managers, Occupational Health, Employee Assistance and Well-being services. The discussions moved on to discuss wider support to BAME staff. The workshop also discussed the relative merits of internal versus external Occupational Health services in the wider response to the first wave of Covid.

Restraint and restrictive practice workshop

The Alliance held a collaborative learning workshop in August to share best practice and new approaches to reduce the use of restraint. The workshop shared experiences of the providers that have begun to use body worn cameras, the use of CCTV and of Virtual Reality headsets for training purposes. The workshop also discussed changes that have been made to the physical environment to improve observation, successes and challenges in rolling out the Safe Ward programme, person centred activity boxes and the use of safety pods.

Providers that had relaxed some smoking rules in response to Covid found that this had the knock-on benefit of reducing the incidence of violent and aggressive behaviour and the use of restraint. Fewer patients were absconding to smoke which had led to improved relations with local police teams.

The workshop led to a number of recommendations to the CEO group including the establishment of a wider restrictive practice patient safety collaborative approach with support from the East Midlands Academic Health Science Network.

CEOs meeting with NHS Providers

The CEO group met with Chris Hopson and Saffron Cordery, CEO and Deputy CEO of NHS Providers, on 4 September. Saffron set out some thoughts on system working, provider organisations working in partnership, the focus of existing structures on acute trusts and particularly on Urgent and Emergency Care. Chris set out some thoughts on the successes and weaknesses of the centralised focus on mental health targets and spend.

The group discussed how bottom up initiatives might be stimulated and the idea of stepping back and thinking about what has and has not worked over the last few years for nationally led development of mental health.

The group discussed potential approaches to unlock the engagement of acute CEOs, developing their understanding of mental health and the impact on the acute sector of decisions and actions relating to mental health.

The meeting covered the importance of data and using data to make arguments for investment and focus. The imbalance in the volume and quality of data between mental health and the acute sector has been much to the detriment of mental health. The group discussed the demand and capacity model being developed in the East Midlands and how the products of the model and the literature review showing the growth in severe mental health, acuity and first-time presentations.

East Midlands Academic Health Science Network

Four staff from the AHSN, including the Regional Director, joined the CEO meeting on 16 October. The CEOs discussed and agreed the proposal to establish a restrictive practice patient safety collaborative.

The AHSN provided an update on the national and regional Patient Safety Improvement work programme. Perinatal mental health transformation is part of the Maternity and Neonatal programme. Mental Health is also a core element of the Managing Deterioration programme. The three priorities within the Mental Health programme are 1) the reduction of suicide and deliberate harm; 2) reducing restrictive practice; and 3) improving sexual safety. The earlier focus is expected to be on suicide reduction and reducing restrictive practice.

The CEO meeting also received an update on the Alliance work with the AHSN on the use of technology to solve common issues. The Alliance Strategy Directors group have taken forward two pieces of work looking at the use of technology to improve the identification of Section 12 doctors and the potential use of technology to replace and improve on paper-based systems to record and remind staff of required actions relating to seclusion.

The CEOs agreed to work with the AHSN to set up a workshop to look at the approaches being taken across the Alliance to measure the impact of moving certain services to a digital platform and the introduction of technology to support mental health.

There are two national mental health programmes that the East Midlands AHSN have taken a lead on. The ADHD programme is focused on an objective assessment tool that supports diagnostic decision-making for children with ADHD. The tool has reduced the time for a diagnostic decision by an average of five months and is now in use in forty Trusts in the England. The second national AHSN mental health programme is rolling out a fast track system targeting 18 to 24-year olds with Eating Disorders. The Leicestershire and Nottinghamshire systems have secured funding for this programme.

The AHSN agreed to share a list of all the programmes being delivered across the AHSN network in England. The CEOs agreed to support the delivery of an AHSN horizon scanning and innovation plan for the region. The CEOs discussed the idea of holding some webinars to share learning from elsewhere in the country. CEOs were keen that the Alliance Nurse and Medical Directors are drawn into this joint work with the AHSN.

Operations Directors

The Operations Directors met in early August to share experiences of the increase in activity and acuity through the summer. The group received a briefing on the positive impact of the Urgent Care Hub in Leicestershire. The group will meet again pre-Christmas to discuss winter planning and potential mutual aid.

Finance Directors

The Alliance Finance Directors met in late September and early November. The group agreed that there may be an opportunity to develop a joint capital brokerage proposal to NHSE/I. The Finance Directors also shared progress with the Phase Three planning submissions and issues with the distribution of transformation and Covid funds in each system. The Finance Directors also discussed the plans and opportunities to establish single finance arrangements across the Provider Collaboratives in the East Midlands. A longer meeting focused on the finance elements of the Provider Collaboratives will take place on 11 December with regional and national Specialised Commissioning finance leads invited to join.

Strategy Directors

The Strategy Directors continue to meet on a bi-monthly basis. The group has held discussions with the AHSN and the Mental Health Clinical Network. The group has been joined by representatives of the NHS England regional mental health and specialised commissioning teams. The Strategy Director group provided input and reviewed the Provider Collaborative single governance and shared staff hub proposals prior to them being considered by the CEO group.

NHS Benchmarking

A presentation from the Director of NHS Benchmarking took place on 13 November. This was well attended by a mix of Strategy Directors, Finance Directors and Operations Directors. The presentation worked through the latest mental health benchmarking report including the impact of Covid on service provision. Four of the five NHS Trusts take part in the monthly Covid returns allowing NHS Benchmarking to produce an East Midlands specific report which has been shared with CEOs.

Alliance demand and capacity model

Work has continued to develop a mental health demand and capacity model for the East Midlands Alliance. There was a significant delay while the national NHS team considered the application to share aggregated data on activity between the Alliance members. Agreement has now been reached and following further development work two versions of the model have been released via the NHS Futures platform for user testing.

The model considers historic demand trends, a set of growth assumptions linked to Covid and the economic and social impact of lockdown, staffing capacity and inpatient beds. There was a

significant piece of work to improve data quality and to look across the Alliance at the alignment on coding of broad areas of activity as part of the development phase.

A literature review has taken place each month to support the development of growth assumptions and that has been placed alongside actual movements in activity seen by the six Alliance members. The model allows the provider to adjust the growth assumptions, the vehicle of service delivery or the volume of capacity. Providers can compare their growth assumptions with other Alliance members.

The Alliance has agreed to receive further funding of £11,000 from the regional NHS England team to continue the North of England CSU hosting of the model for three months which will also allow further feedback and improvement, as the model is used.

