CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Tuesday 24th January 2023 at 9.30 am

Microsoft Teams and Old Patient Library, Main Building, Northampton, NN1 5DG

		Purpose	LEAD	Page No.		Timing
1.	Welcome and Apologies	Information	Paul Burstow	*1*		*09.30*
2.	Declarations of Interest	Information	Paul Burstow		*2*	*09.31*
3.	Minutes from the Board of Directors Meeting in Public on 24 November 2022	Decision	Paul Burstow	✓	*3-11*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*12-15*	*09.35*
Chair's Update						
5.	Chair Update	Information	Paul Burstow		*16*	*09.40*
Executive Update						
6.	CEO Report	Information	Dr Vivienne McVey	✓	*17-21*	*09.45*
Committee Assurance Reports						
7.	**Committee Updates** • Quality & Safety Committee (13/12), incorporating CQC update • Audit & Risk Committee (23/01)	 Assurance Assurance	 Ruth Bagley Elena Lokteva	 ✓ Verbal	*22-25*	*10.00*
Quality						
8.	Integrated Quality & Performance Report, incorporating: • Quality Scorecard • People Scorecard • Finance Overview • IT Security Overview	Assurance	Anna Williams with Andy Brogan, Martin Kersey, Kevin Mulhearn & John Clarke	✓	*26-36*	*10.15*
9.	Establishment Review update	Decision	Andy Brogan	✓	*37-47*	*10.35*
Break 10.55 am to 11.05 am						
Matters Arising						
10.	Mental Health Bill – Board discussion	Information	Stuart Wallace	✓	*48-58*	*11.05*

Service and Patient Story						
11.	Divisional Presentation: Rosie and Keith's road to recovery at Broom Cottage	Information	Dawn Chamberlain & Dr Paul Stankard (and patients)		*59*	*11.45*
Any Other Business						
12.	Questions from the Public	Information	Paul Burstow	✓	*60*	*12.10*
13.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*61*	
14.	What would our patients and staff think about our discussions today?	Information	Paul Burstow		*62*	
15.	Date of Next Meeting – Friday 31st March 2023	Information	Paul Burstow		*63*	
Meeting Closes at 12.15 pm						

Annexes - Items for information only	**Lead**		
Annex A – Governance Oversight Group update	Dr Vivienne McVey	✓	*64-65*

Welcome & Apologies

(Paul Burstow– Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 24 November 2022

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Conference Room, Main Building
and Microsoft Teams
St Andrew's Healthcare, Northampton

Tuesday 22nd November 2022 at 09.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Dawn Brodrick (DB)	Non-Executive Director
Karen Turner (KT)	Non-Executive Director
Steve Shrubb (SS)	Non-Executive Director
Vivienne McVey (VMc)	Chief Executive Officer
Kevin Mulhearn (KM)	Chief Finance Officer
Sanjith Kamath (SK)	Executive Medical Director
Andy Brogan (AB)	Chief Nurse
Dawn Chamberlain (DC)	Chief Operating Officer
In Attendance:	
John Clarke (JC)	Chief Information Officer
Lindsey Holman (LH)	Executive – Organisational Development
Duncan Long (DL)	Company Secretary
Anna Williams (AW)	Director of Performance
Eddie Short (ES)	Director of Strategy & Business Development
Oliver Shanley (OS)	Special Advisor to the Board
Alex Trigg (AT)	Director of Estates & Facilities
Julie Shepherd (JS)	Improvement Director
Antony Miller (AM)	Hospital Director (Essex)
Rupert Perry (RP)	Lead Governor
Melanie Duncan (MD) Minutes	Board Secretary
Apologies Received:	
Martin Kersey (MK)	Executive HR Director

Agenda Item No		Owner	Deadline
1.	**Welcome** PB (Chair) welcomed everyone to the first part of the Board of Directors (Board) meeting, which is a meeting open to attendance by the public. Apologies received from Martin Kersey were noted.		
ADMINISTRATION			
2.	**Declarations Of Interest & Quoracy** 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. Julie Shepherd declared her position with NHFT. The meeting was declared quorate.		

3.	**Minutes Of The Board Of Directors Meeting, held in public, on 29 September 2022** The minutes of the meeting held on the 26 July 2022 were **AGREED** as an accurate reflection of the discussion.	**DECISION**	
4.	**Action Log & Matters Arising** It was agreed to **CLOSE** the following actions: • 26.05.22 **04 Safer Staffing – Refusals Data**. This item to be discussed further at People Committee. • 26.07.22 **01 QSC – Smoking Cessation**. SK updated that the Charity was now part of a Royal College of Psychiatrists Smoking Cessation Group. KT noted that there were funds available to aid in the promotion of smoking cessation. SK agreed to investigate as local funds were no longer available. AT updated that Communications also had a plan for rolling out to staff in the New Year. • 29.09.22 **03 CEO's Report – Staff Turnover**. LH added that further data analysis was currently being undertaken. All other actions on the log remained open, either in line with the agreed target dates or to return at a future Board.	**DECISION**	
CHAIR'S UPDATE			
5.	**Chair Update** PB gave a verbal update, noting his recent 1:1 conversations with the Non-Executive Directors, and highlighting the importance of undertaking mandatory training. PB then welcomed Rupert Perry to the Board, who would take up his position as Non-Executive Director as of 1st December, making this his last Board meeting as Lead Governor. PB also noted that it was SRW's last meeting as a Non-Executive Director as he would be stepping down at the AGM on 25 November. PB thanked SRW for his tenure of 18 years as a Non-Executive Director of the Charity and welcomed his continued support as a Governor. PB outlined the recent engagement with Deloitte during the business review commissioned by NHSE and the Board Strategy Day which fostered many discussions and formed the basis for the coming months and years. PB then gave an update on the recent LDA Summit, which had been held at the Charity along with NHS colleagues from the East Midlands Provider Collaborative, which saw Tom Cahill, NHS National Clinical Director in attendance along with Baroness Hollins. The importance of context and personal narrative were highlighted with the power of relationships being noted. A presentation by Alexis Glennis proved particularly insightful from a lived experience perspective. Dr Paul Stankard's session on Clinical Bravery was also of note. Trauma was also discussed at the Summit with 'Keeping people in their lives' being the key to recovery. PB noted these important principles and how they should be considered for what the Charity should be considering as a contemporary offering. PB concluded that as a Charity we should look up and look out to other partners to signal that St Andrew's has changed, is changing and wants to change. AB added that the introduction of the term 'policy leader' with service users was important along with the type of language used. VMc also noted that the first round of co-production awards had been held within the Charity the previous week, and was eager to co-produce the Strategy and discuss the use of language further with patients. OS commented that it had been an excellent event and that it provided a great opportunity to build further on the work already being done, making it a pivotal point for the Charity. He further		

	extended thanks to ES and the Communications Team for organising the event. The Board **NOTED** the update.		
EXECUTIVE UPDATE			
6.	**CEO's Report** VMc presented her report which was taken as read, adding that more would be presented later in the meeting on the Charity response to Panorama, and highlighted the work being undertaken with the Freedom to Speak Up leads and Guardian had commenced to look at further strengthening the work they do and on the Freedom to Speak Up policy review. New guidance from the NHS in this area would be adopted immediately rather than wait until it comes into effect in 2024, with further training taking place including Executives, on how to receive information. The recent inspection results released for Men's Services had shown good progression which now required to be sustained in order to retain the ratings. With regard to culture, VMc noted that an adequate spread of staff across shifts, across the week was key and the operational staffing board, led by DC would be key in attaining this. The Long Service awards had recently undergone a refresh, with VMc urging the Board to attend the ceremonies if at all possible. The Board **NOTED** the update.		
COMMITTEE ASSURANCE REPORTS			
7.	**Research Committee** SN gave a verbal update and highlighted the work being done by the governance group and research team on the new Research Operational Group and Research Assurance Committee terms of reference. The links to Universities had been discussed, with work in this area ongoing, along with fund raising for special projects. SN also highlighted the decision to hold a Research Day in 2023 for consumers and producers, both internal and external, of research to attend. The Research Newsletter was also agreed by the Committee. RB asked if there were any targets for growth with universities. SN replied that conversations were being conducted however, capacity to deliver would receive consideration prior to decisions being made. The Board **NOTED** the update **People Committee** DB presented the report which was taken as read and highlighted the approvals of the People Plan and Diversity and Inclusion Plan, noting that the Executive would be key in the delivery of them. The Retention Plan and actions had been presented by LH, and would receive regular focus by the Committee. Charity resourcing was discussed in detail and new people metrics had been considered with a new dashboard in production. DB added that she was confident that ongoing review would provide assurance in this area. DB noted that one of the Change Leaders had attended the last meeting, resulting in a very open conversation which would feed into the broader cultural work being undertaken. AL asked if retention targets were in place, which DB confirmed were, in specific areas. RB asked about leaver's feedback and if there was confidence that it was open and honest, and how was training compliance being addressed. LH		

	replied that exit interviews and turnover data were being triangulated in order to give a more holistic view and that T block training would be adopted in order to ensure training compliance was achieved. The Board **NOTED** the report **Quality & Safety Committee** SS presented the report which was taken as read and noted that his first meeting as Chair had been a positive one, with the December meeting covering a narrower focus on four key areas of risk, namely CAMHS; the new operating model, safer staffing and quality risk management with further reviews in 6 months' time. SS and the committee were confident of the resultant assurance. PB noted that the Board would look forward to an update at the next meeting. KT reflected on the discussion regarding CAMHS during the recent meeting and felt that keeping people "in their lives" should be borne in mind during future discussions within the Committee and that it was important to consider this with input from staff. AB commented that he was happy for the focus to be more considered on significant issues in future meetings. SS noted that those challenges that covered all services would be considered in order to give greater change in conjunction with the revised operating model. DC suggested bringing the new operations heatmap to a future Board in order to illustrate further the operating model, with VMc noting the improvement in data quality with new metrics being the next steps. The Board **NOTED** the report **Audit & Risk Committee** EL presented the report which was taken as read and noted that at the previous committee meeting the Annual Report and Accounts had been approved, in line with eth delegated authority from the Board, along with a recommendation to re-appoint the Auditors, Grant Thornton. Assurance had also been given regarding Local Counter Fraud work and Internal Audit. The Committee wished to escalate to the Board concerns regarding the control environment at operational level, specifically at the 2nd line of defence. ARC accepted adequate assurance for Internal Audit with partial assurance offered for Risk Management. EL noted the fragility of the risk management and internal audit function with only 2.8 FTE members of staff. Partial assurance had been noted regarding EPRR and of the 48 standards, full compliance had been achieved on 41, with evidence of compliance being submitted to NHSE for the first time. DC wished to note that she did not attend the meeting but wished to highlight the work being done on operational risk management, and thanked Claire Jones for her work on EPRR, with the non-compliance aspects possibly having occurred due to the lack of desktop testing. NHSE decisions were expected by the end of the month. SS noted that the limited assurance reported on the IA audit of safeguarding would require attention between the Committees, with EL agreeing that the horizontal links with other Committees via internal audits would be beneficial. Resourcing within the risk and IA functions was noted, with DL updating that the new position within risk management had been put on hold. VMc commented that the independent business review had noted a lack of resilience within some functions, with outsourcing possible being considered in order to alleviate this. AL asked for clarity on what resilience meant for the function, with VMc explaining that resilience was of more importance than the function size. AL suggested that merging of responsibilities could be considered. EL added that a more unified approach to the Charity's 2nd line of defence was required to promote resilience. SS added that business models	**DC** **VMc & DL**	**31.03.23** **17.04.23**

