CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Thursday 28th March 2024 at 9.00 am

The Board Room, St Andrew's Essex, Pound Lane, Benfleet, SS12 9JP
& Microsoft Teams

		Purpose	LEAD	Page No.		Timing
1.	Welcome and Apologies	Information	Paul Burstow		*3*	*09.00*
Administration						
2.	Declarations of Interest	Information	Paul Burstow		*4*	*09.01*
3.	No previous minutes for approval				*5*	
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*6-8*	*09.02*
Chair's Update						
5.	Chair Update	Information	Paul Burstow		*9*	*09.10*
Executive Update						
6.	CEO Report	Information	Dr Vivienne McVey	✓	*10-15*	*09.20*
Committee Assurance Reports						
7.	**Committee Updates**				*16*	
	• Quality & Safety Committee (19/12/23)	Assurance	Steve Shrubb	✓	*17-19*	*9.40*
	• Audit & Risk Committee (25/01/24)	Assurance	Rupert Perry	✓	*20-21*	
	• Research Committee (07/02/24)	Assurance	Karen Turner	✓	*22*	
	• People Committee (08/02/24)	Assurance	Dawn Brodrick	✓	*23*	
	• Quality & Safety Committee (27/02/24)	Assurance	Steve Shrubb	✓	*24-26*	
Operations						
8.	Integrated Quality & Performance Report, incorporating: • Quality Scorecard • People Scorecard • Finance Overview	Assurance	Dawn Chamberlain, Stacey Carter & Dr Ash Roychowdhury	✓	*27-36*	*10.10*
Any Other Business						
9.	Questions from the Public	Information	Paul Burstow		*37*	*10.30*
10.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*38*	

11.	What would our patients and staff think about our discussions today?	Information	Paul Burstow		*39*	
12.	Date of Next Meetings: Friday 17th May 2024	Information	Paul Burstow		*40*	
Meeting in Public Closes at 10.35 am						
Break 10.35 to 10.45 am						
Service and Patient Story						
13.	Essex wards walkabout (small groups)	Information	ALL			*10.45*
14.	Essex ward reflections and feedback	Information	ALL			*11.45*
Working Lunch 12.00 – 12.15 pm						

Annexes - Items for information only	**Lead**		
Annex A – Quality & Safety Update Appendices: ○ Mechanical Restraint Reports (Dec & Feb) ○ MHLSG updates (Dec & Feb) ○ QSG update (Feb) ○ Charity QIP (Feb) ○ Safer Staffing & Establishment Report (Feb)	Steve Shrubb	✓	*42-78*

Welcome & Apologies

(Paul Burstow– Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

No previous Minutes for Approval

(Paul Burstow)

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
20.11.23 **01**	**CEO Update – Deaf Services Board session** DL to liaise with DC and the Service Director to organise a Board awareness session from the Deaf Service.	DL & DC	28.03.24	CLOSED	**28.03.24 –** Scheduled for July Board meeting **Propose to close action**
20.11.23 **02**	**IQPR** DC agreed to look into the dissatisfaction scores within MS and reply to RB's question regarding how they would be addressed	DC	28.03.24	CLOSED	**28.03.24 –** Response: We would recognise that our patients in medium secure services are often dissatisfied due to the restrictions placed on them and it can be even more challenging to engage and empower them. In this context the Medium Secure Division have refreshed their approach and now have 'you said' we did' boards up on every ward and the Quality Matrons are leading on ensuring that patient feedback is responded to – this is then discussed at the Matrons clinics with actions to improve. Dean Robinson as the Associate Director of Nursing is taking overall responsibility for this in the Division. **Propose to close action**
20.11.23 **03**	**Board ToR – Board attendees** DL to clarify Executive membership and attendees and update the ToR as required.	DL	28.03.24	CLOSED	**28.03.24 –** Minor revision made to membership section of ToR to clarify Executive membership. NB: Revised ToR included within Annexes **Propose to close action**