The regional NHS England team has agreed to receive a proposal for further development funding to develop the model to include consideration of outcomes and to look across whole pathways to support the New Care Models and the Alliance work on population health and whole pathway review. A draft proposal will be presented to the CEO group following a presentation on the next version of the model.

The Mental Health Network at the NHS Confederation asked to meet to discuss the demand and capacity model with a focus on the growth assumptions generated by the literature and activity review. The Mental Health Network are lobbying the Treasury for further funding to be ringfenced for mental health.

Single governance approach for Provider Collaboratives and a shared staff team

The CEO group has considered a number of proposals from the Strategy Director group over the last year to establish a single governance arrangement for the Provider Collaboratives/New Care Models in the East Midlands and a shared staff hub. The proposals were supported by five of the six Alliance members. Nottinghamshire had some concerns including timing in relation to the Impact forensic New Care Model go-live date.

NHS England began work in August to commission an external review of the existing and planned governance arrangements in the East Midlands as they had concerns about multiple separate Boards and teams being established for each New Care Model. The Alliance agreed with NHS England that they would pause their plans for an external review while the CEOs tried to agree an approach.

The CEO group reached agreement on 3 September to establish a single East Midlands NCM Board and staff hub which was relayed to NHS England by the CEO group on 4 September as part of a gateway review for the Impact NCM assessment process. NHS England welcomed the confirmation stating that it was in line with their expectations. Provider Boards are asked to note that communication will need to be made to NHS England to confirm the change of plan if there is no longer support for the integrated Provider Collaborative governance.

Concerns were raised in mid-September as Nottinghamshire indicated that they were unable to support shared arrangements. Some of the CEOs raised concerns that they had updated their Boards and NHS England with an agreed CEO position that no longer appeared to stand. In late September, Lincolnshire confirmed a change of position and that they were no longer supportive of establishing a single Board and staff hub.

The CEOs invited the Chairs to meet with them on 2 October to try to help find a way forward. A positive meeting focused on the areas of common agreement. All six provider organisations committed to find a way forward on governance and shared staffing. There was agreement to develop an approach to single NCM/Provider Collaborative governance in the East Midlands and clear support for a single staff hub. The group asked that the Strategy Directors to work up a further proposal for consideration by the joint CEO and Chair group in early November.

The Strategy Director group met twice and agreed a set of principles to underpin the proposal and set out an approach that retained broad Partnership Board arrangements for each New Care Model (involving a wide range of NCM specific partners) but brought all of the decision-making Provider Collaborative Board discussions together in a single East Midlands Board (the six Alliance members that have agreed to under-write the New Care Models and sign up to the risk and gain share agreements). The Strategy Directors also proposed bringing the New Care Model and wider Alliance governance together in a single Partnership Agreement and offered to work up Terms of Reference and other detail once support for the broad proposal was re-confirmed by Chairs and CEOs.

The Strategy Director group also agreed to recommend the establishment of a single shared staff team to work across the New Care Models rather than establishing separate teams for each Provider Collaborative. The group identified Finance, Communications, Contracting, Informatics and Quality as the broad areas for a shared staff hub.

The Chairs and CEOs welcomed the progress made asking that some of the operational and technical detail be clarified or removed from this Board update. The Chairs were keen that future detailed proposals should be clear on Non-Executive oversight and audit arrangements. There was encouragement to work up arrangements that are future-proofed and that will function when there are five or six New Care Models in the East Midlands.

The group received information on the arrangements being established in the East of England which has a single Provider Collaborative Board to oversee the three initial New Care Models and future opportunities. There is a single Provider Collaborative Executive meeting and a single Transformation and Commissioning team. The three different NHS lead providers have agreed to work through the Transformation and Commissioning team.

Each organisation reconfirmed their support for the principle of establishing a single Provider Collaborative Board and shared staff hub. The meeting agreed to update provider Boards on the agreement of the principle to move to a single Provider Collaborative Board and shared staff hub and to set out the work required to develop the detail.

The diagram below set out how the governance and staffing arrangements would look if each Provider Collaborative establishes their own Boards and staff teams. The second diagram sets out what is planned by bringing together the governance and staffing for the Provider Collaboratives in the East Midlands.

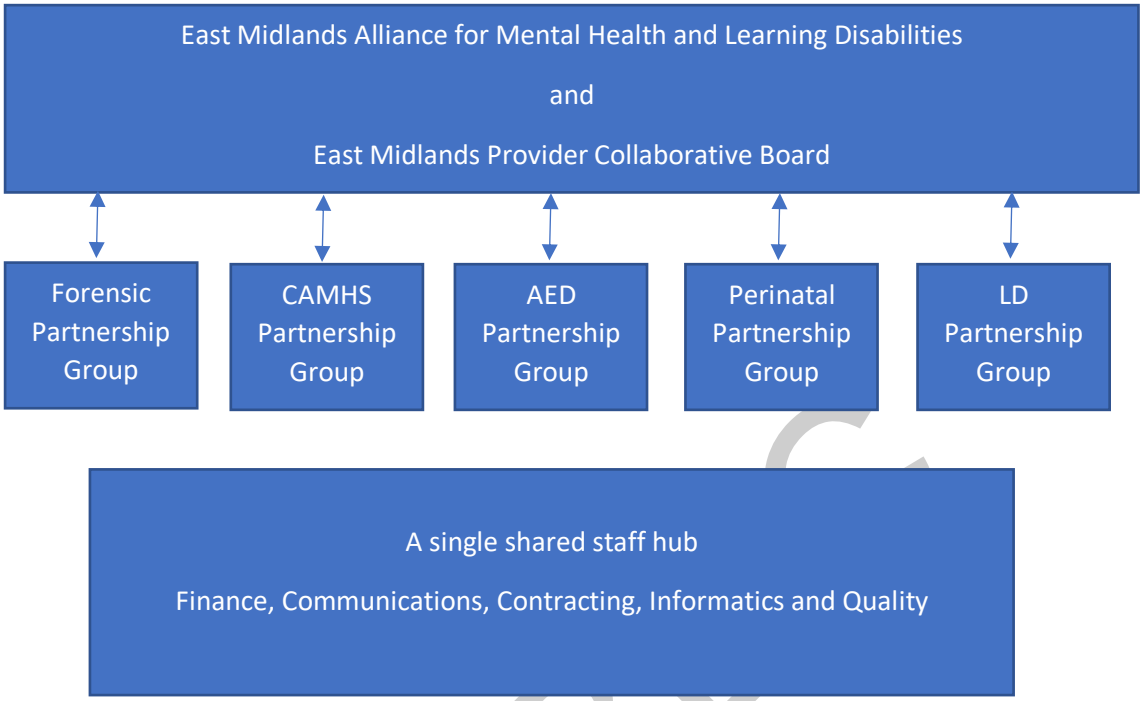
Separate siloed NCM arrangements

If each New Care Model establishes their own decision-making Board and their own staff team the arrangements will be duplicative, inefficient and not promote planning and decision-making across the pathways.