	were difficult, and the skill would be required in assessing what could be contracted out. Other large organisations and charities were also experiencing the same challenges. PB agreed and that seeking views from other organisations could be helpful. The Board **NOTED** the report **Nomination & Remuneration Committee** SRW presented the report which was taken as read, and noted that the Committee had agreed the Gender Pay Gap and Ethnicity Pay reports ahead of Board approval. The Board **NOTED** the report and **APPROVED** the Gender and Ethnicity Pay Reports		
QUALITY			
8.	**CQC Inspection, Report and Actions Update** AB presented the report which was taken as read, noting that the reports had now been received for both Men's and Women's Services, with the work required to attain the standards substantial. There was one amendment for the Men's report, where the LD rating had been taken out, however, generally, the results were very good. In response a charity-wide QIP had been produced which included the must-dos and would be concluded by the end of the financial year, at which point it is planned to be signed off at a meeting with the regulator. The Divisions were also submitting detailed QIPs which would feed into the overarching document, enabling quicker resolution. LH highlighted that the table within the pack rating to the Men's June 2022 inspection was showing the Safe domain as inadequate, when it should be Requires Improvement. AB noted the error and confirmed the Safe domain was rated Requires Improvement. SRW asked what was being done within the Women's service to remove the red ratings. AB replied that reducing restrictive practices was the main driver, which has now been addressed. OS commented that the results were a great achievement, with greater confidence being attained. The next phase would cover further embedding with learning. SN asked if there was cross learning between the divisions as a result. AB confirmed that this was the case and was being done via bi-monthly sharing meetings covering learning and corrective actions. Buddy workstreams were also helping. AB added that challenges remained, however, the work to address them continued. SK added that the inspection of Women's Services resulted in immediate feedback, allowing actions to be undertaken promptly. It was worthy of note however, that inspections were a snapshot in time, but that all areas were showing trends in the right direction, with consistency being tackled. A new forensic Psychiatrist has been appointed, specialising in Women's services. PB extended thanks to all staff involved, noting the achievement but with work continuing to be done. The Board **NOTED** the report		
9.	**Safer Staffing Report** AB presented the report which was taken as read, noting that on this occasion the report did not include fill rates due to the transfer over to Allocate. AB highlighted that staffing had been challenged due to a high number of vacancies during the holiday period, which was comparable to other organisations within the sector. Night shifts were now receiving increased focus, with establishment reviews also being undertaken. These reviews would be done annually in the future and signed off by the Executive. Registered nurse cover was currently lower, however, establishment was more than nursing cover, with utilisation of the MDT being looked at. AB		

	further added that clear operational and staffing policies and practise were now in place. EL asked if the ward manager rotas were based on 7 days. AB replied that with DC, they were looking at a 7 day week for senior cover on the wards, with DC confirming that this would be the case. SN asked about the use of agency staff and if this could be shown within the reports in future. AB confirmed that agency staff could be included in future and confirmed how agency staff could be made best use of during shifts and confirmed that adequate ward cover was now being achieved. A balance was to be struck with the level of agency cover versus Charity staff. PB noted that it was important to highlight that the increased agency spend was intentional and was aimed at supporting the current staffing challenges. SS added that many integrated care systems were overspent on agency staff and that patient safety was paramount. PB highlighted the importance of MDTs in the delivery of therapeutic care and looked forward to seeing the hours per patient day reflecting this. The Board **NOTED** the report		
MATTERS ARISING			
10.	**National response to Panorama and mental health in-patient services** VMc presented, giving the background on the letter received from the National Director of Mental Health, Claire Murdoch, which was sent to all organisations providing Mental Healthcare. A response had been worked on, detailing what we were doing for each of the issues highlighted, including the new hotspot tool and heatmap. SK added that the existing process of identification of challenges had been strengthened via soft and hard intelligence and leading and lagging indicators. Regular meetings for assessment of wards against set criteria were also being conducted, with feedback given. This process allowed for quicker alerts to other wards as a result. DC added that the heatmap had been well received by commissioners, noting that this would be owned at ward level and embedded, as well as at a higher charity level and it would help to inform financial and occupancy requirements. AB added that vigilance was important, and that incidents could and would happen. PB commented that the right mechanisms needed to be in place, and that recent events reported in the Kirkup review of Kent maternity services had themes that were relevant in mental health services or any other service within healthcare. Action plans could only go so far, and it was to be noted that incidents were often systemic in nature. RB thanked the Executives, for ensuring that the Board was aware that all areas were working together. KT noted that there had been similar findings in Shrewsbury and Telford and that lack of reporting was a problem in those instances and issues were not escalated as needed. The importance of 24hr rostering and supporting staff across our services should be kept firmly in the Board's sights. SS commented that the Executives were working way beyond what the NHS was implementing and that DC's comments regarding wards owning the heatmap were key. All of the Kirkup reviews had highlighted teamwork as problems. He also noted the work being done by Andy Bell from the Centre for Mental Health and wondered if the work being done by the Charity should be shared with him accordingly. EL commented that she was glad to see a review of training and inductions, and asked how Executives would ensure that training was embedded, along		

	with how they could ensure that bank and agency staff all worked to the Charity's care values. LH responded and said that she had also reflected on this, and it would form part of the wider People Plan, along with an update of the Leadership Programme and appraisals, ensuring a more values and behaviour based process where leadership competences align to the values and expected Charity culture. VMc reiterated one of her observations in that staff were not being managed properly, due to managers not having the time to be able to conduct regular 1:1s or time for reflection. DB added that culture was key with open conversations from the top down. PB agreed, with OS adding that this area would be important to bear in mind with the implementation of the new Quality Strategy next year. SS commented that co-production could result from this, with DC adding that the patient voice would be strengthened as a result. The Board **NOTED** the report		
OPERATIONS			
11.	**Integrated Quality & Performance Report.** AW presented the report which was taken as read and highlighted the progress seen in the quality and safety scorecard, which aligned with comments already made. The people scorecard reflected agency spend and work on retention planning. DC added that the report was based on September data and that the November data was already looking better, moving many of the red blocks seen in the current report. Non-patient facing shifts were receiving focus with Operations and HR working together with a refresh of policies being undertaken, including tightening some of the . management loopholes currently seen within staff management. DB noted a metric of vacancy rates and asked if it could be included in the report, AW confirmed that it was in the plan to include this metric. EL asked how targets or tolerance levels were aligned to risk appetite and AW explained the target setting process and how they aligned to contractual requirements. The Finance portion of the report would be discussed further during the second part of the Board meeting. IT Security was taken as read with AL wishing to note the level of cyber-attacks made against the network and felt that the Board should be made aware of the heightened risk. JC clarified what was being done to mitigate these risks and online security in general, confirming that our people were in reality the weakest point of the network. In response to this, the IT team are meeting with staff that may have clicked on an inappropriate link and coaching them on the correct processes. EL asked about patient use of the internet and what levels of protection they were served. JC explained that there were soft blocks in the background and that access was balanced based on risk assessments. However, a patient's own device, with its own sim card was a lot less monitored. EL asked about patient education with regard to online security. JC replied that patient and corporate networks were separate and currently they do not provide direct patient focussed training. The Board **NOTED** the report		
12.	**Court, Board of Directors and Committee Calendar 2023-2024** DL presented the calendar for the coming financial year requesting that if in agreement the Board approves the proposed calendar of meetings.		

	SN asked that the Research Open Day be added to the calendar. DL confirmed that it would. The Board **NOTED** and **AGREED** to adopt the calendar	**DECISION**	
SERVICE AND PATIENT STORY			
13.	**Divisional Presentation (Including Patient Voice): Essex: Co-production with Patients and Carers** AM and Tris joined the meeting from Essex and introduced a presentation on climate based co-production work being done in Essex. Tris gave a presentation that he had produced on climate change and that covered the work he was doing within Essex with fellow patients and staff. PB thanked Tris for his presentation and noted the thought provoking topic covered and how well it was presented. SN also thanked Tris and suggested that indirect behaviour change could be considered whilst imparting the message of climate change, in a similar way to how he had presented some of his messages. With people responding to a "nudge" approach. SN shared a link to a website for Tris to gain more understanding of this approach. AT committed to giving consideration to the recycling bins in Essex and outlined the Charity's new Green Plan which was being presented to the Board, and invited Tris to be an energy champion within the Charity. AT agreed to ask Guy Bowden to speak to Tris and to visit the Essex site to meet him. Tris confirmed that Guy had assisted him with some of his data. EL asked if the section of the Annual Report on energy could be more engaging if co-produced, KM confirmed that we could look at that for next year. DC suggested that Tris link up with other sites in order to gain support and Tris agreed and welcomed the opportunity. PB thanked Tris and AM for their attendance and the discussion it had generated.	**AT**	**24.01.23**
ANY OTHER BUSINESS			
14.	**Questions from the Public for the Board** No questions were received for the Board.		
15.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
16.	**What would our Patients and Staff think about Our Discussions Today?** The Board agreed to discuss within Part 2 of the meeting.		
17.	**Date of Next Meeting :** Board of Directors, Meeting in Public – Tuesday 24th January 2023		

Approved – 24th January 2023

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

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

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
26.05.22 **01**	**Risk Appetite – Board Awareness** Following the approval of the Charity Risk Appetite, Board awareness sessions are to be scheduled on Therapeutic risk and compliance.	DL	~~04.11.22~~ 31.03.23	Open	**24.01.23 –** Remains open and due at March Board meeting.
26.05.22 **06**	**Safer staffing – People Committee Assurance** The People Committee are requested to review and provide assurance to the Board on actions being taken to address refusals to re-deploy, specifically in relation to the work being done on the Charity's culture.	PB & MK	~~29.09.22~~ ~~22.11.22~~ 31.03.23	Open	**24.01.23 –** Remains open and due at March Board meeting, as further discussions required at People Committee. Action will remain open until after next PC meeting (9th Feb 23)
26.05.22 **08**	**Integrated Performance Report – Registered Nurse levels** AW to look at how registered nurse levels could be overlaid on the bed occupancy graph within the IQPR in order to view potential correlations.	KM & AW	~~26.07.22~~ ~~22.11.22~~ 24.01.23	**Closed**	**24.01.23 –** The registered nurse related overlays have been completed and can be integrated with occupancy within the IQPR. Propose that this enhancement to reporting is included within the IQPR presented and reviewed at QSC (in conjunction with reviews of safer staffing), with any areas of concern or risk escalated to Board via the QSC assurance report. **Propose Action is closed**
26.07.22 **02**	**QSC – Mental Health Bill** A Board session on the Mental Health Bill is to be scheduled once it has commenced its parliamentary passage.	DL	~~22.11.22~~ 31.03.23	**Closed**	**24.01.23 –** Included in agenda as item 10. **Propose Action is closed**

26.07.22 **03**	**ARC – Committee Risk Oversight** To assist in the effective implementing and embedding of the BAF, Committees are to consider during the next round of committee effectiveness reviews how the review and oversight of the strategic risks allocated to them can be best accommodated in meeting agendas and annual work plans.	DL&MD	~~22.11.22~~ 24.01.23	**Closed**	**24.01.23** – Responsibility over strategic risks has been written into the revised ToRs for each applicable committee. Draft ToR are now out for consultation with Committee Chairs and responsible Executives. Annual work plans are being drafted to support the revised ToRs and these will address the frequency and form of strategic risk reviews. **Propose Action is closed**
26.07.22 **04**	**Governance Oversight Group - ARC visibility over project risks** MD and JC to liaise with Sajid Ali to complete a review of the project risks and escalate any major concerns as required to the ARC, to enable a level of assurance to be developed with regard to progress against project objectives. It was agreed that ARC would review the project risks and that a full assurance report with revised timeline would be brought back to Board.	DL&MD	~~22.11.22~~ 24.01.23	Open	**24.01.23** – Project risk register is included in the January ARC Risk Management update. The project timeline is currently under review in order to accurately determine key milestones and deliverables for the remaining elements of the project. Assurance on risk management and revised project timeline to be shared at March Board.
26.07.22 **06**	**BAF – Finance Risk** Following the approval of the initial proposed BAF Assurance Ratings, it was agreed that the Finance Committee would complete further reviews on the financial strategic risk.	KM & AL	~~22.11.22~~ 31.03.23	Open	**24.01.23 –** This will be part of making the changes to FinCom in line with the Governance Review. This will be done for March 2023 as agreed with the Chair and CEO to give the CEO time to organise the Executive Control Structure.
29.09.22 **01**	**Board Minutes** DL and MD to review the format of Board minutes and to bring a summarised version of the September Board minutes to the next meeting for review versus the existing format.	DL&MD	~~22.11.22~~ 24.01.23	Open	**24.01.23 –** Action remains open and propose defer to a future Board meeting.

29.09.22 **02**	**Board Action Log** Following discussions on a number of actions, PB requested that Board actions and actions from Board committees be brought together (using a Gantt chart) so that the timeline of all actions and how they align could be viewed.	DL&MD	~~22.11.22~~ 24.01.23	Open	**24.01.23 –** Action remains open and propose defer to a future Board meeting.
22.11.22 **01**	**QSC Update – Operations dashboard** DC to present the new Wards Heat Map to the Board at a future meeting in order to illustrate further the new operating model.	DC	31.03.23	Open	**24.01.23 -** Remains open and due at March Board meeting.
22.11.22 **02**	**ARC Update – Functional resilience** VMc and DL to review resilience within the IA & Risk function and consider appropriate solutions to be shared with the ARC at the April committee meeting.	VMc & DL	17.04.23	Open	**24.01.23 -** Remains open and due at May Board meeting.
22.11.22 **03**	**Service and Patient Story – Essex** AT to ask Guy Bowden to speak with Tris from Essex site and arrange to meet with him, with the view to making Tris an energy champion within the Charity.	AT	24.01.23	**Closed**	**24.01.23 –** In progress, with Tris invited to next energy champion's meeting on 26th January, as well as other on-going discussions with Tris on energy awareness and recycling. **Propose Action is closed**

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of Meeting	Tuesday, 24 January 2023
Agenda Item	**6**
Author	Vivienne McVey, CEO
Responsible Executive	Vivienne McVey, CEO
Discussed at Previous Board Meeting	Updates have been discussed at the Executive meetings.
Patient and Carer Involvement	A number of these items would have been discussed with patients and carers
Staff Involvement	A number of these items would have been discussed with staff
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☒ Finance & Sustainability ☒ Service Innovation ☒ Quality ☒ Research & Innovation ☒ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☒
Committee meetings where this item has been considered	Executive Meetings

Report Summary and Key Points to Note

The attached is the Chief Executive's report to the January Board of Directors.