31.03.23 **04**	**People Committee update – Non-Exec Mandatory Training** A review of Trustee related mandatory training to be undertaken, in conjunction with the Nomination and Remuneration Committee, that includes the consideration for a passport approach for using comparable training completed within the NHS.	RB, DL & SC	~~21.07.23~~ ~~28.09.23~~ ~~30.11.23~~ 28.03.24	CLOSED	**28.09.23 –** To be done in conjunction with work being completed on the Board skills matrix (via NomRemCo), this is to be concluded by November. Whilst a passport style approach will be considered, L&D currently accept comparable training at NHS Trusts and update NED records accordingly. Meeting with L&D scheduled for Sept 21st **30.11.23 –** Aligned with actions from NomRemCo and to be concluded in the New Year. In the meantime any comparable Trustee training completed within the NHS is acknowledged within their training records. To be revisited at March Board **28.03.24 –** New process now provisionally agreed with L&D to cover NED passport style training record and confirmation of required training courses and frequency. Update to be provided to next NomRemCo. **Propose to close action**
21.07.23 **02**	**CEO Update – Research partnerships** Future ERT updates to include updates on research partnerships, clearly outlining the approach by the Charity to ensure full value is received.	SK	~~28.09.23~~ 28.03.24	Open	**28.09.23 –** Propose that action is moved from KM to SK, with action remaining open for update at November Board. **30.11.23 –** Update to be received at next Board (now confirmed as March 2024) **28.03.24 –** ERT update is included within the CEO Report in Part 2 as well as Item 10 on the Part 2 Agenda

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors		
Topic	CEO Board Update	
Date of Meeting	Thursday, 28 March 2024	
Agenda Item	**6**	
Author	Dr Vivienne McVey, CEO	
Responsible Executive	Dr 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 Focus Area	Voice Community Quality Service Development Workforce Learning and Research Financial Sustainability	☒ ☒ ☒ ☒ ☒ ☒ ☒
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 March Board of Directors.

Appendices –

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.

Three highly respected members of our Charity have died since the last Board meeting: Michelle Kirk (Pharmacy), Marian Reidy (Main Building Reception) and David Laing CBE, (Governor). We are grateful for their loyal service and extend our best wishes to their family and friends.

As previously discussed with the Board, the Executive Team is currently in the middle of delivering what is perhaps the most challenging part of the Thrive programme, as well as ensuring we are delivering our strategy, improving quality and managing the risks across the organisation.

Financial performance has continued to exceed the forecast presented to the Board in November 2023, with the positive performance consistently achieved over recent months. Although this improved performance is reflected in a positive position for the 2023/24 financial year, new financial challenges exist as we move into 2024/25. A more detailed summary will be presented along with the four-year financial plan in Part 2 of the Board meeting.

Securing the growth of our services along with developing our capability and processes to support growth will become increasingly important in 2024/25. At our last Board meeting we talked about the opening of Lime Tree Cottage, a transitional house in our grounds. A thorough 'lessons learned' process was undertaken during February/March which will help inform our developments of the future, and also inform how we structure and resource teams across the organisation as we fulfil our growth plans.

1. Strategy

As we close the first year of our five-year strategy we reflect on the milestones that we set collaboratively with patients and staff for 2023/24. As can be seen from the table below, we have made significant process towards our mission to be a leader in transforming the lives of people with complex mental health needs.

Review of the 23/24 milestones for each of the strategic ambitions						
Voice	Social Impact	Quality	Service Development	Workforce	Research & Education	Financial sustainability

As we move into 2024/25 we continue to refine our strategy and we have evolved the ambitions that come together to achieve our mission. We have recognised that we are using data in innovative ways to further patient outcomes and experience and to improve operational effectiveness, so with this in mind 'data' has now become one our ambitions. In line with this change, we have identified enablers that support the achievement of our ambitions, and 'financial sustainability' becomes one of our key enablers.

We have organised our ambitions into groups that help to summarise our focus: **Champion** – we champion the voice of people with complex mental health needs, **Leading Provider** – we provide leading services for people with complex mental health needs, and **Expert** – in order to be great at what we do, we must be experts, this means we employ and investment in the right people, we research to drive forward patient outcomes and we use data to inform our decisions.

In order to deliver the above we have ten strategic plans setting out our approach to achieving our ambitions and the role our enablers take. We are currently finalising our milestones for 2024/25.

For us, co-production is cultural and to that end we are striving to work increasingly collaboratively with those in our care, and their carers, as we continue to implement and refine the strategy.

We have invited patients, carers, staff and volunteers to our new Annual Round Up scheduled to take place 26 March. We have patients and people with lived experience as part of the production team and we will be sharing a look back on 2023/24 as well as looking forward to the coming year. There will be opportunities for questions and a sign-up session, seeking volunteers to be involved in helping to shape key activities across the Charity in the coming year.

2. People and Culture

Wellbeing week - March 18 – 22 saw us host a range of exciting wellbeing events. These covered financial, emotional and physical wellbeing. Activities included free health checks for the over 40s which were delivered free by Northampton Town Football Club. Massage and yoga taster sessions and even forest bathing were also available. Many of the events were open to patients too!