Five separate NCM Boards and five separate NCM teams. Separate from the broader work of the Alliance.

Establishing a single Provider Collaborative Board and shared staff hub

The aim of the principle agreed by CEOs and Chairs is to bring the New Care Model decision-making boards together to create a single Board working through a single shared staff hub.



The key next steps to deliver the detail of the agreed approach are:

Area of detail	**Lead directors**
Shared staff hub, common HR policies and TUPE of a wider pool of NHS England staff	HR Directors NCM lead Directors
Role of Non-Executive Directors, terms of reference and Partnership Agreement	Strategy Directors NCM lead Directors
Finance, audit and risk and gain share arrangements	Finance Directors

Recommendation

The Provider Boards are asked to note the significant progress made by the Alliance during 2020 and to note the commitment made to move to a single Provider Collaborative governance arrangement with a shared staff hub.

Appendix one - Feedback from Provider Boards

Derbyshire

- Important role for the Alliance in developing services and defining clinical pathways and best practice.
- Opportunity to reduce the work programme by bringing together the lead role for NHS Trusts with their STP MH and LD programmes (objective 4) with the MHIS objective (5).
- There is value in mental health modelling work taking place at regional level particularly in the comparative element that would not be possible locally.
- Querying who would be responsible for completing the end to end pathway reviews and how resource could be recruited to complete this work by October.
- Need to clarify whether any of the planned objectives should sit with Trusts rather than the Alliance.

Lincolnshire

- Supportive of the Alliance and the work programme
- Positive about the workshops and opportunities to share learning and best practice
- Keen to take that further with pathway reviews and development
- Keen to use the collective voice to increase influence at local, regional and national level

St Andrew's

- Very well received
- Welcomed the opportunity to work as part of wider system
- Significant opportunity to share expertise and learning
- Recognised the critical nature of alliance role given changing landscape of commissioning
- Opportunity to increase the service user voice – how can we bring this into the alliance?
- Build links with AHSN
- Consider research opportunities

Leicestershire and Northamptonshire

- Both boards are supportive and think this is the right strategic direction to provide parity and to champion outcomes for MH and LD service user

- Supportive of the key programme areas - nothing additional identified at the moment, things will emerge, important to deliver on our agreed areas.

- Supportive and organisation committed to the work programme priorities.

- Supportive of light governance with Provider Board primacy

- Interested in sharing the briefing or messages from it with CCG, local authority and STP partners and this will increase the influence and opportunity to deliver more improvements as others understand the joint working and opportunity for improvements.

Nottinghamshire

<u>To comment on the opportunity on offer to take a more central role in the local and regional organisation of mental health and learning disabilities</u>

- Welcome opportunity to take on a more central role where it;
  - drives quality improvement,
  - shares experience and skills of leaders and clinicians,
  - shares learning to reduce variation in outcomes across a larger geographic footprint and identifies potentially sharing services to meet the needs of smaller disadvantaged, hard to reach groups.
- Clearly this approach aligns with LTP and the unpublished strategic direction of 'scaling up' provider landscapes.

<u>To provide feedback on the planned approach to service/quality improvement through clinical networks sponsored by lead CEOs</u>

- Supportive; although need greater clarity on how this 'knits' together with other clinical networks such as ICS and Provider Collaborative networks.
- There is a risk of local to regional duplication of effort, differing prioritises or 'mismatched' pace of change.

<u>To review the ten-step work programme for the remainder of 2020/21</u>

- Broadly supportive; will want to consider again in second stage of Board assurance. Several of the objectives such as lead in ICS is already in practice.
- No3. – Complete end to end pathway reviews, identification of total resource and sign off priorities for improvement in October – needs greater clarity and in context of the Phase 3 letter needs to be more specific.
- No7. – Launch the NCMs, establish a single approach to NCM governance and a shared staff hub is broadly supported.

To comment on the model of light governance with Provider Board primacy

- There is commonality between providers / Boards.
- For Boards to exercise primacy; Boards require time to scrutinise proposals and consider interdependencies with local issues and border interdependencies with other regions and non-East Midlands ICSs.
- The sensitivity around decision taking and risk ambition will need to be balanced between the pace of the quickest and slowest Boards.
- The power of 'veto' needs describing in this context.
- 'Lite' governance needs to be further described in terms of the Alliance and NHSE's role(s).

Sharing the briefing or messages from it with CCG, local authority and STP partners

- This will need to be done through a lens of what is right for the local system.

Other comments

- The MOU dated November 2019 sets out an objective to establish a vehicle through which to take strategic decisions relating to the East Midlands New Care Models – while operational management of New Care Models will take place at each Partner's respective Board there are some decisions that require CEO input and others that require a broader strategic view to be taken across rather than within a New Care Model. This objective requires further discussion.
- Strategic decisions will be taken by Provider Collaboratives through their Partnership Agreements so the inter-relationship between the Alliance and Collaboratives needs to be understood.
- There remains a difference between the independent sector providers being able to influence strategic decisions through their Collaboratives but not through the Alliance.

Divisional Presentation Willow Ward – Women's Blended Pilot

(Alastair Clegg – Verbal)

Paper for Board of Directors	
Topic	Your Voice 2020 Survey
Date of meeting	Thursday, 28 January 2021
Agenda item	**10**
Author	Tom Bingham, Director of Communications
Responsible Executive	Martin Kersey, Executive HR Director
Discussed at previous Board meeting	Not previously discussed.
Patient and carer involvement	This item was discussed at the People Committee on 14 January 2021 with Carer and Employee representatives in attendance.
Staff involvement	Staff were involved by providing their comments for the survey.
Report purpose	Review and comment ☐ Information ☒ Decision or Approval ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Charity Executive Committee 6 January 2021 People Committee 14 January 2021

Report summary and key points to note

This report provides the Board of Directors with an update on this year's Your Voice Survey results.