Appendices – N/A

CEO Report

This is the CEO report to the Board of Directors providing an update on areas of focus for the Executive Committee over the last reporting period and matters that are not dealt with under other agenda items for the Board.

The last two months have been a busy period for the Charity with many external and internal events as outlined below. At Board in November we agreed the five key priorities for the Executive Team November-March 2023:

- Stabilising staffing and increasing operational grip
- Achieving sustainable quality
- Resetting our strategy
- Review of our operating model and implementation
- Achieving our financial targets

At the moment we are broadly on track to deliver these five priorities with more detail contained in the rest of this report and the Part Two Board papers.

At the last Board meeting we also agreed our vision and mission for 2023-2028, and the seven ambitions which will deliver that mission. Our current and former MBA students will be leading working groups throughout the next three months made up of patients, patient representatives, staff and governors to co-produce the milestones for each ambition, and the final 'Strategy on a slide' will come to the Board in May for review and sign off.

1. **Quality**

    - **CQC action plans:** The Quality Improvement Plans developed at ward, divisional and Charity level to address the issues identified following the Men's and Women's CQC inspections in 2022 continue to be monitored through the governance structures and through bi-weekly Quality Improvement meetings Chaired by Andy Brogan, Chief Nurse.

    - **CQC inspection October 2022:** We have been informed that a formal report will be shared in the next few weeks following the CQC inspection undertaken in October 2022 in response to whistleblowing concerns. The feedback received immediately following this inspection was widely positive with the inspectors reporting assurance that patients and the site were being managed appropriately.

    - **CQC Registration:** The process for registering the Northampton site under a single CQC registration is currently progressing.

    - **The Quality Strategy:** The Quality Strategy and associated architecture has been completed with engagement from staff across the Charity, and a roll out is planned during this quarter.

    - **Nursing Establishment Review**: The nursing establishment review has been completed for all wards, across all divisions with each ward clinical team being fully engaged in the review, with MHOST results triangulated with quality and safety data with professional judgement. This will be discussed in Part Two of the Board.

2. **People and Culture**

- **Staffing levels:** it has been noticeable that the staffing levels across the Charity have improved slightly over the past six weeks or so with fewer red risks and action cards being highlighted in the daily staffing report. I am receiving fewer patient complaints about staffing and anecdotally more patients seem able to get to their activities. The period does include several Bank Holidays however (when staffing is usually adequate), so we will keep this under close review.

- **Recruitment:** 958 new joiners were inducted in 2022 (787 in 2021), including 41 in December. 75 Nurses started in 2022 and 407 substantive HCAs. Our first 15 International Nurses have been going through their OSCE training and exams. 9 have passed so far with 4 NMC registered and 5 awaiting PINs. The remaining 6 have OSCE exams this month. All 15 have now been allocated to and are working on their wards.

- **Lead the Change**: The programme continues to have a high level of engagement with 100 Change Leaders across the Charity. For each of the 9 priority themes identified a Change Leader lead and Subject Matter Expert has been identified. Work stream meetings commenced in January assessing related projects already in place and collating suggestions of how we can further improve the employee experience.

- **Wellbeing**: A number of staff wellbeing initiatives have kicked off in the past two months:
    - A Menopause Guidance handbook was written to support staff experiencing the Menopause and those managing them.
    - Compassion Focussed Staff Support training has been held in Northampton and Birmingham for over 25 staff, with regular support groups continuing across a number of Divisions.
    - REDS Recovery College launched 4 wellbeing-focussed courses to support both individuals and teams to improve their wellbeing.
    - A staff Swap Shop is being trialled where staff can donate unwanted clothes and toys to colleagues that may be struggling.
    - The CAMHS Division have been offered the opportunity by NHS England to trial a wellbeing app with staff in Q4 22/23, launching 9 January.
    - A 6-week Yoga course for staff starts in Northampton on 18 January

- **Centre for Developmental and Complex Trauma:** Despite the highly competitive nature of the conference market we have retained our position and extended our reach in providing events for specialist populations that reflect the St Andrew's patient mix. Three international trauma focused conferences have been offered since the last Board meeting, with the Moral Injury Conference attracting over 200 delegates from 16 countries. We continue to attract speakers with global reputations and delegate rated metrics for events are consistently 100% (learnt something new, will change practice and will attend future events). We continue to collaborate with the British Psychological Society to support our events and have developed co-hosting relationships with NHS and US non-profit based partners. International and NHS bookings continue to grow with an expansion of conferences planned for the next year. For 2023-2024 the existing programme will continue and expand to include two additional specialist events.

- **Staff deaths**: Sadly in October there were 2 staff deaths, one a permanent member of staff and the other a Work Choice colleague. There was a further permanent colleague death in November. We have provided emotional support

to families and staff, along with financial support in line with the benefits owed to individuals. This has been greatly appreciated by the families affected.

3. **Operations**

As part of our priority to increase operational grip the newly formed Operations Committee, reporting to the Executive Committee has met twice since the last Board meeting and approved ToR for its remaining sub-groups. The 2 sub-groups which were already established met in December 2022:

a. The Operational Staffing Programme Board

- **Allocate/ autoroster**: the project continues on track with Birmingham site as the early adopter for the e-roster with built in T-block training in Feb 2023. The aim of this is to ensure that all our staff have dedicated time to attend their Statutory and Mandatory training.
- **Divisional structures:** a full update on strengthening our divisions and clinical services will be given in Part 2.
- **MDT reviews:** In addition to our nursing establishment a review of our MDTs has also been completed and this will be presented in Part 2.
- **HR Policy and staff management review**: revisions to our significant staff management policies have been undertaken and are being reviewed by HR
- **Bank and Agency:** plans to centralise these have been agreed
- **Mandatory and Statutory training**; Capacity has been agreed with Learning and development to enable completion by the MDTs by February 2023; dedicated capacity for bank staff by the end of March 2023 and T-block (Training blocks) for nursing in the roster from April.

b. **EPRR Steering Group:** met for the first time in December 2022 – We achieved partial compliance with the NHSE EPRR Review (2 other providers in our ICS are non-compliant). An internal audit review of our gaps has been completed and a desk-top exercise and fire evacuation are to take place by end Feb 2023

4. **Communications and engagement**

- **The Hope Headlines**: In December we launched our new monthly newsletter The Hope Headlines which is aligned with our new strategy. The newsletter aims to shine a spotlight on all the positive things happening across the Charity and improve employee engagement and morale.

- **The Learning Disability and Autism Summit:** Our first LDA Summit took place in November and was attended by almost 200 people. Plans are now underway for a follow up later this year.

- **Wednesday Service Visits:** To better understand both the good things happening across the Charity as well as the issues arising, all members of the Charity Executive Team are spending time every other Wednesday visiting wards and teams across the organisation. Communications are following up with any areas of good practice which need showcasing.

- **Communications principles**: We also launched our five communications principles to ensure staff are consistent when they communicate internally and externally. The principles are for us to be: Clear, Concise, Compassionate, Consistent and Complete.

Finally I would like to commend all those staff who made Christmas a joyous occasion for our patients. The German–themed Christmas market, carol service and disco were all well attended and enjoyed by patients and staff alike and the fancy dress on show at the disco was impressive. I would like to thank all our kitchen staff who got Christmas dinner out to all patients and staff, and also our lead Speech and Language Therapist, Kimberlee Ferrari, who along with her team, the dieticians and three of our chefs designed a Christmas dinner especially for those patients with dysphagia (difficulty swallowing). Making Christmas special for those with dysphagia (nrtimes.co.uk)

Members are invited to review this report and seek clarification on any of the salient points.

Dr Vivienne McVey
Chief Executive Officer

Committee Updates

Quality & Safety Committee
(Steve Shrubb)

Audit & Risk Committee
(Elena Lokteva - Verbal)

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 13 December 2022

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- In-line with the revised approach to the content of the QSC the committee is currently focussing on four specific areas of risk:
    - Status of CAMHS division
    - Quality Strategy and Governance Structure
    - Safer staffing
    - Quality Risk Management
- Risk of failing to appropriately support/resource the new Quality Strategy during implementation and ability to maintain day-to-day activities.
- The transition from the existing approach to quality (and assurance) to the new approach supported by the Quality Strategy and new Operating Model will require the Board to be prepared to tolerate potentially increased risk whilst the new approaches are implemented and bedded in.

Key issues/matters discussed:

- **CAMHS Division Update**

  The Committee received a comprehensive update on the division, which covered the many improvements being seen, including in recruitment and retention, with staffing stabilised; admissions had re-commenced and action plans completed. The Committee were assured with the progress being made and noted that these improvements had been recognised by the commissioners and further acknowledged the quality of the continuous monitoring via the QIP and BAU processes. The Committee concluded that there was still work to be done, and the division was fragile in places (linked to historical challenges), however they agreed with the proposal that regular updates should be removed from the standing agenda.

- **Quality Strategy and Governance Architecture**

  The Committee were provided with a detailed presentation on the new Quality Strategy and Governance Structure that covered what quality meant for the Charity, revised ward to Board reporting, improved quality surveillance, increased use of CQI, a new process covering the identification of wards of concern, along with detail of other factors supporting quality and the implementation timescales and associated risks.

  The Committee agreed that this new strategy, model and structure was where the Charity was required to be, and that work would be done to simplify the messaging in order to communicate to staff accordingly. Discussions focussed on the resource and capacity required to deliver the programme effectively, seeking confirmation that the implementation of this new approach must be adequately resourced and that there

would be the required investment available for it. The Committee requested assurance be provided on the availability of suitable investment and resource to ensure the effective roll-out, implementation and embedding of the strategy in order to provide the necessary assurance to the Board.

It was agreed to have further detailed discussions on the Quality Strategy, including resourcing, investment and oversight of key milestones at the February QSC meeting.

The Committee agreed that the new Quality Strategy was impressive and agreed that it should be recommended to the Board for the adoption. The Committee also wanted to formally recognise the work of all those involved in developing it, in particular Dr Ash Roychowdhury and Jenny Kirkland.

- **Safer Staffing**

  The Committee received a revised Safer Staffing report that included a greater degree of detail, along with an update on the Establishment review. The committee acknowledged the improvements being seen and the level of work undertaken to date to both improve the reporting and actual position for staffing. The committee gained an improved level of assurance, however requested a clearer view of where the major challenges lay at the next meeting, and how these were being addressed.

- **Quality Risk Management**

  The Committee received a paper on the strengthened process around Quality risk management that included divisional risk registers and Quality related Material Risks that had been approved by the Executive Team. Following work undertaken by the Head of Risk with the divisions on their risk registers and in-line with the new Operational Governance meeting structure, the Quality Risk process had been strengthened by the inclusion of Estates and Facilities, as well as clinical and operational aspects. The Quality related Material Risk registers were to be discussed and scrutinised at the Operations Committee, with updates then provided at the Executive Team meetings. The Committee were assured regarding the revised processes being undertaken to improve Quality Risk management and saw the process as a way to provide greater opportunity for discussion, review and management of specific risks.

Decisions made by the Committee:

- The Committee agreed to reduce the regular updates from the CAMHS Division, following the recognised and demonstrable improvements, resulting in a reduction in risk
- The Committee approved the new Quality Strategy & Governance Architecture ahead of future submission to the Board

Implications for the Charity Risk Register or Board Assurance Framework:

- Committee were assured regarding the revised processes being undertaken to improve Quality Risk management, with Quality related Material Risks scrutinised by the Operations Committee, with updates then provided to the Executive.

Issues/Items for referral to other Committees:

- On-going request for continued collaboration with the People Committee on staffing concerns

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- None

Paper for Board of Directors	
Topic	Integrated Quality & Performance Report
Date of Meeting	Tuesday, 24 January 2023
Agenda Item	**8**
Author	Anna Williams, Director of Performance
Responsible Executive	Vivienne McVey, CEO
Discussed at Previous Board Meeting	Routine Board paper
Patient and Carer Involvement	Patient and Carer voice is captured via My Voice inclusion
Staff Involvement	Staff are involved in the performance processes that feed the analysis and actions
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Quality, Workforce and Finance metrics are considered at their associated committees.