Hope Award nominations now open - This year's Annual Awards will be held on the evening of Thursday 23 May to celebrate nominated outstanding people who inspire hope every day. Nominations are now open with entries closing at the end of March.

Allocate for all - April will see the roll out of Allocate, our rostering system to all colleagues across the Charity. This will provide one place for all colleagues to record annual leave and any other absences. The system also allows colleagues to review and book their annual leave via an app called Loop.

People plan - Work is ongoing to finalise the People plan which will set out our people vision to support the Charity strategy. A full update will be shared with the board in May.

3. Quality including CQC

CQC inspections and Preparation - The action plan from the July inspections for Men's and Women's have been submitted back to the CQC and are being progressed through the Charity and Divisional QIPs as appropriate.

The Quality Account for 2023/24 is being prepared and draft priorities for 2024/25 have been identified through liaison with staff, patient groups, the Executive Team and the Quality and Safety Committee. The Quality Account will contain new sections on Informatics/Data and CQI, areas previously not covered.

Mental Health Learning Event: *East Midlands Alliance in partnership with Health Innovation East Midlands: Caring Together: Improving Safety Through Experiences*. Dr Sanjith Kamath co-chaired and I gave the keynote talk at this meeting in Nottingham earlier this month, attended by all our EMA partner organisations. I was proud that our Peer Support Workers were strongly represented and we presented a number of posters on improving patient safety. The workshops were co-facilitated by Experts with Experience from across the region and this led to some powerful learning on prevention of suicide, reducing restrictive practice and improving sexual safety in inpatient settings.

4. Estates & Facilities

Workbridge Retail were thrilled to both be the venue and provide support for the 'Car Meet' on Friday 2 February, organised by our Communications team. Over 200 cars and enthusiasts attended with live television coverage from ITV News. The event represented the evolution of the 'Breaking Silence' car meetings established last year, which supports young people's mental health. It was wonderful to have the support of a work experience patient who worked tirelessly with the team on the BBQ. The 'Breaking Silence' meetings now run fortnightly, supporting our community's mental health and wellbeing.

Main Building Consolidation: We have commenced a project to substantially consolidate the occupation of the Main Building. The intentions are twofold: to maximise our occupancy of the central core, thereby vacating the outer wings and placing these out of use to reduce our expenditure, and to better manage the physical occupation of the building from a health and safety perspective. Our Education, Research and Training teams are consolidating their operations within the building and exiting the Braye Centre on a phased basis to allow this to be released for re-purposing.

5. Operations

The Clinical Services Senior Leadership Team (SLT) has been established to progress the continuous improvement required across our Clinical Services. The core membership includes the following:

Chief Operating Officer, Deputy Medical Directors, Director of Nursing, Director of Operations, Deputy Director Quality, Director Psychology, Allied Health Professional Lead, Interim Director of Social Work, Director Finance, Deputy Director of HR.

The SLT meets weekly with the following cycle every month:

Performance SLT:

- In partnership with Chief Clinical Information Officer and Chief Data Officer
- Receiving the monthly outputs from the Divisional Quality Performance Reviews (QPRs) and ensuring shared learning and Charity-wide processes for improvement across quality and workforce measures as well as finance and material risks
- Development of stronger external performance reporting to commissioners in partnership with Head of Contracts & Pricing

Business Development and Clinical Estate SLT:

- In partnership with Business Development and Estates & Facilities
- Development of new business in line with Executive strategic intent
- Ward moves coordination following Exec approval

Programmes & Projects: (see Part Two for proposed programmes)

Operational BAU SLT (replaces OpComm)

- In Partnership with Service Directors, Estates & Facilities and IT
- Operational policies & procedures
- Reports from five sub-groups: Safety & Emergency Planning (including H&S and EPRR), Security Sub-group, Creative Recruitment, E&F prioritization, IT delivery relevant to Clinical Services

6. Communications

Awards: We reached the finals in four categories at the Third Sector Awards earlier this month. Although we didn't win any of the awards it was very gratifying to be recognised for our co-production and data innovations, compassion and campaigning (see below). Additionally, we have been shortlisted in the Health Investor Awards, within the Specialist Care Provider category. Internally, we are getting ready for our own Annual Awards ceremony with official launch of our nominations process. This year, there is a real focus on encouraging staff to submit good quality submissions, as we want to hear about the frontline colleagues who are really helping to inspire hope and transform lives among our patients.