- The shorter snapshot survey was run in November 2020, to give us an indication of staff engagement levels across our charity
- 1,803 people responded to the survey, which equated to 51% of the total number of people invited to participate, a decline of 16% points when compared with 2019
- An Engagement Score of 57% this year shows a disappointing 11% point drop from the previous year

- The scores are not uniformly low, 11 wards achieved an engagement score as good as or better than last year's charity-wide engagement score of 68%. 1 Division and 4 Enabling Functions also managed to get a higher Engagement score than last year

- To establish what lies behind these engagement scores, a series of focus groups will be held over the next 3 months, in addition to a results review and local action planning that we expect each Division / Ward / Enabling Function to complete

Appendices

Appendix A - Your Voice Snapshot 2020 – Engagement Scores

Your Voice Snapshot 2020 Results

Introduction

This year's Your Voice Survey, run in November 2020, was a shorter snapshot survey to give us an indication of staff engagement levels across our charity, whilst at the same time managing it in-house in a more cost efficient manner.

The survey ran between 2 November and 27 November and contained just our six engagement questions (around pride, energy and optimism) rather than the 52 questions in the full survey.

Executive Summary

An Engagement Score of 57% this year shows a disappointing 11% point drop from the previous year (see the table below).

This is the second time that we have run the snapshot survey in-house and anecdotal feedback suggests that a lack of trust in the survey's confidentiality may have played a part in the lower response rate. This is supported by the relatively low response rate in 2018.

The survey was undertaken against a backdrop of the pandemic, a rightsizing programme of our secure services and a number of other influencing factors (e.g. no pay rise, changes in overtime procedures, negative media coverage) however, when discussed at the CEC recently, it was made clear that these could not be used to mask the issues that exist in parts of the charity.

The scores are not uniformly low however. 11 wards achieved an engagement score as good as or better than last year's charity-wide engagement score of 68%. 1 Division and 4 Enabling Functions also managed to get a higher Engagement score than last year, despite some of the internal and external factors outlined above.

To establish what lies behind these engagement scores, a series of focus groups will be held over the next 3 months, in addition to a results review and local action planning that we expect each Division / Ward / Enabling Function to complete. A charity-wide action plan will be finalised once the focus groups are complete.

We are also currently selecting a new provider to support future surveys and will incorporate a review of the shorter snapshot survey as part of the process.

	Response Rate	Engagement Score
2020*	51%	57%
2019	67%	68%
2018*	56%	66%
2017	62%	64%
2016	64%	64%
2015	49%	59%

* Shorter 'snapshot' surveys

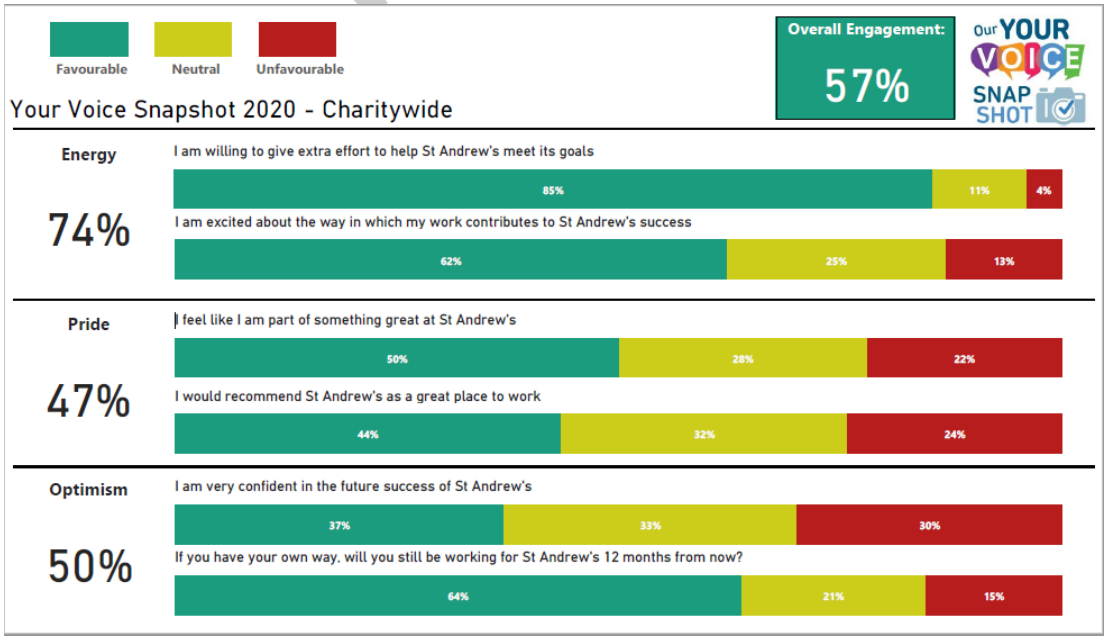
Response Rates

1,803 people responded to the 2020 snapshot survey, which equated to 51% of the total number of people invited to participate. This is a decline of 16% points when compared with 2019 (see table above). Further analysis of the response rates demonstrate that:

- The primary issue/challenge was due to lower participation from clinical staff in our Divisions (45% response rate) with participation amongst our Enabling Functions holding up reasonably well at 64%
- Divisional response rate is 49% if we exclude the WorkChoice response rate of 21%
- Response rates within each Division (excl WorkChoice) are not uniformly high or low. 17 wards achieved response rates of 67% or greater. 10 wards had response rates of less than 30%. Ranges in each Division were:
    - ASD / LD (32% overall): 15% (Spencer North) to 100% (Hawkins)
    - Birmingham (56% overall): 42% (Northfield) to 85% (Hazelwell)
    - CAMHS (41% overall): 43% (Sitwell) to 76% (Seacole)
    - Essex (72% overall): 54% (Frinton) to 100% (Maldon)
    - LS&R (49% overall): 38% (Spring Hill / Hereward Wake) to 94% (Berkeley Lodge)
    - MS (40% overall): 27% (Rose) to 67% (Fairbairn)
    - Neuro (44% overall): 17% (Redwood) to 100% (Aspen)
- Response rates within the Enabling Functions (64% overall) ranges from 40% in Estates & Facilities to 89% in Strategic Partnerships.

Engagement Scores

The full 2020 results were as follows:



As would be expected, given the decline in the overall engagement score from 68% in 2019 to 57% in 2020, the pride, energy and optimism category results also declined from 2019:

- Energy: compared to the 2019 result (76%) this category remained relatively stable. '*Willing to give extra*…' effort saw a decline of 2% points but '*Excited about*…' dropped by a more significant 6% points.

- Pride: This saw a significant drop from 2019 (63%) with both '*Part of something great*…' and '*I would recommend*…' reducing by 16% points.

- Optimism: This also saw a significant drop from 2019 (63%) with '*Confident about in the future*…' dropping by 18% points and '*Working for STAH in 12 months*…' dropping by 7% points.