Report Summary and Key Points to Note

<u>Review of the period ending November 22</u>

Quality

- October & November discharge data is shared – showing 79% of non-PICU patients were transitioned to a lower level of security (work is on-going to increase the visibility of onward trajectories).
- Division level SPCs show 17 improvements and 15 concerns, explanation of the concerns is shared. At ward level 5% of the metrics show concern and 6% show improvement, with the remaining 89% in control, having little or no data or showing a statistically insignificant trend.
- Assurance is provided through the performance and governance processes.
- The quality scorecards for each division and ward are routinely shared with Quality & Safety Committee.
- My Voice response rate improvement remains a focus. Feedback themes are shared.

- The work on Quality strategy and framework has moved into implementation stage.

People

- Consistent with the national context of workforce shortages, performance across the people metrics remains highly challenged. Consequently ward based staffing is suboptimal in some areas.
- Divisional level (aggregated), with the exception of agency spend, all KPIs are adverse to target.
- MDT establishment has been added – to be considered in the context of occupancy levels.
- Training levels are notably challenged – rectification has been implemented, July target date.
- Plans and mitigations have been shared with People Committee.

Review of the period ending December 22

Finance

- Net deficit £5.7m - £0.03m behind FYF. Operating Deficit £0.14m worse than FYF
- Occupancy is inline with forecast, despite service changes to Bayley PICU in December.
- At December 2022 cash held was £4.7m (inline with FYF) and no covenant risk existed

Accessing metrics

Should members of the Board wish to view IPR graphs for individual metrics, they can be accessed here -> Integrated Performance Report - Power BI Report Server

Appendices -

St Andrew's Healthcare Integrated Quality Performance Report

reviewing the period ending November 2022 for Quality & People, ending December 2022 for Finance & IT

St Andrew's HEALTHCARE

Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info

Concerns Improvements In Control

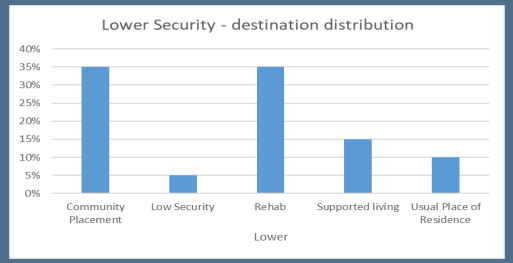
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

Quality

-	Incident	Violence	Incident L1	Incident L2	Incident L3	SI	Restraint	Seclusion	Seclusion Hours	LTS	LTS Days	Safegrd	Rapid Tranq	ES Episodes	ES WTE	Ptn Leave
Birmingham																
CAMHS																
Community Services																
Essex																
LDA																
Low Secure & Specialist Rehab																
Medium Secure																
Neuro																

Discharges – during October & November (excluding PICUs) 38 people moved on from St Andrew's. The majority, 79%, transitioning to a lower level of security, including a third returning to their usual residence.



PICUs transitioned a further 29 people in October & November.

Division	Wards	SPC Concern	SPC Improvement	SPC Common Cause	Trend Concern
Birmingham	8	1 %	2 %	13 %	10 %
CAMHS	4	14 %	5 %	19 %	22 %
Community Services	2	3 %	0 %	19 %	3 %
Essex	6	0 %	3 %	20 %	15 %
LDA	13	9 %	9 %	26 %	12 %
Low Secure & Specialist Rehab	10	7 %	4 %	12 %	8 %
Medium Secure	12	2 %	4 %	21 %	9 %
Neuro	12	3 %	10 %	21 %	8 %
Totals	**67**	**5 %**	**6 %**	**19 %**	**10 %**

When aggregated, ward level SPC concerns have increased by 2% with improvements static. Common cause has reduced by 2%. The remaining % is metrics with little or no data or trends with too little data for statistical significance

Exceptions –17 improvements, continued cluster in Neuro (6) and a new cluster in Essex (4). Increase to 15 concerns – performance & governance processes confirm clinically appropriate management:

- **LDA** – consistent LTS concern, due to inappropriately placed patients. All external reviews completed. Every effort made to secure suitable next placement (weekly discharge meeting with external stakeholders). ES concern correlates with acute new admissions being stabilised.
- **CAMHS** – OBD measures are inherently less useful for small patient numbers. Seacole has stabilised. Concerns are mostly driven by a period of relapse for two patients, both have had their discharge delayed with pending community placements. A number of the concerns have returned to typical levels for December.
- **COMM SERV** – two new patients admitted across the summer, both requiring enhanced support.

The following wards are receiving focus within their division, with targeted quality team support; Sunley, Church, Meadow, Wantage Gate, Silverstone, Heygate, Sitwell, Prichard, Rose, Willow, Cranford & Fenwick. The new wards of concern process will further strengthen clinical management, patient care and experience. Emerging focus: ES for Neuro and patient leave.

My Voice – Good or very good response remains at to 75%, the rate of response remains below the desired level, with work on going to address. Verbatim comments suggests varied experience, with positive themes focusing on supportive staff & valuable therapeutic sessions. Less positive feedback focuses on: food, staffing levels, activity & leave.

People

Measure	Voluntary Turnover In Year		Voluntary Turnover In Month		RN Establishment Ratio		HCA Establishment Ratio		MDT Establishment Ratio		Mandatory Training		Agency Spend		Sickness % In Month		Non-Patient Facing Shifts	
Target	12%		1%		95%		95%				90%		5%		6%		25%	
	Nov	Trend	Nov	Trend	Nov	Trend	Nov	Trend	Nov	Trend	Nov	Trend	Nov	Nov	Nov	Trend	Nov	Trend
St Andrews	14.9%	↑	1.2%	↑							87.3%	↓			7.3%	↓		
Functions	11.3%	↔	0.8%	↔							90.6%	↓			4.1%	↓		
Divisions	16.5%	↑	1.4%	↑	81.7%	↓	79.8%	↓	92.7%	↑	86.4%	↓	7.0%	↑	8.8%	↓	36.7%*	↓
Birmingham		↓		↑		↓		↓				↑		↑		↑		
CAMHS		↑		↑		↑		↓				↓		↑		↓		↑
Community Partnerships		↓		↑								↓				↓		
Community Services		↓		↔		↔		↓				↓		↑		↑		
Essex		↑		↔		↓		↓				↓		↑		↓		
LDA		↓		↓		↑		↑				↑		↑		↓		↓
Low Secure & Specialist Rehab		↑		↓		↓		↓				↓		↑		↓		↓
Medium Secure		↔		↑		↓		↑				↓		↑		↓		↑
Neuro		↓		↑		↑		↑				↓		↑		↓		↓

Waterfall – month on month net growth, correlates with increased MDT establishment. Whilst there is a net improvement in HCAs this has not driven an improved HCA ratio as the required number has increased.

Voluntary turnover – October cost of living support and pay rises were received positively, there was a corresponding reduction with a small reduction in turnover followed by a period of stabilisation (the adverse trend Oct to Nov . New retention framework is being implemented.
RN & HCA establishment – the current establishment level, plus above model non-patient facing shifts and suboptimal WorkChoice results in a challenging nursing staffing position. The new approach to agency has provided short term mitigation. Positively there has also been an increase in MDT from 81 to 93%. Overall the focus on retention remains. The MHOST review will impact the establishment ratio.
Mandatory training – challenging ward staffing levels continue to hinder divisional training. BLS & Safeguarding level 3 are static (71%) and (88%). SIT continues with a negative trend. Multifaceted training plan is underway, with phased focus on differing staffing groups – target rectification date pending.
Agency Spend – adjustments have increased bookings, supporting key vacancies.
Sickness – seasonal increases in sickness are being felt.
Non-Patient facing shifts – Reduction correlates with seasonal reductions in annual leave. Improved management of discretionary leave introduced. Note, Northampton only data.

*improvements in people data quality and presentation have been impacted by Allocate transition and have been given a high priority following go live. *trend is to the prior month

Finance Overview
24th January 2023

Transforming lives together

Financial Performance 2022/23

December 2022 Actual Performance v Full Year Forecast (FYF)

- **Net deficit £5.7m - £0.03m behind FYF. Operating Deficit £0.14m worse than FYF**
- Occupancy is inline with forecast, despite service changes to Bayley PICU in December.
- Net contribution inline with FYF but Enabling Services costs £0.18m above FYF (higher estate repairs in Qtr3)
- At December 2022 cash held was £4.7m (**inline with FYF**) and no covenant risk existed

Full Year Outlook Performance v Full Year Forecast (FYF)

- Occupancy growth, controlling ward staffing costs inline with FYF, inflation/cost of living pressures and reduction in investment portfolio valuation (linked to stock markets) remain the main risks to achieving the 2022/23 FYF.
- Cash and covenants are expected to track in line with FYF.

	December 22 YTD			Full Year		
Financial Performance - £m	Actual	Forecast	Variance	Forecast	Budget	Variance
Income	127.56	127.19	0.37	171.45	176.08	(4.6)
Direct & Indirect Costs	(95.35)	(95.02)	(0.33)	(126.93)	(130.41)	3.5
Net Contribution	**32.21**	**32.17**	**0.04**	**44.52**	**45.67**	**(1.1)**
Enabling Services	(24.37)	(24.19)	(0.18)	(32.25)	(31.88)	(0.4)
Depreciation	(8.18)	(8.19)	0.00	(10.74)	(11.26)	0.5
Operating Surplus/(Deficit)	**(0.34)**	**(0.20)**	**(0.14)**	**1.53**	**2.53**	**(1.0)**
Non Operating Costs	(0.37)	(0.37)	(0.01)	(0.51)	(0.37)	(0.1)
Exceptional Costs	(2.41)	(2.42)	0.00	(2.68)	(1.00)	(1.7)
Disposal of Fixed Assets & Impairment	0.01	0.01	0.00	0.86	(0.25)	1.1
Project Costs - OPEX	(1.60)	(1.71)	0.11	(2.88)	(3.33)	0.5
Investment Gains/Losses	(0.94)	(0.94)	0.00	(1.34)	0.00	(1.3)
Net Surplus/(Deficit)	**(5.66)**	**(5.63)**	**(0.03)**	**(5.02)**	**(2.42)**	**(2.6)**

Balance Sheet Dec 2022

St Andrew's Consolidated Balance Sheet	Mar-22 Audited	Jun-22 Actual	Sep-22 Actual	Oct-22 Actual	Dec-22 Actual
	£M	£M	£M	£M	£M
Intangible and tangible fixed assets	196.6	193.9	191.9	191.0	190.5
Investments					
Stock Market Investments	11.6	11.6	11.7	10.7	10.8
Investment Properties	5.7	5.7	5.7	5.7	5.7
Current Assets					
Stock	0.4	0.5	0.5	0.5	0.5
Trade debtors	8.2	9.4	10.0	10.2	9.4
Other Debtors & Accrued Income	4.1	4.4	4.6	4.8	5.0
Prepayments	1.8	1.2	1.0	1.1	2.1
Cash	6.0	5.1	6.0	5.5	4.7
	20.5	**20.6**	**22.1**	**22.1**	**21.7**
Current Liabilities					
Trade Creditors	(3.3)	(3.7)	(3.1)	(3.5)	(3.9)
Taxation and Social Security	(2.8)	(3.3)	(2.8)	(3.6)	(2.8)
Other Creditors & Accruals	(8.5)	(8.5)	(8.8)	(9.1)	(8.1)
Staff Accruals	(4.3)	(3.4)	(3.5)	(3.5)	(4.2)
Deferred Income	(2.9)	(2.6)	(3.3)	(2.1)	(2.6)
	(21.8)	**(21.4)**	**(21.4)**	**(21.7)**	**(21.7)**
Net Current Assets/(Liabilities)	**(1.3)**	**(0.8)**	**0.7**	**0.4**	**0.0**
Total Assets Less Current Liabilities	**212.6**	**210.5**	**210.0**	**207.9**	**207.0**
Bank Loans (between 1 and 5 years)	(20.0)	(20.0)	(20.0)	(20.0)	(20.0)
Pension Scheme Liability	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)
Total Assets Employed	**192.0**	**189.9**	**189.4**	**187.3**	**186.4**
Reserves	**192.0**	**189.9**	**189.4**	**187.3**	**186.4**