Front page news: Dr Muthusamy Natarajan, Consultant Psychiatrist and Clinical Director for our Neuropsychiatry Service is the cover star of the latest edition of Neuro Rehab (NR) Times. In the cover feature he shares the exciting news about the opening of our new brain injury ward. Church ward, which opens in the spring, which becomes the fifth specialist ward within the male brain injury pathway.

Data drive: Murtz Daud, our Chief Data Officer, has been recognised as one of the most influential people in data. Murtz who was pivotal in introducing a data platform to our Charity has been named on the DataIQ 100, a list of 100 chief data officers from across the UK.

Sleep study: We have had local news coverage on a sleep study working in partnership with Loughborough University. Sarrah Fatima, a researcher here is looking at how various factors can contribute to insomnia and poor sleep quality in secure psychiatric inpatient populations and how to tackle them.

Successful patient story: A patient from our Deaf service on Fairbairn ward has been working in the community part-time at Workbridge. The 26-year-old has been making granola behind the scenes at Daily Bread since October. Staff there have been praising his efforts and have said he has become a valuable part of the team.

Your Voice Survey: Following the progress of our Thrive Programme, and as we continue to embark on our new strategy to become a leader in caring for those with complex mental health needs, we want to ensure that our staff are happy and engaged. Therefore, at the start of June we will be launching a full Your Voice Survey, which will give individuals the chance to have their say about their roles, teams, leadership, wellbeing and development.

Other internal projects: Communications are also supporting a number of internal projects, including the full rollout of Allocate, Wellbeing Week and the patient TV upgrade.

7. Voluntary Services

Our Voluntary Services remain very active, delivering some great work. We are proud to have been put forward for the Kings Award for Volunteering which will be announced in November. Two of our volunteers have been invited to attend a Royal Garden Party at the palace in May in recognition of the amazing work they have been doing. During February we actively engaged with a number of organisations who either currently work with us on schemes or who are interested in partnership activities including Hermes, John Lobb, Stone Technologies, RICOH and Nationwide. These are early discussions as part of our future corporate partnership programme which links into fundraising and sponsorship.

I am happy to answer any questions on any of the issues above.

Dr Vivienne McVey
Chief Executive Officer

Committee Updates

Quality & Safety Committee
19/12/23
(Steve Shrubb)

Audit & Risk Committee
25/01/24
(Rupert Perry)

Research Committee
07/02/24
(Karen Turner)

People Committee
08/02/24
(Dawn Brodrick)

Quality & Safety Committee
27/02/24
(Steve Shrubb)

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meetings: 19 December 2023

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- The new material risks relating to Occupancy and Leadership within the LDA Division were discussed, with it being agreed that the solutions and support for LDA outlined by Executives would be given time to embed before an update would be brought back to the Committee. It was noted, that if challenges continued within LDA, then the QSC would allocate time for a focus session .

Key issues/matters discussed:

- **CQO Quality Update**
  The update was discussed, with the Committee discussing the various aspects of the report, particularly the work being done on policies, along with the actions included within the Charity QIP. Measurement of the impact of completed actions was discussed with the impact of the dashboards indicating ongoing progress being noted. It was noted that outcomes were now highlighted within the report and also agreed that a Committee seminar be scheduled to discuss further the impact of actions on patient outcomes.

- **Quality Risk Management**
  Those risks relating to quality were discussed with the Committee noting and accepting the adequate assurance offered.

- **Safer Staffing**
  The Committee received the report and were informed on the new way in which staffing requirements would be driven by care plans and then extracted from RiO, resulting in an advanced understanding of staffing across the Charity, with the process underpinned by staff huddles, providing the check and challenge element which was still required. Thanks were extended to the team and to the leaders who had given their direction and support in being able to attain the current situation.

- **Mechanical Restraints and Use of Force**
  The Committee received the report, and noted the levels of use. It was agreed that further consideration would be given to MoJ stipulations prior to a meeting with the Director for Health and Justice in NHSE.

- **Safeguarding**
  The report was presented to the Committee where it was acknowledged that discussions were ongoing with the local authority with regard to the levels of reporting and subsequent Section 42 reports. The reduction in self-harm was noted, along with work being done by the Director of Social Care who would look to integrate safeguarding further into operations via social work. The improved levels of training

were acknowledged, and that levels of aggression had greatly reduced from the previous year.

- **Serious Incident and Patient Safety Incident Response Framework (PSIRF)**
  The Committee received a report outlining the Charity's transition from SI reporting to PSIRF and discussed how the new framework would differ from the previous reporting. It was agreed that the policy would return to the Committee for formal approval at the next meeting, prior to being recommended to the Board.