The engagement score for our Divisions was 53% and for our Enabling Functions 64% (details below).

	Engagement %	**Energy %**	**Pride %**	**Optimism %**
Divisions	53	71	42	41
Enabling Functions	64	74	50	57

If we look at the engagement scores across each Division and Enabling Function they are as follows:

	Engagement %	**Energy %**	**Pride %**	**Optimism %**
ASD / LD	51	71	42	41
Birmingham	60	74	50	57
CAMHS	44	68	31	32
Community	64	83	54	57
Essex	68	78	61	65
LS&R	47	67	35	40
MS	52	70	41	46
Neuro	46	64	34	41
Education / Research	63	86	53	51
Estates	58	75	44	55
Fin & Procurement	58	77	44	51
HR	81	91	78	72
IT	64	81	56	55
Medical Dir / Pharmacy	66	80	57	52
Ops Support	59	68	45	64
Physical HC / AHP	39	64	28	24
Quality	61	81	52	50
Strategic Partnerships	72	85	63	67
Workbridge	56	73	48	45

Engagement Score Analysis

It would be easy to try and put the decline in our engagement score this year down to the unprecedented impact that COVID-19 has had on St Andrew's and our staff. However, although no formal external benchmarking is available, anecdotal feedback from a number of suppliers suggests that the impact of COVID on engagement scores in companies most impacted by the pandemic is a negative 3-4% points.

There have also been a number of other factors which could have caused the drop in engagement levels – the quality issues in CAMHS and our Women's services and accompanying negative external media coverage; the changes in terms and conditions and overtime rules; pay increases for only those paid the least in the charity.

However that would imply that engagement scores would be uniformly low across the charity. That has not been the case:

- 11 wards achieved an engagement score as good or better than last year's Charity engagement score of 68%. A further 7 wards achieved scores of between 60% and 67%.
    - Maldon 81%; Hadleigh 75%; Hazelwell 75%; Colne 74%; Audley 73%; Danbury 73%; Berry 70%; Northfield 70%; Berkeley Close GF 69%; Moor Green 69%; Edgbaston 68%
    - Winslow 67%; Cranford 66%; Prichard 66%; Spencer North 64%; Stowe 61%; Cherry 61%; Marsh 60%
- 2 Enabling Functions achieved over 70% engagement scores (HR – 81% and Strategic Partnerships – 72%). A further 4 Functions scored over 60%.
- The range of engagement scores in each division were:
    - ASDLD (51% overall): 17% on Lower Harlestone to 70% on Berry
    - Birmingham (60% overall): 51% on Hawkesley to 75% on Hazelwell
    - CAMHS (44% overall): 28% on Sitwell to 61% on Stowe
    - Essex (68% overall): 49% on Frinton to 81% on Maldon
    - LS&R (47% overall): 26% on Heygate to 59% on Berkeley Lodge
    - MS (52% overall): 35% on Willow to 66% on Cranford and Prichard
    - Neuro (46% overall): 13% on Redwood to 69% on Berkeley Close Ground Floor.

In addition 5 Divisions / Enabling Functions also managed to improve their Engagement Scores from 2019:

- Birmingham (+1% point), Estates & Facilities (+2% points), HR (+5% points), IT (+2% points) and Medical Director (+8% points)

Similarly, when looking at the low scores for Pride and Optimism, the quality issues and the rightsizing that has taken place this year could lie behind the significant reductions at a Charity-wide level. However, once again there are a number of wards

and Enabling Functions where the Pride and Optimism scores were the same or better than the results achieve in 2019.

- Pride (47% overall in 2020): 7 wards and 2 Enabling Functions had a score at or above the 2019 score (63%): Maldon 83%; Hadleigh 76%; Berry 75%; Hazelwell 73%; HR 72%; Colne 68%; Strategic Partnerships 63%; Watkins House 63%; Edgbaston 63%;
- Optimism (50% overall); 11 wards and 2 Enabling Functions had a score at or above the 2019 score (63%): Maldon 83%; Audley 74%; Moor Green 72%; Hadleigh 71%; Hazelwell 70%; Danbury 70%; Colne 66%; Northfield 65%; Berkeley Close FF 64%; Edgbaston 63%; Prichard 63%;

This suggests that, although external factors (COVID, negative media) and Charity-wide factors (pay, T&C and overtime changes) have undoubtedly had an impact on engagement, a number of local factors, for example leadership, have resulted in these being mitigated.

Next Steps

1. Communication of results to Nurse Managers (**Thurs 7 Jan**)
2. Communication of results to all staff via email and at Team's call (**Mon 11 & Thurs 14 Jan**)
3. Results discussion at the People Committee (**Thurs 14 Jan**)
4. Presentation of the results at the Board (**Thurs 28 Jan**)
5. Action planning at a ward and Enabling Function level to address local issues / actions (**Jan – Mar**)
6. Focus Groups discussions at each site to explore: (**Jan - Mar**)
   - what's good about working for STAH
   - what could be better
   - why the Pride and Optimism scores were so low
   - what we could do in 2021 to address the concerns staff had, particularly in the Pride / Optimism categories.
7. Analysis of Focus Group outputs and development / implementation of resulting charity-wide actions (**Apr – Nov**)
8. Action plans for teams with top 5 / bottom 5 engagement scores to present their actions plans to the People Committee (**Mar – Nov**)

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Appendix

Your Voice Snapshot 2020 – Engagement Scores 2020, 2019, 2018

Team	2020	2019	2018
	Engagement score	Engagement score %	Engagement score %
CEC	71%	93%	91%
Division - ASDLD	51%	73%	66%
Division - Birmingham	60%	59%	65%
Division - CAMHS	44%	61%	68%
Division - Community	64%	72%	69%
Division - Essex	68%	71%	63%
Division - LS&R	47%	65%	68%
Division - MS	52%	71%	64%
Division - Neuro	46%	69%	64%
Education, Research & Recovery College	63%	63%	62%
Estates & Facilities	58%	56%	54%
Finance & Procurement	58%	65%	65%
HR	81%	76%	74%
IT	64%	62%	52%
Medical Director	66%	58%	55%
Operations Support & Nursing	59%	77%	n/a
Physical Healthcare, AHP & Infection Contr	39%	52%	n/a
Quality	61%	n/a	59%
Strategic Partnerships	72%	73%	53%
Workbridge	56%	74%	66%
Total	57%	68%	66%

NB – not enough people responded in 2019 (min of 10) to register an engagement score for the Quality Team. Also n/a for Ops Support and Physical Healthcare in 2018 are due to structural / hierarchy changes

Paper for Board of Directors

Topic	External Governance Review Update
Date of meeting	Thursday, 28 January 2021
Agenda item	**11**
Author	Duncan Long, Company Secretary
Responsible Executive	Katie Fisher, Chief Executive
Discussed at previous Board meeting	26 November 2020.
Patient and carer involvement	Findings from the CQC Well Led Review have been shared widely across the organisation, including engaging with our Carer Governors.
Staff involvement	Findings from the CQC Well Led Review have been shared widely across the organisation. One of the actions from this review was the commissioning of an external governance review
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 ☒ *(Governance and assurance across all the strategic focus areas)*
Committee meetings where this item has been considered	Charity Executive Committee

Report summary and key points to note

This report provides an update on the External Governance Review tender and supplier selection process, highlighting the timeline for key stages and progress to date.