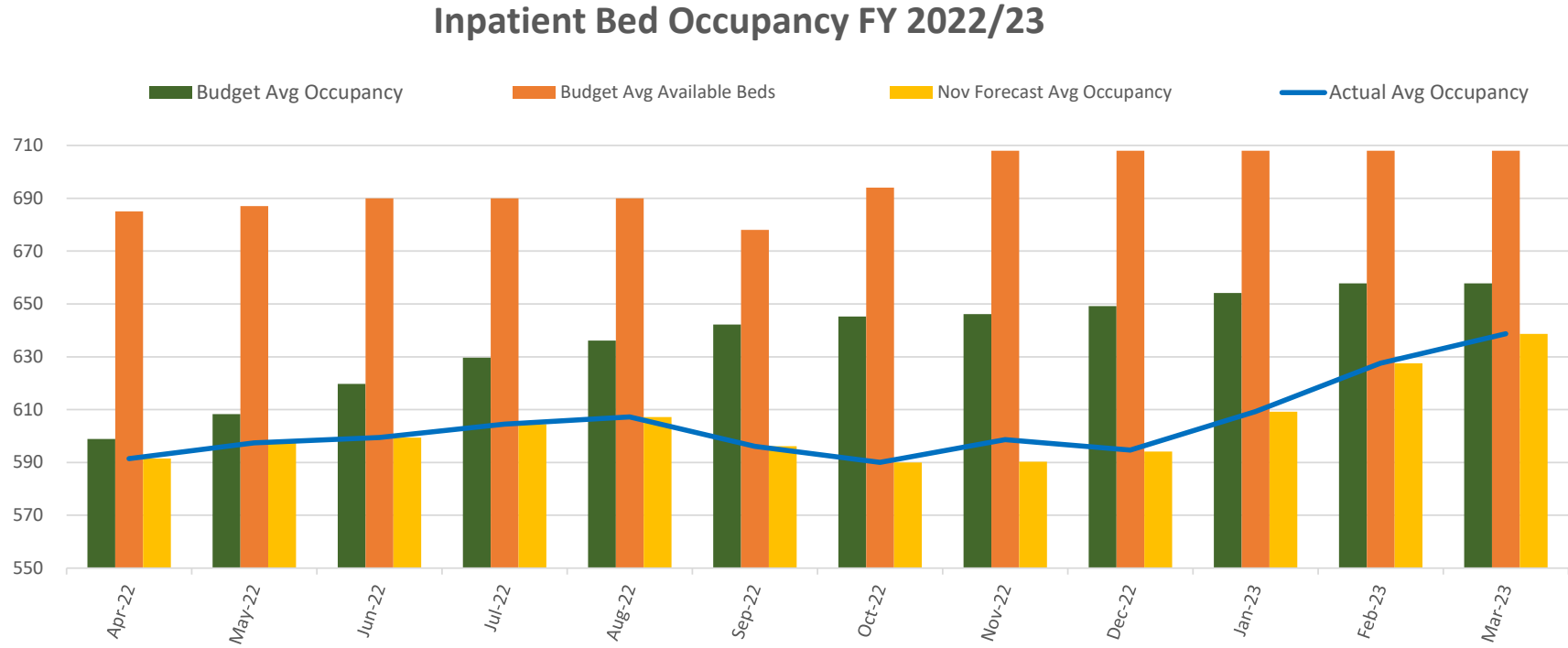
Cashflow Dec 2022 YTD

Cashflow Summary - £m	December 22 YTD			Full Year		
	Actual	Forecast	Variance	Forecast	Budget	Variance
Net Surplus/(Deficit)	(5.7)	(5.6)	(0.0)	(5.0)	(2.4)	(2.6)
Add Back Non Cash Items						
Depreciation	8.2	8.2	(0.0)	10.7	11.3	(0.5)
Fixed Asset Impairment/(Profit on Disposal)	0.0	0.0	0.0	(0.9)	0.3	(1.1)
Investment Portfolio Valuation Movement	0.9	0.9	(0.0)	1.2	0.0	1.2
Net inflow/(outflow) from Operations	**3.4**	**3.4**	**(0.0)**	**6.1**	**9.1**	**(3.0)**
Total inflow/(outflow) - Working Capital	(2.5)	(1.5)	(1.0)	(0.6)	(0.4)	(0.2)
Total inflow/(outflow) - Capital Expenditure	(2.1)	(2.3)	0.2	(4.5)	(5.9)	1.4
Total inflow/(outflow) - Asset Disposal	0.0	0.0	0.0	1.2	0.6	0.6
Total inflow/(outflow) - Investment Portfolio	0.0	0.0	0.0	0.0	0.0	0.0
Total inflow/(outflow) - Loan Facility	0.0	(1.0)	1.0	(4.5)	(5.5)	1.0
Net Cash (Outflows) / Inflow	**(1.3)**	**(1.4)**	**0.1**	**(2.3)**	**(2.1)**	**(0.2)**
Cash at the 31.3.2022	**6.0**	**6.0**	**0.0**	**6.0**	**6.0**	**0.0**
Total Cashflow Movement	(1.3)	(1.4)	0.1	(2.3)	(2.1)	(0.2)
Cash at the end of the period	**4.7**	**4.6**	**0.1**	**3.7**	**3.9**	**(0.2)**

Net Debt - £m	December 22 YTD			Full Year		
	Actual	Forecast	Variance	Forecast	Budget	Variance
Cash Held	4.7	4.6	0.1	3.7	3.9	(0.1)
Bank Loan Balance	(20.0)	(20.0)	0.0	(15.5)	(14.5)	(1.0)
Investment Balance	10.7	10.7	0.0	10.3	11.6	(1.3)
Net Debt	**(4.5)**	**(4.7)**	**0.1**	**(1.5)**	**1.0**	**(2.4)**
Credit Facility	27.0	27.0	0.0	27.0	27.0	0.0
Credit Facility Headroom	7.0	7.0	0.0	11.5	12.5	(1.0)

Working Capital movement are timing variations compared to forecast assumptions, with debtors slightly higher and creditors lower than projected. Not an area of concern.

Occupancy



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Budget Avg Available Beds	685	687	690	690	690	678	694	708	708	708	708	708
Budget Avg Occupancy	599	608	620	630	636	642	645	646	649	654	658	658
Nov Forecast Avg Occupancy	591	597	599	604	607	596	590	590	594	609	628	639
Actual Avg Occupancy	591	597	599	604	607	596	590	599	595	609	628	639
Actual % Achievement of Budget	99%	98%	97%	96%	95%	93%	91%	93%	92%	93%	95%	97%
Budget Avg Occupancy of Available	87%	89%	90%	91%	92%	95%	93%	91%	92%	92%	93%	93%

Actual occupancy to Dec 2022

IT Security Metrics (Oct – Dec 2022)

Legend	No Change	Trending Down	Trending Up

	OCT	NOV	DEC	RAG Rating	December	
					Causal	Remediation
Vulnerabilities not fixed within SLA Highlights the amount of infrastructure vulnerabilities that haven't been fixed within the agreed timescales	1	0	0		**Causal Analysis**: Vulnerabilities are actively tracked to ensure compliance, any breaches in terms of SLA's are either presented for risk acceptance or dispensated to investigate a fix.	**Remedial Actions:** IT Security will continue to monitor and track SLA breaches and raise any Non-Conformances if required.
Overdue Penetration Test Remediation The last Pen test for the Charity was in July 2021. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: The network segregation penetration test was conducted, awaiting results.	**Remedial Actions:** None
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 0 P3 5	P1 0 P2 1 P3 2	P1 0 P2 0 P3 0		**Causal Analysis**: There have been no reported security incidents in the month of December. IT Security continue to monitor for phishing threats.	**Remedial Actions:** Advanced have implemented a email vetting service to make sure incoming emails are legitimate and not intercepted. 1:1 conversations with staff who click on links have been implemented to provide more targeted awareness as well.
Blocked Network Attacks These are blocked network attacks directed at our external network edge	81420	86857	91467		**Causal Analysis**: We are constantly being port scanned and probed by external threat actors. High risk IPs are automatically dropped and blocked at the firewall. This trend is seen globally and follows NCSC and NSA trend analysis due to present conflicts.	**Remedial Actions:** Enhanced monitoring owing to the ongoing war in Ukraine and the increased cyber risk to the west.
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	0	0	0		**Causal Analysis**: The 2 actions with Physical Security have now been updated and resolved.	**Remedial Actions:** Actions were escalated to Head of Soft FM. They have both since been resolved.
% of Fully Patched Systems % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 89.13% Client = 93.878%	Servers = 84.2% Client = 91.32%	Servers = 82% Client = 84%		**Causal Analysis**: An Overall percentage - an average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). A small amount of servers did not auto patch to 100%.	**Remedial Actions:** The team are working through the non-patched to ensure they are fixed and up to date.
Anti-Malware Installation Compliance % of machines on the network that have anti-malware protection installed and enabled	95%	94%	98%		**Causal Analysis**: Older versions will be updated as computers come back online, the update process is fully automated.	**Remedial Actions:** IT Security will continue to monitor and chase Advanced for any stragglers.
Blocked Attacks on Staff Accounts Attempted logins from malicious actors to staff accounts. These aren't successful and are flagged by our SIEM tool	36	14	10		**Causal Analysis**: Number of attempts has decreased back down to average. All attempts were unsuccessful and typically target clinical staff members. Proactive monitoring and alerting takes place with SenseOn.	**Remedial Actions:** IT Security continues to monitor all external access. New proactive AI based scanning and reporting is active and is proving very successful.
Security Awareness % of applicable staff who have completed their e-learning module on cyber security & information governance	85%	85%	88%		**Causal Analysis:** L&D are seeing challenges in staff booking and being released to attend training with the current staffing challenges. Not at the required level of 90% for the Data Security & Protection Toolkit.	**Remedial Actions:** All staff who are out of date with any of these areas prioritise completion of this e-learning. Managers to check via SAP to ascertain who in their times has outstanding e-learning and enable them to complete.

Paper for Board of Directors	
Topic	Nursing Establishment Annual Review
Date of Meeting	Tuesday, 24 January 2023
Agenda Item	**9**
Author	Chloe Annan, Deputy Director of Nursing
Responsible Executive	Chief Nurse
Discussed at Previous Board Meeting	Not been discussed at previous Board meetings as this is the outcome of the annual nursing establishment review.
Patient and Carer Involvement	Patients are involved in discussions around safer staffing levels and establishment setting, where appropriate, in Community Meetings.
Staff Involvement	All wards were fully engaged with and involved in dedicated ward establishment review meetings. Heads of Division and other Multidisciplinary Team members also contributed.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	

Report Summary and Key Points to Note

The November 2022 nursing establishment review is now complete for all wards, across all divisions. This review was completed in line with our own Safer Staffing Policy and National Quality Board Guidance. This is the first full nursing review we have completed of this kind, whereby each ward clinical team was fully engaged in the review, and MHOST results were triangulated with quality/safety data and professional judgement.

As a Charity total, this review is proposing an increase in the total number of staff we have in the ward establishments, including qualified staff. This increase, however, is compared to the current budgeted nursing establishments in which the MHOST tool was not used in full and nor was the triangulated approach. This total increase recognises the levels of enhanced support, occupancy, and acuity that the wards have been experiencing in the last six months. Staffing fill rate data for each ward for the last six months was also reviewed, and in many cases indicated that they have had to regularly 'flex up' above their base planned number since its implementation.

Although the total nursing establishment is increasing, wards are currently working at these levels or higher (with their current flex). They are however, filling these extra needs with temporary staff, including agency/Workchoice/overtime. This is not only contributing to increased cost but also to the unfamiliarity of staff on the ward and reducing skill mix.

It is important to note that there have been some significant changes to wards in the last six months (including new wards opening in Birmingham, Essex and Low Secure) and as such, a follow up data collection has been recommended in the new year to ensure these establishments remain appropriate.

It is also clinically recommended that these new establishments go live in the new year (January 2023). There is a risk that if the changes are not made until the new financial year, that they will then be clinically out of date and wards made still need to continue to work at these levels, but without the permanent establishment to support them.

Appendices -

Nursing Establishment Reviews:

We now have an agreed establishment review template to provide consistency in how we approach these for all wards. This template has been based on best practice and linking in with a NHS trust well versed in this approach, as well as local feedback as to what should be included. This forms part of our Safer Staffing Policy & Procedure. This template will be used for all establishment reviews and ensure these discussions are well documented for evidence.

MHOST training has been rapidly rolled out across the summer as planned. Within these two months we have been able to increase the number of staff trained in the application of the tool from 19 to over 50. We now have senior nursing leaders trained in the use of this tool across all divisions and regional sites. This has improved our capability of using the tool with accuracy.

An unedited version of the MHOST tool was obtained and has been used in this review. The Registered Professional percentage is set specifically for specific areas based on best practice and benchmarked wards. This has not been amended. Where our professional judgement has deviated in any way from this percentage, this is well documented.