- **Rapid Review into Mental Health**
  A report was received by the Committee on the recommendations within the report, and approaches to the data requested. DL confirmed to the Committee that NomRemCo had noted the MHA aspects and that he would liaise with the MHA team on related training for Board members and report back to the Committee. The Committee discussed the IT aspects of the report, noting the timelines involved with implementation of the recommendations.

  Leaders (including Non-Executive board members) with lived experience was also discussed with it being suggested that this could also be covered at NomRemCo from a Board skills matrix perspective, along with the involvement of Governors.

- **Patient and Carer Experience Strategy**
  The strategy was presented to the Committee with it being noted that it was an part of the Quality improvement along with the Voice Strategy. The strategy had been developed to ensure the voice of patients and carers are heard and they involved in the development of the charities services .It was acknowledged that engagement was an important step in the this process The Committee proposed to support the strategy, (but felt that further work was required to ensure that the patient/carer strategy and the voice strategy were integrated).

- **CAMHS – Update to new model**
  An update on the new model being adopted within CAMHS was presented, preceding a fuller update in February. The Committee acknowledged that the feedback was that the model had been positively welcomed and gave consistency. It was also noted that the model was already in use elsewhere in the system, as a result of national policy.

Decisions made by the Committee:

The Committee considered the following reports and agreed that they could be submitted to the Board for approval:

- None

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- NomRemCo to consider lived experience to be included to the Board Skills Matrix

Issues Escalated to the Board of Directors for Decision:

- None

Appendices (included at Annex A):

- Mechanical Restraint Report
- Mental Health Law Steering Group Update

Committee Update Report to the Board of Directors

Name of Committee: Audit and Risk Committee

Date of Meeting: 25 January 2024

Chair of Meeting: Rupert Perry

Significant Risks/Issues for Escalation:

- **Strategic Risks (BAF)**
  Following the Board's request for ARC to consider the Charity's strategic risks, the Committee considered and supported the inclusion of the estates risk within the BAF, along with the proposal to escalate the material risk relating to culture as an eighth strategic risk. The Committee also considered and approved the proposal to change reporting frequency of the BAF to full review three times per year, as opposed to the current bi-monthly basis.
  The Committee agreed:
    - That the correct and appropriate risks had been identified and recorded and that they encompassed the expected consequences.
    - That the reported risk scores were accurate and in line with the Committee's understanding.
    - That the identified controls and sources of assurance were appropriate
- **Charity Risk Appetite Review**
  The Committee considered and discussed the paper which proposed to revisit the operationalisation and embedding of risk appetite whilst actively managing risks across the Charity, ahead of the formal review of the Charity's Risk Appetite Statement later in 2024.
  Whilst the current statement, written in 2022, developed against nine key risk domains would meet key regulatory requirements, it was felt that the risk appetite had not been as embedded into key decision-making processes as required and that further work was required to integrate it into the risk management framework. Following discussion, it was agreed that review of the risk categories would be undertaken and presented to Board with the corresponding appetite level. The timescales involved in developing the categories and appetite, along with the anticipated 12 month period of embedding were acknowledged.

Key issues/matters discussed:

1. **External Audit**
   Grant Thornton updated the Committee on early progress with the external audit, noting an interim visit due at the beginning of February 2024. There were no significant changes to the plan to report. The external audit plan, strategy and fees were considered and approved by the Committee together with the statutory risks reported. The Committee discussed the timetable, with it being noted that the timescales were as previous years with all meetings in place to ensure milestones would be met.

2. **Risk Management**
   The Committee received and noted the risk management update, along with the addition of two new material risks, and two material risks escalated to strategic risks. Functional risk scores remained stable, with some retired since the previous report. Plans to link risks to policies and procedures were discussed and noted as ensuring

that the correct risks were captured and documented. The Committee particularly noted the increased review and management of risks within the Charity and agreed that there were no additional risks which required escalation.

The Risk Management Effectiveness Review was presented to the Committee, with the self-evaluated score of 3.01 reported, which indicated an improvement from the previous score from EY contained within the Governance and Risk Review (Aug 2021) of 2.25. The Committee noted the aim of gaining a rating of 3.50 by later in 2024 which would indicated an evolved status. The Committee noted the adequate assurance offered.

3. **Internal Audit**
   The Committee received and noted the adequate assurance offered by the paper along with the progress made on the delivery of the Internal Audit plan for 2023/24, together with the update on the implementation of actions agreed by management. The Internal Audit Framework (IAF) was discussed, with it being noted that it was subject to active management by Executives and the Operational Delivery Committee.