The Board is asked to note the intended timeline and the progress made with the review process.

Appendices

None

External Governance Review update

As agreed at the November Board, we have commenced the process to procure an external supplier to undertake a comprehensive Governance Review. The purpose of this paper is to provide the Board with an update on the tender and supplier selection process, highlighting the timeline for key stages and progress to date.

The procurement process is being supported by the Strategic Sourcing Buyer and follows the Charity's agreed procurement and approval process. Expression of Interests were sent to 12 potential suppliers on 21st December, outlining the basis of the external governance review, requesting that those that wished to be included respond by 4th January 2021 and that they complete the Charity's Non-Disclosure Agreements.

Nine suppliers confirmed their interest that included a number of the "Big Four", other top ten audit/accounting firms with industry experience, legal and governance experts and consultancy firms. These were subsequently sent a more detailed Service Specification and Request for Proposal (RFP). RFPs are due to be returned by 8th February.

A technical evaluation matrix has been created, that is based on the specification and includes the key areas of the review, the required outputs and relevant procurement based technical requirements. This will be used to formally evaluate the proposals.

The review and shortlisting will be completed by:

Paul Burstow, Chair

Andrew Lee, Non-Executive Director

Katie Fisher, Chief Executive

Jess Lievesley, Deputy Chief Executive

Duncan Long, Company Secretary

Kwame Efah, Strategic Sourcing Buyer

This review process will identify a shortlist of 3 preferred suppliers, who will be invited to present on 4th March, with each providing a 30 minute presentation, followed by a 30 minute Q&A. Currently this is planned to be in Northampton, however we will review this in line with guidance from CPAC. The final review and decision/contract award is planned for week commencing 8th March, and it is therefore envisaged that the actual governance review will commence in April.

The Board is asked to note the intended timeline and the progress made with the review process.

Paper for Board of Directors

Topic	Interim Governance and Assurance Map Refresh
Date of meeting	Thursday, 28 January 2021
Agenda item	**12**
Author	Duncan Long, Company Secretary
Responsible Executive	Katie Fisher, Chief Executive
Discussed at previous Board meeting	26 November 2020
Patient and carer involvement	Not appropriate in this instance
Staff involvement	Discussed with a selection of staff for feedback
Report purpose	Review and comment ☐ Information ☒ Decision or Approval ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Charity Executive Committee 13 January 2021 (Discussed with group members and attendees, as well as relevant administrators and support staff).

Report summary and key points to note

Following a recent high level review, this paper provides an update on the Charity's Governance and Quality Assurance Map. The current format of the Map was introduced in January 2020, and reflected a number of the recommendations following the CQC Well-Led inspection. Since its introduction there have been a number of new Board Committees and changes to numerous groups and committees within the structure, along with the assurance reporting lines.

The attached interim version of the assurance map has been completed ahead of the planned external governance review and ensures we have a map that reflects where we are now.

The Board is asked to note the revised structure.

Appendices

StAH Governance and Quality Assurance Map – January 2021

Interim Governance and Quality Assurance Map Review and Refresh

Introduction and background

The current format of the Charity's Governance and Quality Assurance Map was introduced in January 2020, and reflected a number of the recommendations following the CQC Well-Led inspection. Since its introduction there have been a number of new Board Committees and changes to numerous groups and committees within the structure, along with the assurance reporting lines.

We are currently in the process of confirming a comprehensive external governance review that will support the design and implementation of a new set of governance arrangements covering the Charity's corporate, regulatory and clinical governance responsibilities and the purpose of this interim review and refresh is to ensure we have a map that reflects where we are now ahead of this external review. The current map does not reflect the meeting structure the Charity is currently working within, whereas the revised one does and can therefore be used by staff to understand the Charity's Governance structure, as well when providing CQC responses, or responses to other requests (such as within contract tendering processes).

Summary

With the external review in mind, we have not deviated far from the existing layout, however the map now represents the current meeting structure and includes the new Finance and People Board committees. The committee and group alignment to the Quality Domains has been developed a little further to show that multiple domains align to each meeting and whilst these are subjective at the moment, and undoubtedly up for further discussion, they assist in demonstrating how the quality domains are accounted for. The new map also re-aligns those meetings where the Board committees can seek assurance over key processes from, and those meetings that are directly linked to the CEC (and where the board sub-committees do not have a direct line of assurance).

The introduction of the new Finance and People Committees resulted in both changes to delegated Board responsibilities and many revisions to the lines of assurance and reporting for the existing groups and committees. The review was undertaken in order to document the above changes. This interim refresh of the structure is supported by a revised and updated on-line Meetings Library and a series of Terms of Reference reviews, which are currently being undertaken. Alignment to the Quality Domains has been taken a little further, to now show multiple domains against each meeting/group.

In alignment with the move to SharePoint for our information sharing, this new map will form a central point within the new Governance pages (using the new version of SharePoint). The map, much like the one it replaces will be interactive and link to the meetings library pages which include Agendas, Minutes and Terms of Reference (where it is appropriate for them to be accessible).

The interim map was presented and approved by the Charity Executive Committee at its Strategy meeting on 13 January and is to be uploaded onto the Charity internet, supported by an internal communications programme.

Conclusion

This latest version of the assurance landscape now demonstrates our current position in readiness for the upcoming external review. In the meantime, this map will give us an up to date illustration when providing any internal or external governance related enquiries and requests. The Board is asked to note this interim Governance and Quality Assurance Map.