We have now completed a full nursing establishment review for all wards, as per our agreed process and in line with Developing Workforce Safeguards. Each ward's clinical team, as well as the divisional leadership teams, have been fully engaged in this process. Each establishment meeting followed the agreed template and the minutes documented. A triangulated approach has been used successfully involving the MHOST calculator, a review of quality and safety data and professional judgement. This has now formulated proposed establishment changes. **The ward level detail of the proposed establishments is at the end of this report.**

The table below shows a breakdown of the total day and night numbers that each division is working on currently (including current flex), compared with each division's proposed total (baseline).

*Current flexed planned totals taken as of 11/12/22.

Division	Budgeted Day Total (Baseline)	Current Day Total (Flexed)	**Proposed Day Total (Baseline)**	Budgeted Night Total (Baseline)	Current Night Total (Flexed)	**Proposed Night Total (Baseline)**
ASD/LD	98	113.9	105.9	81.4	93.8	88
Birmingham	50.6	61	56.5	32	43	34
CAMHS	22.2	24.1	24	20.8	23.4	23
Essex	33.1	36.1	35.2	26.4	29	25.5
Low Secure	55	58.6	58	41.4	45.8	44.8
Medium Secure	79.7	83	76.6	64	71.2	64.6
Neuropsychiatry	77.7	87.2	83.1	56.4	64.6	63
Total	416.3	463.9	**439.3**	322.4	370.8	**342.9**

This establishment review does propose a total increase in the number of planned staff day and night, and therefore a total increase in the Charity's nursing establishment. The only divisional exception to this is Medium Secure, who see a small reduction in their baseline day numbers and therefore total establishment. This reflects some of their focused work around reducing levels of enhanced support, particularly on Bracken where both their enhanced support and acuity has significantly reduced since the last review in 2021.

It is important to note that although an increase in total establishment is being proposed, wards are currently working at these levels or higher. These higher levels include the 'flex' wards are having to apply on top of their baseline number due to increases in acuity, enhanced support, or occupancy. The increased use of flex within the last six months would also support that baseline numbers have not been sufficient, and wards are then having to try and fill this additional requirement with Workchoice or agency staff, increasing cost and reducing skill mix. The proposed establishment sees the total baseline number increase, however, remains less (as a Charity total) than the current flexed figures.

The table below shows a breakdown of planned qualified totals day and night, comparing the current qualified numbers with the proposed qualified numbers.

Division	Current Day Qualified	**Proposed Day Qualified**	Current Night Qualified	**Proposed Night Qualified**
ASD/LD	23.5	27.3	14.4	15.3
Birmingham	17.5	20.5	10	12
CAMHS	6	6	5	5
Essex	13.5	16	10	9
Low Secure	21	22	14	13.5
Medium Secure	21.1	24	11.8	12.4
Neuropsychiatry	21.5	25	12.6	13.6
Total	124.1	**140.8**	77.8	**80.8**

This review recommends an overall increase in the qualified nursing establishment for all divisions. The MHOST tool used in this review was used without any amendments to the qualified proportion. These proportions are set differently in the tool for different descriptors/specialisms and are benchmarked against best practice wards in these areas in the UK. It was also recognised during professional judgement discussions and review of quality data, that some wards required an increase in their qualified establishment to meet the needs of their patients and demands of the ward.

The Charity also manages high levels of enhanced support for the number of patients it cares for. Some other organisations have noted that where they have been able to increase the qualified ratio on the ward (therefore enhancing the skill mix) they have been able to reduce total levels of enhanced support. Currently, it is generally our least skilled staff (Workchoice/agency/HCAs) that care for our most complex patients and cover enhanced support. By increasing our qualified ratio, it is anticipated that the next review will be able to evidence a reduction in enhanced support.

The proposed night qualified total has also increased, recognising the current qualified demand and acuity. There have also been difficulties (across the Northampton site in particular) with Registered Nurses getting protected break cover at night. The slight increase in total qualified staff at night would help support this. All divisions look to have sufficient qualified provision at night to support with break cover, except for Neuropsychiatry. Clinically, only one of their wards requires two qualified staff at night. Operationally therefore, the division will require an increase of around 1.2 qualified staff per night to support with the hours of qualified break cover required (*not included in totals above).

Neuropsychiatry are also the only division that are proposing the introduction of Nurse Associates within the ward establishment. This recognises the increased physical health complexity present within the division and the introduction of this role will support qualified nurses. Nurse Associates sit between Qualified staff and HCAs, they are registered professionals that can independently complete medication, however, are unable to take charge of a ward for the entire shift on their own.

It is clinically recommended that the new nursing establishments take effect from early in the new year (February) as they reflect the acuity, enhanced support, and occupancy the wards have been experiencing within the last six months.

Divisional Establishment Detail:

ASD/LD							
Ward	**Jan-23**	**Day**	Q	HCA	**Night**	Q	HCA
Acorn	38.5	8.4	3	5.4	7	1	6
Q	10						
HCA	28.5						
Berry	37.5	9	2.5	6.5	6	1	5
Q	8.75						
HCA	28.75						
Brook	37.5	9	2.5	6.5	6	1	5
Q	8.75						
HCA	28.75						
Hawkins	40	9	2.5	6.5	7	2	5
Q	11.25						
HCA	28.75						
Oak	55	11	2	9	11	2	9
Q	10						
HCA	45						
Church	57.5	12	2.5	9.5	11	1.4	9.6
Q	9.75						
HCA	47.75						
Marsh	36.25	8	2.5	5.5	6.5	1	5.5
Q	8.75						
HCA	27.5						
Meadow	40	9	2.6	6.4	7	1.4	5.6
Q	10						
HCA	30						
Fern	37.5	8	2	6	7	1	6
Q	7.5						
hca	30						
Wantage (	11.25	2.5	0.7	1.8	2	0	2
Q	1.5						
HCA	9.75						
Sunley	55	12	2.5	9.5	10	1.5	8.5
Q	10						
HCA	45						
Garden Cc	13.75	3	1	2	2.5	1	1.5
Q	5						
HCA	8.75						
Sycamore	22.5	5	1	4	5	1	4
Q	5						
HCA	17.5						

Birmingham							
Ward	**Jan-23**	**Day**	Q	HCA	**Night**	Q	HCA
Edgbastor	27.5	7	2.5	4.5	4	2	2
Q	11.25						
HCA	16.25						
Hawksley	35	9	3	6	5	2	3
Q	12.5						
HCA	22.5						
Hazelwell	25	6	2	4	4	1	3
Q	7.5						
HCA	17.5						
Hurst	27.5	7	3	4	4	1	3
Q	10						
HCA	17.5						
Lifford	35	9	2.5	6.5	5	2	3
Q	11.25						
HCA	23.75						
Moor Gre	26.25	6.5	2.5	4	4	2	2
Q	11.25						
HCA	15						
Northfield	22.5	5	2	3	4	1	3
Q	7.5						
HCA	15						
Speedwell	27.5	7	3	4	4	1	3
Q	10						
HCA	17.5						

CAMHS							
Ward	**Jan-23**	**Day**	Q	HCA	**Night**	Q	HCA
Seacole	36.25	7.5	2	5.5	7	2	5
Q	10						
HCA	26.25						
Stowe	36.25	7.5	2	5.5	7	2	5
Q	10						
HCA	26.25						
Sitwell	45	9	2	7	9	1	7
Q	7.5						
HCA	37.5						

Essex							
Ward	**Jan-23**	**Day**	Q	HCA	**Night**	Q	HCA
Audley	27.5	6	3	3	5	2	3
Q	12.5						
HCA	15						
Danbury	27.5	7	3	4	4	1	3
Q	10						
HCA	17.5						
Maldon	16.25	3.5	1.5	2	3	1	2
Q	6.25						
HCA	10						
Benfleet	26.75	6.7	3	3.7	4	1	3
Q	10						
HCA	16.75						
Frinton	27.5	6	3	3	5	2	3
Q	12.5						
HCA	15						
Colne	26.25	6	2.5	3.5	4.5	2	2.5
Q	11.25						
HCA	15						

Low Secure							
Ward	**Jan-23**	**Day**	Q	HCA	**Night**	Q	HCA
Bayley	30	7	3	4	5	2	3
Q	12.5						
HCA	17.5						
Heygate	32.5	7	3	4	6	2	4
Q	12.5						
HCA	20						
Spencer N	26	6	2	4	4.4	1	3.4
Q	7.5						
HCA	18.5						
Naseby	30	7	2	5	5	2	3
Q	10						
HCA	20						
Spencer S	26	6	2	4	4.4	1	3.4
Q	7.5						
HCA	18.5						
Silverston	30	7	3	4	5	1.5	3.5
Q	11.25						
HCA	18.75						
Lower Har	32.5	7	3	4	6	2	4
Q	12.5						
HCA	20						
37 The Av	15						
Q	0	3	0	3	3	0	3
HCA	15						
Watkins H	17.5	4	2	2	3	1	2
Q	7.5						
HCA	10						
Berkley Lo	17.5	4	2	3	3	1	2
Q	7.5						
HCA	10						

Medium Secure							
Ward	**Jan-23**	**Day**	Q	HCA	**Night**	Q	HCA
Cranford	45	10	3	7	8	2	6
Q	12.5						
HCA	32.5						
Prichard	36	8	2.5	5.5	6.4	2	4.4
Q	11.25						
HCA	24.75						
Bracken	42.5	9	2.5	6.5	8	2	6
Q	11.25						
HCA	31.25						
Maple	28.5	6	2	4	5.4	1	4.4
Q	7.5						
HCA	21						
Willow	41	8.6	2.5	6.1	8	1	7
Q	8.75						
HCA	32.25						
Fairbairn	36	8	3	5	6.4	1.4	5
Q	11						
HCA	25						
Robinson	32.5	7	3	4	6	1	5
Q	10						
HCA	22.5						
Rose	38.75	8.5	2.5	6	7	1	6
Q	8.75						
HCA	30						
Mackanes	32.25	7.5	3	4.5	5.4	1	4.4
Q	10						
HCA	22.25	2	0	2	2	0	2
23 The Av	10						
Q	0						
HCA	10						
21 The Av	10	2	0	2	2	0	2
Q	0						
HCA	10						

Neuropsychiatry									
Ward	**Jan-23**	**Day**	Q	NA	HCA	**Night**	Q	NA	HCA
Aspen	27.5	6	2		4	5	1		4
Q	7.5								
HCA	20								
Redwood	27.5	6	2		4	5	1		4
Q	7.5								
HCA	20								
Elm	30	7	2	1	4	5	1.4		3.6
Q	10								
NA	2.5								
HCA	17.5								
Cherry	30	7	2	1	5	5	1	1	3
Q	7.5								
NA	5								
HCA	17.5								
Walton	31	8	2	1	5	4.4	1		3.4
Q	7.5								
NA	2.5								
HCA	25.5								
Fenwick	32.5	7.6	2		5.6	5.4	1		4.4
Q	7.5								
HCA	25								
Tavener	27.25	6.5	2.5		4	4.4	1.4		3
Q	9.75								
HCA	17.5								
Tallis	52	12	3		9	9	2		7
Q	12.5								
HCA	39.5								
Allitsen	41	9	3		6	7.4	1.4		6
Q	11								
HCA	30								
19 & 38	25	5	1.5		3.5	5	1		4
Q	6.25								
HCA	18.75								
Elgar	41	9	3		6	7.4	1.4		6
Q	11								
HCA	30								

Paper for Board of Directors	
Topic	Mental Health Bill 2022
Date of Meeting	Tuesday, 24 January 2023
Agenda Item	**10**
Author	Stuart Wallace, Head of Legal
Responsible Executive	
Discussed at Previous Board Meeting	Not previously discussed
Patient and Carer Involvement	Not applicable
Staff Involvement	Not applicable
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☒ **C** ☐ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Not applicable

Report Summary and Key Points to Note

The Mental Health Bill was published in June 2022 and sets out how the Mental Health Act 1983 will be amended.

The purpose of this report is start the conversation on the amendments to the Mental Health Act 1983 by informing the Board of key changes and to suggest some key areas that will affect the Charity in the coming years.

Appendices - Appendix 1: Detailed Summary of the Mental Health Bill 2022

Draft Mental Health Bill 2022

What is it?

The draft Mental Health Bill 2022 (the draft Bill) sets out a number of amendments to the MHA 1983 (MHA 1983), which is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. The main function of the MHA 1983 is to provide a legal framework that authorises the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves and/or others.

Why is it being implemented?