   The draft Internal Audit Annual Plan for 2024/25 was received and approved, with it being acknowledged that the plan had been prepared with a reasonable degree of flexibility in order to ensure that it continued to reflect both current and emerging risk areas.

4. **Counter Fraud**
   An update was presented to the Committee, with one open investigation noted. It was acknowledged that due to the timescales involved and lack of progression on the investigation that closure would be considered. The Committee also discussed and were assured with regard to the proportion of time spend on Counter Fraud activity, with clarification on the contractual requirements being highlighted.

Decisions / Approvals made by the Committee:

- Approval of the fee structure proposed by Grant Thornton for the external audit.
- Agreement to the statements relating to the Charity's Strategic Risks
- Approval of the draft Internal Audit Plan for 2024/25
- Agreement that following review of the risk categories, the revisions and corresponding appetite levels would be presented to the Board for consideration

Implications for the Charity Risk Register or Board Assurance Framework:

None

Issues/Items for referral to other Committees:

None

Issues Escalated to the Board of Directors for Decision:

- There were no issues deemed necessary to escalate for decision.

Appendices **(included within the Annex section of Board pack):**

- None

Committee Escalation Report to the Board of Directors

Name of Committee: Research Committee

Date of Meeting: 7 Feb 2024

Chair of Meeting: Sanjith Kamath (Karen Turner to be Chair for future meetings)

Significant Risks/Issues for Escalation:

Key issues/matters discussed:

1. R&I Strategy
2. Wills and Research Donations
3. Centre for Progressive Neurological Conditions
4. MeOmics Commercial collaborations

Decisions made by the Committee:

1. Create Subgroup of committee to review existing strategy and identify priorities
2. R&I and Business Development to meet to discuss funding opportunities
3. RC endorsed proposal for CPNC to open 1st April
4. Decision pending on recommendations

Implications for the Charity Risk Register or Board Assurance Framework:

Potential Risk Register amendment required dependent on MeOmics commercial recommendation.

Issues/Items for referral to other Committees:

None

Issues Escalated to the Board of Directors for Decision:

None at this time

Appendices:

Committee Escalation Report to the Board of Directors

Name of Committee: People Committee

Date of Meetings: 8th February 2024

Chair of Meeting: Dawn Broderick

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- **Thrive Programme-** discussion on progress with particular focus on people elements of the programme.
- **Establishment review** update provided to the Committee and discussion around enablers to the programme.
- **People KPIs-** the Committee received a report on People KPIs relating to January 2024 data. Sickness had increased in line with previous seasonal trends however training and voluntary turnover were both showing an improving trend.
- **Equal pay audit** -findings shared, no concerns identified with current approach.
- **STEER committee** -update provided to the Committee on the progress of the group and positive feedback to date. Staff network groups now attending.

Decisions made by the Committee:

- None

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meetings: 27 February 2024

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- **QIP & CQO Quality Update**
  The update was discussed, with the Committee discussing the various aspects of quality improvement, particularly the work being done on the digitalisation of recording systems in order to foster greater assurance. The transition period was noted as being important in order to ensure a smooth roll out and that staff were fully versed in the changes implemented. It was agreed that LDA would be a focus area at the next meeting with the corresponding QIP being included in the reporting.
- **Quality Risk Management**
  The Committee reviewed all assigned quality risks noting the two risks relating to meaningful activity and security at Birmingham as being recently escalated as Material. It was agreed that a further report on the new CAMHS clinical model be brought to the Committee for discussion. The Committee welcomed the escalation of the Culture material risk to being seen as a Strategic Risk within the Board Assurance Framework and agreed to review how focus could be given to this risk by the Committee in future meetings. A workshop on risk management would also be scheduled to give the Committee greater insight into the background, process and reporting of risk.
- **Clinical Audit Plan Progress**
  An update on the current plan was presented with it being agreed that the format adopted for ARC would be beneficial in the future, which would include assurance levels against each audit completed. Assurance was gained on clinical audit actions now being owned by specifically assigned Governance Groups.
- **Quality Surveillance and Visit Updates**
  The key issues were outlined to the Committee along with an update on the KLOE inspection process. The Committee noted the results of an NHS Wales inspection, with the highest rating being achieved.
- **Mechanical Restraints and Use of Force**
  The Committee received the report, and noted the actual recorded levels of use. The development of a MR dashboard within Datix was noted, along with the next step of including MR within the IQPR.
- **PSIRF Policy**
  The policy was presented to the Committee, with response times being discussed. It was noted that the current SI reporting would continue until Autumn 2024. The Committee fully supported the policy and AGREED to its adoption.
- **Safer Staffing & Establishment Review**
  The Committee received the report and were informed that the new clinically informed