St Andrew's Healthcare Governance and Quality Assurance Map – January 2021

Court of Governors
4 per annum

Board of Directors
8 per annum

St Andrew's College Governing Body
3 per annum
Chair – Chief Executive Officer
To provide strategic leadership and accountability to the St Andrew's College by ensuring clarity of vision, ethos and strategic direction

Investment Committee
Quarterly
Chair – Non-Executive Director
To advise the Board of Directors and the Directors of the St Andrew's Healthcare Pension Scheme on investment strategies

People Committee
Bi-monthly
Chair – Non-Executive Director
To develop and deliver the overall Engagement strategy, building positive links between patients and carers with the aim of increasing engagement across the Charity.

Quality Safety Committee
Bi-monthly
Chair – Non-Executive Director
To provide effective governance over all aspects of quality and clinical safety by defining the Quality strategy for the Charity; monitoring and measuring the implementation of the strategy and identifying and recommending the implementation of controls of associated risks

Charity Executive Committee
Weekly
Chair – Chief Executive Officer
In partnership with the Board of Directors to develop a clear strategy for the Charity, ensure delivery of the strategy and ensure that the Charity is Well-Led, that value based outcomes are delivered to patients and that best use is made of the Charity's resources.

Audit & Risk Committee
Quarterly
Chair – Non-Executive Director
To provide effective governance over the quality and integrity of risk management, clinical governance, compliance and internal control systems, legal and regulatory requirements, the external auditors and the performance of the Internal Audit function.

Finance Committee
Quarterly
Chair – Non-Executive Director
To provide assurance and governance oversight of the Financial Management of St Andrews Healthcare to the Charity's Board of Directors, via the '5Fs' model of financial exellence.

Research Committee
3 per annum
Chair – Governor
To provide strategic leadership and direction to the Research Centre in support of the Charity's research strategy and provide the interface between research undertaken and the Board of Directors of St Andrews Healthcare.

Nomination & Remuneration Committee
Bi-monthly
Chair – Non-Executive Director
To lead the process for Board of Director and Governor appointments, ensuring that the Board and Court of Governors are made up of diverse members and have the appropriate balance of skills, experience, independence and knowledge; and to assess and recommend the remuneration policy and packages for the Executive Directors and senior managers.

Board Assurance oversight by People Committee
- Learning & Development Group – *Bi-monthly* – Chair – Executive HR Director (W, E)
- BENNS Forum – *Bi-monthly* – Chair – Elected Patient Rep (R, C, E)
- Inclusion Steering Committee – *3 times per annum* – Chair - CEO (C, W)
- Health & Safety Steering Group – *Monthly* – Chair – CIO (S, C)
- Water Safety Group – *Monthly* (S, C)
- Fire Safety Group – *Monthly* (S, C)
- Employee Safety Representatives Group – *Bi-monthly* (S, C)

Board Assurance oversight by Quality Safety Committee
- Mental Health Law Steering Group – *10 per annum* – Chair – MH Law Lead (W, E)
- Quality Safety Group – *Bi-monthly* – Chair – Executive Medical Director (S, E, W)
- Physical Healthcare Group – *Monthly* (E, S)
- Medicines Management Operational Group – *Monthly* (S, E)
- Infection Prevention & Control Monitoring Group – *Every 6 weeks* (S)
- Restrictive Practice Monitoring Group – *10 per annum* (S, E)
- Mortality Surveillance Group – *Bi-Monthly* (S, W)
- Therapies Advisory Group (S, E)
- Serious Incident Group – *Weekly* (S, W)
- Clinical Audit Group – *Bi-Monthly* (W, E)
- Children & Adults Safeguarding Group – *Weekly* (S, C)

Charity Executive Committee
- Clinical Governance Oversight Group – *Monthly* – Chair – Deputy Medical Director (E, R, W, S)
- Strategic Projects Oversight Group – *Bi-weekly* – Chair – Deputy CEO (W, R)
- Finance & Performance Meeting – *Monthly* – Chair – COO (R, W)
- Divisional Clinical Governance Meeting – *Monthly* (E, S, R)
- Operational Quality Meeting – Monthly (R)
- Ward Clinical Governance Meeting – *Monthly* (E, S)
- Divisional / Ward Operations Meetings – *Monthly* (R)

Board Assurance oversight by Audit & Risk Committee
- Emergency Planning, Resilience & Response Committee – *6-monthly* – Chair – COO (S, W, R)
- IT Steering Group – *Quarterly* – Chair – CIO (R, W)
- Information Governance Group – *Bi-monthly* – Chair – CIO (R, W)
- Emergency Exercises Sub-Committee – *TBC* (S, W, R)
- Health Records Group – *Monthly* (R, W)
- Information Security Management Forum – *6-monthly* (R, W)
- Information Technology Assurance Group (R, W)

Board Assurance oversight by Finance Committee
- Finance & Contract Management Group – *Bi-weekly* – Chair - CFO (R, W)
- *Fundraising & Donations Group* – *TBC* (R, W)

Quality Domain Key
- S – Safe
- E – Effective
- C – Caring
- W – Well-Led
- R – Responsive

Heads of Nursing Meetings | **Heads of Operations Meetings** | **Clinical Director Meetings**

DIVISIONS

WARDS & SERVICES

Sub Committee Updates

People Committee
Tansi Harper

Quality and Safety Committee
Professor David Sallah

Audit and Risk Committee
Elena Lokteva

Pension Trustees
Martin Kersey

Committee Update Report to the Board of Directors

Name of Committee: People Committee

Date of Meeting: 14 January 2021

Chair of Meeting: Tansi Harper

Significant Risks/Issues for Escalation:

-

Key issues/matters discussed:

Each meeting rotates to focus on matters related to either patients, carers or employees. The January agenda focused on patients:

- Risk register update including recruitment overview
- Health and Safety update
- Your Voice results
- Patient Experience Dashboard
- Patient survey working group approach and outputs
- PREMS project update
- Technology for patients
- Patient Trauma research
- REDs and Peer Support Workers

Decisions made by the Committee:

- The Committee will have 6 meetings a year with an additional meeting for 21/22 in September
- The February Committee will focus on Carer engagement
- Carer engagement award to be reviewed

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- Employee Engagement on January Board Agenda

Appendices:

- None

Committee Update Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 19 January 2021

Chair of Meeting: Professor David Sallah

Significant Risks/Issues for Escalation:

- **Incident on Hawkins Ward**
  On 14 November there was a significant organised disturbance on Hawkins ward (Men's Medium Secure ward for patients with learning disability). The incident involved significant violence from 4 patients towards staff requiring police assistance. Initial assessment of the disturbance appeared to have been planned.

  The incident is being investigated by a senior Consultant Psychiatrist and a Senior Nurse but immediate findings indicate that there were adequate numbers of staff on the ward at the time of incident. Staff involved in the incident have been referred to the trauma service and the Charity has informed the necessary external agencies including the CQC, NHSE and HSE.