The Government's 2017 and 2019 Manifestos both included a commitment to reform of the MHA 1983 to give patients greater control over their treatment and to make it easier for people with learning disabilities and autism to be discharged from hospital. Prime Minister Theresa May subsequently commissioned an Independent Review of the MHA 1983 chaired by Professor Sir Simon Wessely to consider the following issues:

- the reasons for the rising number of detentions under the MHA, which had increased by 40% between 2007 and 2016;
- the disproportionate number of people from black and minority ethnic groups detained under the Act, with black people four times more likely than white people to be detained, and
- Processes that are out of step with a modern mental health care system.

The Review published its final report, Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion, in December 2018. The Review contained 154 recommendations, covering both legislative reforms and reforms to policy and practice.

The Government's Response to the Independent Review was published in its White Paper, Reforming the Mental Health Act, on 13 January 2021. In the response, the Government accepted the majority of the Review's recommendations. The subsequent consultation on the White Paper reported in July 2021. The draft Bill was published on 27 June 2022.

What are the changes?

The proposed legislative changes are centred on four guiding principles that were developed by the Independent Review and the people with lived experience it consulted with:

- **Choice and Autonomy:** ensuring service users' views and choices are respected
- **Least Restriction:** ensuring the MHA 1983 powers are used in the least restrictive way
- **Therapeutic Benefit:** ensuring patients are supported to get better, so they can be discharged from the MHA 1983
- **The Person as an Individual:** ensuring patients are viewed and treated as individuals

The draft Bill is organised around 14 headings which set out amendments that will be made to the MHA 1983:

1. **Autism and learning disability:** the main change of note is that people with learning disabilities and/or autism will only be able to be detained under Part 2 of the MHA 1983 (i.e. s.2 and s.3) if they have an additional mental disorder.

2. **Grounds for detention and community treatment orders:** the main change of note is that the criteria for admission under Part 2 of the MHA 1983 will require the demonstration of "serious harm may be caused to the health or safety of the patient or of another person" and secondly that the decision has considered "the nature, degree and likelihood of the harm, and how soon it would occur. Similar changes have also been made to the Community Treatment Order (CTO) criteria.
3. **Appropriate medical treatment:** the definition of "appropriate medical treatment" is to be amended so that the treatment must have a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations, to ensure that there is a therapeutic benefit to the treatment.
4. **The responsible clinician:** the main change of note is that hospital managers will have to nominate responsible clinicians.
5. **Treatment:** the greatest change is that patients will need to be more involved in their treatment and their wishes and feelings will have greater prominence. The periods where treatment can be given without consent will be reduced.
6. **Community treatment orders:** the main changes of note are that CTOs will only be made where necessary and there will be greater involvement of the community clinician in agreeing to implement a CTO and the conditions it imposes.
7. **Nominated persons:** the significant change is the abolition of the nearest relative and the patient being able to choose a nominated person to be involved in their care. The nominated person will have greater involvement in the patient's care than the nearest relative did.
8. **Detention periods:** the detention periods for all patients detained under Part 2 MHA 1983 have been reduced.
9. **Periods for applications and reference:** the periods in which a patient can apply to the Mental Health Tribunal (MHT) have been reduced to reflect the detention periods.
10. **Patients concerned in criminal proceedings or under sentence:** the most significant change is that the MHT and the Secretary of State will have the power to conditionally discharge patients with conditions that include a Deprivation of Liberty (DoL).
11. **Help and information for patients:** hospital managers will need to ensure patients are aware of their right to make a complaint internally and to the PHSO – in effect a more robust s.132 rights.
12. **After-care:** the most significant change for the Charity is that the MHT will have the power to make recommendations to a patient's care to help facilitate their discharge from hospital.
13. **Miscellaneous:** the most significant change of note is that police stations and prisons will no longer be places of safety.
14. **General:** this heading contains mainly administrative provisions.

A more detailed overview of the main amendments most relevant to the Charity are set out in appendix 1 to this paper.

The draft Bill will be supported by a new code of practice and a reference guide, which will provide greater detail on the draft Bill once it becomes an Act of Parliament.

When will the draft Bill be implemented?

The Joint Committee on the Mental Health Bill is due provide a report later this month. It is anticipated the draft Bill will continue through the parliamentary process and receive Royal Assent later this year. Implementation of the Mental Health Act 2022 will be staggered over time, with first duties to be introduced in mid-2024/2025. The first duties to be introduced include the new detention criteria, including for people with learning disabilities and autism, Nominated Person, and automatic referral of formal patients to

Independent Mental Health Advocacy (IMHA) services. The estimated commencement dates of Mental Health Act powers are on Page 14 of the Impact Assessment to the draft Bill, but full implementation is estimated to take decades.

What are the Consequences for St Andrew's?

The overwhelming positive of all these amendments is the benefits they will hopefully bring to the people the Charity provides care for. These change will inevitably generate a great deal of work for the Charity. Some issues to consider are:

1. **Overarching Principles:** It might be worth adopting these principles to decisions the Charity takes centrally, so that the Charity is already considering them when the draft Bill becomes law?
2. **Capacity Assessments:** it is clear that patients will need to become more involved in their care and their capacity to make decisions about aspects of their care and treatment will need to be carefully considered. It may be worth the Charity thinking about improving the knowledge and competence of clinical staff to undertake capacity assessments.
3. **Learning Disability and Autism Services:** people with learning disabilities and autism will only be admitted under Part 2 MHA 1983 if they have a diagnosis of another mental disorder. The Charity may want to think about the services it provides to this patient group and not admitting any new patients who fall into this category as they may prove difficult to discharge in the future.
4. **Care Plans:** the Charity will need to ensure its care plans meet the statutory requirements. It may be too early to develop new care plan templates as all of the detail required is not known.
5. **Therapeutic Benefit:** the Charity will need to think about how it is going to evidence therapeutic benefit. This will need to be included in individual patient care plans, records and MHT reports, but it might also be worth looking at the clinical models for each ward and consider if they evidence therapeutic benefit?
6. **Patient Involvement:** the Charity may want to consider how patients are being involved in their care and decisions across the Charity. Is there a greater role for co-production?
7. **MHTs:** with the change in detention periods, the number of tribunal hearings may increase. Does the Charity have the resources to meet this demand?
8. **Nominated Person:** Given patients will be able to change their nominated person more frequently. How is this going to be monitored and complied with?
9. **Electronic Changes:** it is also suspected that regulations and/or the code of practice will allow for greater use of electronic forms and remote MHT hearings. Does the Charity have sufficient IT resources to deal with this change? Can more be done electronically to drive efficiencies?
10. **Resources and Training:** all of this is going require resources and training. Will financial and practical assistance be available from NHSE? It is worth considering the Impact Assessment to the draft Bill (available here) as it considers the administrative impact on healthcare providers (at p25-26).

Stuart Wallace
Head of Legal

16/01/2023

Appendix 1: Detailed Overview of changes relevant to St Andrew's Healthcare

The bill is arranged around fourteen headings that propose to implement the following changes:

1. **Autism and learning disability**

   Clause 1: Application of 1983 Act: autism and learning disability

   - Currently people with a learning disability and/or autistic people can be detained under Part 2 MHA 1983 on this diagnosis alone. The draft Bill changes the definition of mental disorder so that it is split into psychiatric disorder, learning disability and autism. People with learning disabilities and/or autism will only be detainable under Part 2 MHA 1983 if they also have a 'psychiatric disorder'.
   - Patients with learning disabilities and/or autism who have committed a crime will still be detainable under Part 3 MHA 1983.

   Clause 2: People with autism or learning disability

   - CETRs are put on a statutory footing.
   - The RC will have to 'have regard' to the recommendation in the CETR report following the review meeting.

2. **Grounds for detention and community treatment orders**

   Clause 3: Grounds for detention

   - Amends the criteria for detention under s.2, 3 and 5 MHA 1983 and the s.20 MHA 1983 criteria for renewal.
   - The new provisions set out two new tests for detention under s.2 that must be met to fulfil the criteria for detention: firstly that "serious harm may be caused to the health or safety of the patient or of another person" and secondly that the decision maker must consider "the nature, degree and likelihood of the harm, and how soon it would occur."
   - The purpose of this is twofold: (1) Clarify the level of risk of harm a person must present with to be detained; and (2) the clinician will need to consider the likelihood of harm and how soon it will occur.
   - These amendments also apply to the criteria for admission under s.3 and 5 and renewals under s.20.

   Clause 4: CTOs

   - The criteria for a CTO are amended to align with the new risk criteria for detention, which are that firstly that "serious harm may be caused to the health or safety of the patient or of another person" and secondly that the decision maker must consider "the nature, degree and likelihood of the harm, and how soon it would occur." These criteria will also have to be met on renewal.
   - These criteria will also apply to unrestricted Part 3 patients who are to be discharged on a CTO.

3. **Appropriate medical treatment**

   Clause 6: appropriate medical treatment: therapeutic benefit

   - In considering whether medical treatment under the MHA 1983 is "appropriate" for a patient, the definition is being amended so that consideration must be given to whether there is a

reasonable prospect that the outcome of the treatment would have a therapeutic benefit for that patient.

- The definition of "appropriate medical treatment" will be amended so that the treatment must have a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations, to ensure that therapeutic benefit is considered both in relation to the purpose and likely outcome of the treatment.
- This definition will apply to detentions under s.3 and a CTO, so that in order to be detained or put on a CTO, there must be a reasonable prospect of the patient's detention or placing on CTO resulting in a therapeutic benefit to the patient, as well as the purpose of the detention or CTO being for a therapeutic benefit.

Clause 7: Discharge of prisoners etc. from hospital: treatment condition

- Although the test for appropriate medical treatment is being amended, prisoners will still be able to be remitted back to their place of detention if they refuse to engage in treatment or behave in a disruptive manner that means treatment cannot practically be given.

4. The responsible clinician

Clause 8: Nomination of the responsible clinician

- The significant change is that the managers of hospital will have to nominate suitably qualified individuals to act as responsible clinicians.

5. Treatment

- Part IV of the MHA 1983 deals with the medical treatment of certain detained patients

Clause 9: Making Treatment Decisions

- A new s.56A is to be inserted into the MHA 1983, which introduces a duty on clinicians in charge of a patient's treatment to consider certain matters and take a number of steps when deciding whether to give treatment under Part IV.
- This is sort of like a 'clinical checklist and includes:
    - Considering the patient's wishes and feelings as far as ascertainable.
    - Taking reasonably practicable steps to assist and to encourage the patient to participate in treatment decisions,
    - Consult those close to the patient.
    - Identify and evaluate any available forms of medical treatment
- Where certification of treatment is required under the MHA1 1983 n order for it to be given, the SOAD or the AC (if applicable) must confirm in writing whether treatment was given in accordance with the duty under s.56A.

Clause 10: Appointment of SOAD

- A new s.56B is to be inserted to formalise that the CQC is responsible for appointing SOADs.
- SOADs will be responsible for assessing if the patient's treatment has a therapeutic benefit and the new duty under s.56A to consider a number of matters has been complied with.

Clause 11: Medicine etc: treatment conflicting with a decision by or on behalf of a patient

- Introduces a new s.57A which sets out a new safeguard for patients who are refusing treatment either with capacity or competence at the time, or in a valid and applicable advance decision, or where treatment is in conflict with a decision made by a donee or deputy or the Court of Protection (see subsection (1)). These safeguards only apply to medical treatment for

mental disorder falling in the scope of section 58, and those specified in regulations made under section 58 subsection (1)(a).

- Where section 57A applies, and the urgent circumstances under section 62 are not met, then the patient may not be given any forms of medical treatment unless there is a 'compelling reason' to give the treatment and a SOAD has provided certification.

Clause 12: Medicine etc: treatment in other circumstances

- Section 58 is amended to shorten the 3 month period where treatment can be given without SOAD certification to 2 months
- In summary, the conditions for administering treatment to patients will be changed as follows:

	Patient Presentation	Conditions for administering treatment
1	Consenting with capacity/competence at the time	The effect of clause 12 is that, if the patient is consenting to treatment, after a period of two months an AC or SOAD must certify that: • The patient is validly consenting and • the treatment is appropriate (within the new meaning)
2	Refusing treatment with capacity/ competence at the time, or the patient lacks capacity and treatment is in conflict with any valid and applicable advance decision or a decision made by a donee or deputy or by the Court of Protection	The effect of clause 11 is that treatment can be given only if there is 'compelling reason' to do so and certification has been provided by a SOAD, which must provide that: • the treatment in question is appropriate; • the decision to give treatment was made by the AC in line with the duties under section 56A and • in respect of any available alternative treatment/s either the patient has not given valid consent, or they appear to conflict with a valid and applicable advance decision, or a decision made by a donee or deputy or the Court of Protection
3	Lacks capacity/competence and cannot validly consent to treatment	The effect of clause 12 is that treatment can be given but, after a period of two months, a SOAD must certify that: • the patient lacks the relevant capacity/competence to consent; • the treatment is appropriate.