dashboard had gone live. The new dashboard included seclusion information along with information regarding enhanced observations. The Committee were updated on the conclusion of the Establishment Review, and its outcomes. It was noted that this review was the most clinically informed review date and was in line with National Quality Board guidance. Discussions regarding how staff viewed the review and how challenges, particularly regarding night staff were undertaken. It was also noted that the MDT team were now not included within care hours, along with wards being shown the flexibility they now had with regard to the utilisation of their care hours especially during night time.

- **My Voice & Patient Feedback**
  The Committee received an update on patient experience with it being noted that ultimately, the wards would own the process, in order to better receive feedback and be in a better position to foster a co-productive way of addressing improvements. The Committee agreed that a better understanding of the strategies involved and how they interacted would be important.
- **Quality Account Priorities**
  The Committee discussed those priorities suggested and agreed that drafts of the three main topics would be circulated to the Committee prior to the Draft Account being presented in April.

Decisions made by the Committee:

The Committee considered the following reports and agreed that they could be submitted to the Board for approval:

- PSIRF Policy

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices at Annex A:

- Mechanical Restraint Report
- Mental Health Law Steering Group Update
- Quality Safety Group Report
- QIP
- Safer Staffing Report

Paper for Board of Directors	
Topic	Integrated Quality & Performance Report
Date of Meeting	Thursday, 28 March 2024
Agenda Item	**8**
Author	Anna Williams (Director of Performance), Stacey Carter (HR Director) and Ash Roychowdhury (Chief Quality Officer) – supported by the Clinical Services SLT.
Responsible Executive	Vivienne McVey
Discussed at Previous Board Meeting	Routine paper
Patient and Carer Involvement	My Voice patient feedback included in the paper
Staff Involvement	This paper builds from ward governance, divisional governance, divisional IQPR, Exec IQPR to Board – varying staff groups are involved through from ward to Board.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S ☒ E ☒ C ☒ R ☒ W ☒**
Strategic Focus Area	Voice ☒ Community ☒ Quality ☒ Service Development ☒ Workforce ☒ Learning and Research ☒ Financial Sustainability ☒
Committee meetings where this item has been considered	The relevant sections are assured via the aligned committees.

Report Summary and Key Points to Note

The IQPR process has been evolving – enabled by the inception of the Senior Leadership Team (SLT) in Clinical Services.

The monthly IQPR reviews with each division are now chaired by the SLT. These are drawn together and reviewed in aggregate at a monthly performance version of the Clinical Services SLT – which is chaired by the COO. From here the IQPR is reported to the Executive team meeting and then culminates in this report to the Board.

Enabled by the development of the Operating Plans the BAU performance review will be broadened to include the functions of the wider Charity. Balanced scorecards are being considered, as a means of communicating the core performance metrics, associated expectations and actual outturn.

Appendices

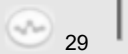
St Andrew's Healthcare Integrated Quality Performance Report