- **Medium Secure Division**
  The Medium Secure Deep Dive identified a number of challenges that have been exacerbated by the recent surge in Covid related issues. The current stressors include extremely stretched staffing numbers, stress related to outbreaks and restrictions on staff and patient movement due to isolation protocols. There are plans within the Division and on each ward to address specific concerns and progress is being made, particularly on the women's admission ward Sunley.

Key issues/matters discussed:

- **Covid 19**

  The Committee was updated on the Charity's current situation and challenges including the specific problems around access to surveillance testing around outbreaks and the delay in systematically accessing vaccines for staff. There have been a number of outbreaks that were being managed with support from colleagues in NHSE/I and PHE. The Infection Prevention and Control Team has expanded in capacity and Andy Brogan, Chief Nurse has taken over the role of Director of Infection Prevention and Control (DIPC) thus allowing James Severs to focus on his role has Director of Physical Healthcare. The Covid Board Assurance Framework was presented and accepted for submission to the Board. The thematic review into the Covid related deaths in the first wave of the pandemic has been completed and is being reviewed with plans to present to QSC.

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

  The Quality and Safety Group report was received and noted.

- **Physical Healthcare**

  The committee was presented with a paper on the assurance process around the delivery of physical healthcare including the data available to clinicians, the management of long terms conditions and the plans to present information in an integrated manner to facilitate clinical decision making.

- **Integrated Performance Report (IPR)**

  The Integrated Performance Report was presented There was evidence of an improving trend in terms of reduced incidents of violence, stabilising numbers of safeguarding with a reduction in externally reported safeguarding incidents and reduced prone restraint. However, levels of Long Term Segregation remain high and episodes of patient leave have reduced significantly due to the Covid pandemic.

- **Clinical Effectiveness update**

  An update on the progress made towards achieving the goals set out in the clinical effectiveness strategy was given alongside the clinical audit programme evidencing a wide range of audit related activity across the Charity.

Decisions made by the Committee:

- **Mental Health Act Managers**

  The Committee agreed that a forum for MHA managers be set up, with the chair of the forum attending the Mental Health Law Steering Group. Chair of QSC to meet regularly with the Forum Chair (preferably a MHA Manager) and the Chief Nurse to ensure that there is a link between the Forum and the Board.

Implications for the Charity Risk Register or Board Assurance Framework:

- R224 – Integrated Patient Healthcare Management – the Residual risk score remains 28
- R1011 – Unwarranted Clinical Practice Variation – the Residual risk score remains 31
- R1271 – Covid 19 Infection &Pandemic – the Residual risk score increased to 27
- R264 – Restrictive Patient Interventions – the Residual Risk score remains 23
- R1446 – Violence and Aggression – the Residual Risk remains 28

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- None

Committee Update Report to the Board of Directors

Name of Meeting: Audit and Risk Committee

Date of Meeting/s: 28 January 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.

Key Issues/Matters Discussed:

1. The Committee received an update and proposal from our audit partner PWC for FY20/21. Whilst this reflected an uplift on previous years, the Committee endorsed the proposal subject to further scrutiny and challenge from the CFO in relation to the final value of the contract.

2. ARC reviewed and approved the specification, the process and the timeline for the procurement of a new audit partner, the procurement process.

3. ARC received an update on the Charity's Risk Management Improvement Project.
    - ARC is satisfied with Risk Management Improvement progress and supports an implementation of the Board Assurance Framework as a natural extension of risk management.
    - It was agreed that the overview of material risks would be further refined with the Board Committee Chairs and that ultimately this will feed into the Board Assurance Framework.
    - Committee remains very conscious that current risk management system can provide the Board with partial assurance only.

4. ARC was presented with the material risk update. The Committee noted the inclusion of an additional material risk R1446 Violence and Aggression.

5. The Committee was pleased to receive the COVID-19 related risks update and was able to take considerable assurance from the dynamic nature of the risk oversight. The Committee recommended to apply the similar approach to management and presentation of the other material risks.

6. The Committee received the Internal Audit reports which provided a summary of progress to date against the plan of work 20/21. While satisfied with the progress made against the Internal Audit Plan, the Committee noted that IAs completed during the reporting period have the assurance rating "Adequate" (yellow) or "Limited" (red).

7. The Committee received an update against the implementation of the Internal Audit recommendations. While acknowledging activities at executive and functional levels to ensure

implementation of IA recommendations, the Committee has registered it concerns about the number of actions in the Tracker and their timing.

8. The Committee received counter fraud update and challenged the sufficiency of "Inform and Involve" actions and adequacy of "Prevent and Deter" actions. Although no fraud referrals have been received during the last two reporting periods, the Committee will decide on the level of ongoing assurance required in this area after review of the 20/21 Annual Report and 21/22 Counter Fraud Plan at the next ARC meeting.

9. The Committee noted Internal Audit Line Management Reporting Change Review and Governance Compliance Review.

10. The Committee reviewed the Information Governance Group report presented by the Charities Chief Information Officer and whilst recognising the value of the report, including the proposals to work towards ISO accreditation, the group considered if this was the most suitable committee to oversee this work going forward.

11. Finally, The Committee reviewed and approved their work plan for 2020/21 subject to additions related to the Quality Account.

Decisions Made by the Committee:

- The Committee endorsed PWC proposal subject to further scrutiny and challenge from the CFO in relation to the final value of the contract.
- The Committee agreed an approach to secure an external audit partner commencing Y/E 31/03/2022

Implications for the Charity Risk Register:

- ARC reviewed the material risk update and noted the inclusion of an additional material risk relating to the Health and Safety consequences of Violence and Aggression.

Issues/Items for referral to other Committees:

- For the board to review the alignment of the Information Governance reporting to ARC as the corresponding subcommittee

Issues for Escalation / Decisions by the Board of Directors:

- PWC fees for the FY20/21

Appendices:

- None.

Committee Update Report to the Board of Directors

Name of Committee:

Special meeting of Directors of St Andrew's Pension Trustees Limited

Date of Meeting: 04 December 2020

Chair of Meeting: Martin Gaskell

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- Considered the Scheme's long-term objectives and agreed to discuss these objectives with the Charity

Decisions made by the Committee:

- Reviewed the funding position of the Scheme, and agreed to move the strategy position to the Scheme 2023 strategy position with an allocation to c.60% to bond like assets and c.40% to growth assets

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

Appendices:

- None

Questions from the Public for the Board

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Date of Next Board Meeting – 25 March 2021

(Paul Burstow - Verbal)