Clause 14: Review of Treatment

- Section 61 MHA is expanded to include patients who are consenting to treatment falling under sections 58 and 58A. The AC in charge of treatment must give a report to the CQC if so required. For patients in receipt of section 58 treatments, an equivalent report must be given to the regulatory authority by the AC when the patient's detention is renewed.

Clause 15: Urgent Treatment to Alleviate Serious Suffering

- Clause 15 removes the power to administer urgent treatment to patients with the relevant capacity or competence on the basis that it considered immediately necessary to alleviate serious suffering by the patient, as is currently permissible under s.62 MHA. This does not apply to patients who lack capacity, including those who made an advance decision.

Clause 16: Urgent Electro-Convulsive Therapy etc

- This clause inserts new section 62ZA, which introduces additional safeguards for patients who have refused urgent section 58A treatments with capacity/competence, either at the time or in a valid and applicable advance decision, or where the urgent treatment would conflict with the valid decision of a donee or deputy, or a decision of the Court of Protection.

Clause 17: Capacity to consent to treatment

- This clause changes the wording of capacity or competence to consent to or refuse treatment so that it reflects the shared legal framework between the MHA 1983 and MCA 2005.

Clause 18: Care and Treatment Plans

- This clause introduces a statutory care and treatment plan with respect to certain patients.
- Clinicians will be required to prepare and regularly review a personalised care and treatment plan for certain patients detained under the MHA. This should set out the patient's current and future needs. It will need to provide evidence of important clinical decisions etc.
- Clause 18 introduces a new section 130ZA which sets out who is eligible to receive the plan, who is responsible for the plan, the scope of the plan, and how it should be reviewed.
- The care plans will need to be prepared by the appropriate practitioner. Regulations are likely to be made setting out what needs to be included in the care plans. The care plans will need to reviewed at certain points such as at MHT hearings, CETR meeting or when the patient or NP makes a reasonable request. When the practitioner prepares or reviews the plan they must do so in consultation with the patient, their family, NP and IMCA.
- A new section 130ZB is to be inserted which sets out how the plans will be monitored to ensure the plans are prepared in accordance with section 130ZA.

6. Community treatment orders

Clauses 19 (Consultation with the community clinician) and 20 (CTO Conditions)

- There is a new duty to involve the community clinician in the use and operation a CTO. If the inpatient RC is different to the community clinician, then the latter will have to agree in writing that the CTRO criteria are met and a CTO is appropriate. They will also have to be involved in any decision to recall the patient to hospital.
- The criteria for including conditions will also change so that they can no long be included if they are "necessary or appropriate" to only where they are necessary to serve one or more purposes specified. The MHT will also have a new power to recommend that the RC consider whether a particular CTO condition is necessary in cases where the MHT has not discharged the patient from a CTO.

7. Nominated persons

Clauses 21 to 25

- Currently, a person detained under the MHA 1983 has a nearest relative appointed, who identified in a hierarchical list set out in the MHA 1983. The patient had no choice as to who their nearest relative was.
- The Nominated Person can be chosen by the person and changed at any point. It is envisaged this will be in advance of detention, at the time of the MHA assessment or during detention. For patients who lack capacity to choose a Nominate Person, an appointment can be made by an AMHP.
- The Nominated Person will have all the rights of the nearest relative, but in addition will have a right to be consulted about statutory care and treatment plans; consulted about transfers between hospitals and renewals and extensions to the patient's detention and CTOs; and a power to object to the use of a CTO.
- The Nominated Person will also have to be consulted (unless it is not reasonably practicable) before the RC makes a CTO.
- The changes to the MHA 1983 set out detailed provisions for the appointment of the nominated person by an AMHP and how to apply to the court to terminate the appointment.
- The role of the nominated person has also been extended to patients remanded to hospital under s.35 for assessment and under s.36 for treatment and those on interim hospital orders under s.38. Nominated persons for restricted patients are limited to them receiving information only – they have no right to object to and admission or to discharge a patient.

8. Detention periods

Clause 26: Detention Periods

- All the periods of detention under s.20 have been reduced:

	Current Period	**New Periods of Detention**
First period of detention for treatment under s.3 MHA 1983	6 months	3months
First renewal	6 months	3 months
Second renewal	Up to 1 year	6 months
Subsequent renewal	Up to 1 year	Up to 1 year.

- Existing periods for guardianship have been retained.
- The shortened detention periods will apply to unrestricted Part 3 patients who have been transferred from guardianship to hospital or whose CTO is revoked, and the revocation occurs six months after the original hospital order was made. The current detention periods are retained for all other unrestricted Part 3 patients.

9. Periods for applications and references

Clause 27

- The periods in which a patient detained under the MHA 1983 can apply to the MHT are all changing:
    - A patient detained under s.2 will have the right to apply to the MHT extended from 14 days to 21 days from the date of admission.
    - A patient detained under s.3 will be able to apply to the MHT from 6 months to 3 months to reflect the change in the shorter periods of initial detention.
    - Conditionally discharged patient who are not subject to a DoL can make an application to the MHT for a review of the detention between 12 months and 2 years from the date on which the patient was conditionally discharged or ceased to subject to DoL conditions, and thereafter every 2 years.

- Conditionally discharged patient who are subject to a DoL can make an application to the MHT for a review of the detention between 6 and 12 months from the date on which the patient became subject to DoL conditions, and thereafter every 2 years.

Clause 28: References to the MHT

- Where a patient chooses not to or lacks capacity to make a request for an MHT hearing in a relevant period, the hospital managers have a duty to refer the patient to the MHT for a hearing. These periods have been changed as follows:
  - Section 2: the hospital managers will have to refer patients who have not had an MHT hearing 3 months from the day they were first detained.
  - Section 3: Hospital managers must refer the patient to the MHT if they have not requested an MHT hearing within 3 months from the day the patient was first detained under section 3, including any period in which the patient was detained under s.2 for assessment. Thereafter, a referral to the MHT should be made 12 months from the date the patient was first detained.
  - CTOs: The hospital managers are under a duty to refer a community patient to the MHT on the expiry of six months, 12 months and thereafter every subsequent period of 12 months from the date on which the CTO was first made.
  - There is now no automatic referral when a CTO is revoked. Where the patient remains in hospital, the patient is treated as if the period of detention started on the date on which the CTO was revoked. The hospital managers will be under a duty to make a referral to the MHT on the expiry of three months, 12 months and thereafter each subsequent period of 12 months from the date that the CTO was revoked.
  - Automatic referrals for all Part 2 and unrestricted part 2 patients will be reduced from 3 years to 12 months.

Clause 29: References to the MHT for patients involved in criminal proceedings

- The automatic referral period for restricted patients is to be reduced from 3 years to 12 months.
- For patients who have been conditionally discharged, the MHT will have the power to vary or impose conditions to which the patient is living, including DoL conditions.
- Conditionally discharged patients will be automatically referred to the MHT in the first 2 years and 4 years thereafter for cases with no DoL and in the first 12 months and then every 2 years for cases of conditionally discharged patients who are subject to a DoL.

10. Patients concerned in criminal proceedings or under sentence

Clause 30: Conditional discharge subject to deprivation of liberty conditions

- A new power for MHT and the Secretary of State is to be created to place conditions that amount to a deprivation of liberty on a patient as part of a conditional discharge.
- These conditions will only be in a small number of cases where a patient has complex needs and poses a high risk of harm to the public through violent or sexual behaviour, which results from their mental illness, but are no longer benefiting from the extremely restrictive regime of detention in hospital.
- Such conditional discharges will take place where the Secretary of State or MHT are satisfied that they are needed to protect the public from significant harm.

Clause 31: Transfers from prison to hospital

- There is a new statutory 28-day time limit within which individuals with severe mental health need must be transferred from prison to hospital for treatment under the MHA.

11. Help and information for patients

Clause 34: Independent Mental health Advocates (IMHAs)

- Voluntary patients now have a statutory right to access an IMHA.
- Hospital managers will have a statutory duty to inform providers of advocacy services about qualifying patients. The advocacy services will then have duty to arrange for qualifying patients to be interviewed to find out if they want to use the IMHA services.

Clause 35

- There will be a statutory duty to provide patients and NPs with complaints information. This information must be provided both verbally in writing as the hospital mangers will be under a duty to ensure patients understand how to exercise their right to complain.

12. After-care

Clause 38

- Where a MHT does not direct the discharge of a Part 2 patient or community patient during an application or referral to the MHT, the MHT is empowered to make certain recommendations regarding the patient's care, with a view towards facilitating the discharge of the patient on a future date. These powers of recommendation are set out in section 72(3) and (3A) of the MHA, which also provides the MHT with the power to reconvene to reconsider a case in the event that any such recommendation is not complied with

Divisional Presentation
Rosie & Keith's
Road to recovery
at Broom Cottage

Presentation on the day

Dawn Chamberlain & Dr Paul Stankard
And Patients

Questions from the Public

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Meeting Reflections

"What would our patients and staff think about our discussions today?"

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public

Friday 31st March 2023 9.30am

(Paul Burstow - Verbal)

Annex A
Governance Oversight Group Update

Governance & Risk Project

Board Update January 2023

Project Headlines

- Cross-referencing of Terms of Reference with the Matters Reserved and new Authority Matrix - Complete
- Final reviews of Terms of Reference for ARC, QSC, People Committee, FinCom and NomRemCo – Out for consultation
- Socialising of Terms of Reference with Committee Chairs and Executives responsible – Reviewing initial feedback
- Matters Reserved updated to reflect new Authority Matrix and new Terms of Reference – pending further input from Legal
- Project Plan will be further developed for more detail for final 6 months of the project.

Timeline Summary & Milestones

The project remains on target for completion in July 2023, with the following milestones in the coming months:

- Terms of Reference to be ready for agreement and adoption by all committees by the end of Q1 (April 2023)
- Revised Governance Structure and Assurance Map to be ready for agreement by the end of Q4 (March 2023)
- Board Code of Conduct adoption Q1 (April 2023)
- Skills Matrix format to be finalised ready for roll out the following month after the annual declarations process (End of April 2023)

Work in Progress

- New Board Terms of Reference to be developed after Matters Reserved reviewed
- Research and Education – work to commence on alignment with Education and develop Terms of Reference to reflect this
- Board Code of Conduct – final review prior to issue for comments
- Skills Matrix – final reviews prior to initial issue in April for completion
- Assurance Map – drafted, to include the new Quality Governance structure. Further review for alignment with assurance levels prior to adoption.
- Meeting templates – revisions and benchmarking to comparable trusts.

Risk Summary

Risk Register

Risk ID	Risk Title	Brief Risk Description	Initial Risk Ratings			Existing Controls	Current Risk Ratings			Current Risk Trajectory
			Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	
April/001	Project Scope	The project scope may not be well defined or incomplete resulting in poor effectiveness and potential project failure	Moderate	Possible	High	Development of Project Initiation Document outlining full scope of project taking into account E&Y review, and additional Charity requirements. [PE]	Insignificant	Rare	Low	⇔
April/002	Priorities	Lack of control of staff or charity priorities or unanticipated events may lead to project disruption, delay or non-delivery	Moderate	Possible	High	Clear communication with GOG and key stakeholders in order to mitigate any potential adverse occurances [PE]	Minor	Possible	Medium	⇔
April/003	Communication	Lack of effective communication and oversight could result in lack of confidence in the project by the Board and the Charity	Moderate	Possible	High	Regular project reporting and 1:1 meetings with key stakeholders. Regular GOG meetings [E]	Minor	Possible	Medium	⇔
April/004	Dependencies	Key person dependencies being compromised may lead to project slippage	Major	Possible	High	1:1 meetings with stakeholders and GOG meetings in order to provide forum for discussion and mitigation if necessary [E]	Insignificant	Possible	Low	⇔
April/005	Project Resourcing	Insufficient resources and bandwith due to recruitment issues, lack of applicants, lack of experience or market forces could result in poor delivery of objectives and project slippage	Major	Possible	High	Regular communication with HR and Recruitment in order to ensure that effective resourcing is in place. [PE]	Minor	Possible	Medium	⇔
April/006	Sustainability	Failure to adopt the framework and sustain the principles across the Charity	Moderate	Possible	High	Embedding and monitoring phase of project will utilise effectiveness reviews and internal audit to ascertain progress and level of adoption and understanding [E]	Insignificant	Unlikely	Low	⇔
April/007	Timeline	Additional and unprecedented risks being identified thereby adversely affecting the length of the project	Moderate	Possible	High	Clear communication of potential slippage to stakeholders and GOG in order to mitigate as quickly as possible. [E]	Moderate	Unlikely	Medium	⇩