for Quality & People reviewing the period ending January 2024

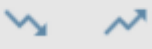
see CEO report financial performance

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 

Performance headlines

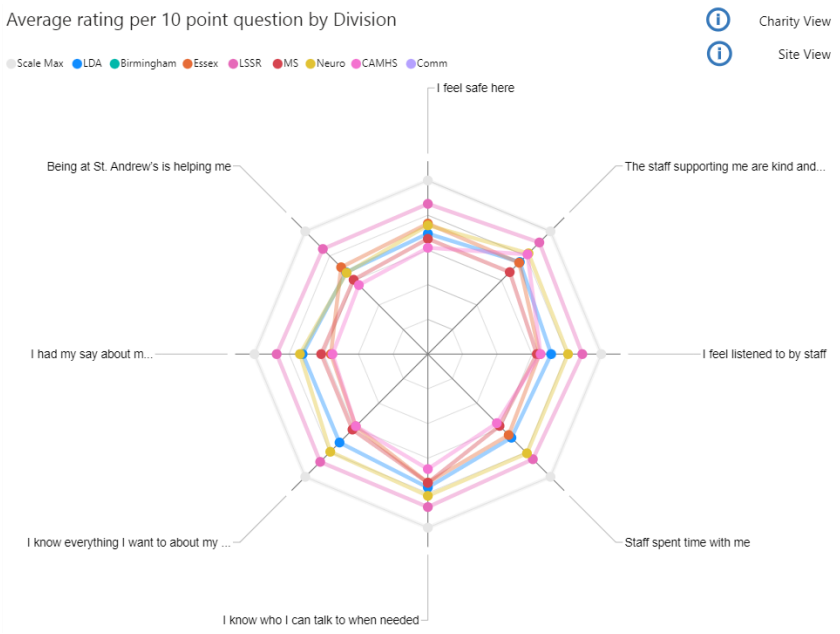
What has gone well

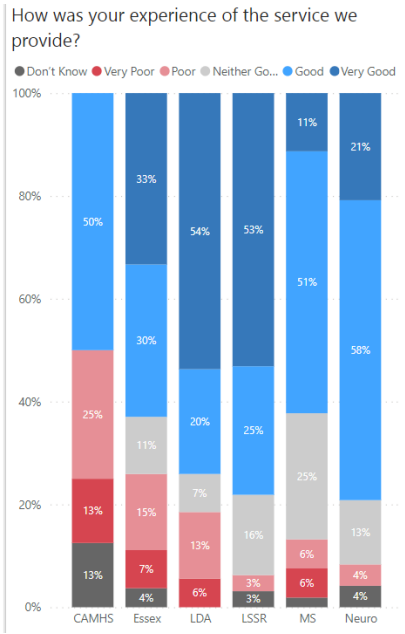
- **Discharge destination** – 72 people were discharged in Dec & Jan, with just over 50% moving to a lower security level – 97% of those remaining at the same level moved closer to home and a further 30 were transitioned by PICUs
- **Incidents –** seven consecutive months below average for total incidents and Level 1 incidents
- **Special cause improvements in violence and restraints** at Charity level, driven by CAMHS and MSU
- **E-obs compliance – continued strong performance** with a further reduction in the number of missed or late observations
- **New supported transition service open –** providing a next step not available in the community
- **All but one of the people metrics remain favourable to target:**
  - Voluntary turnover, in year – meeting target and showing a statistical improvement
  - Sickness – returned favourable to target
  - Mandatory training – meeting target (noting trend required focus)
  - Non patient facing shifts – within budget (noting link with training)

What is being focused on

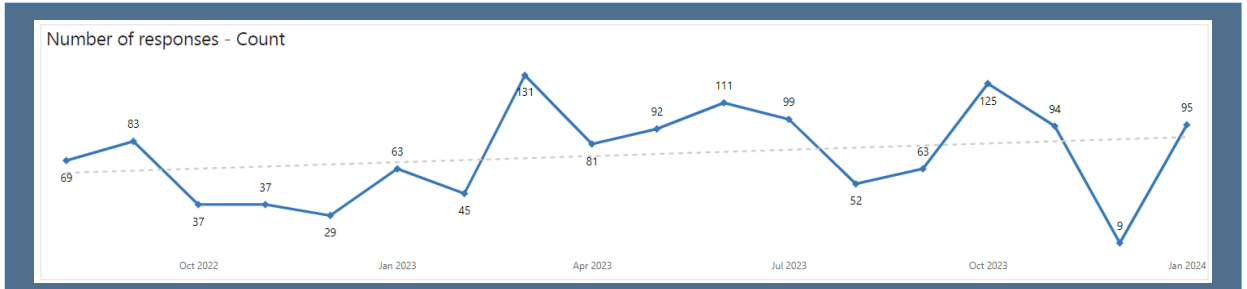
- **LDA** – continued challenges with high levels of ES, LTS and acuity. Additional layer of senior accountability and oversight started Feb 24
- **Divisional Quality Improvement Plans (QIPs)** – focus is on ensuring that SMART actions are created by the Triumvirate/GMs/QMs/Leads. Reviewed in Divisional weekly QIP meetings with central Quality team going forward
- **Meaningful activity** – continued focus on documentation and outcoming
- **Mandatory training trending down** – specific focus on SIT, ILS, BLS. Focus is on ensuring staff are able to be released for training
- **My Voice** – working to ensure consistent utilisation of feedback to improve patient experience
- **Clinical Supervision:** below target at **Clinical Services** level **–** favourable to target were Low Secure, Medium Secure, Essex, Neuro and Birmingham. Additional focus needed on LDA and CAMHS.
- **Establishment review** – revised registered and unregistered staffing levels to go live late April, implementation work is on going

Quality – My Voice & Discharges





*My Voice responses data for period Nov 23 – Jan 24

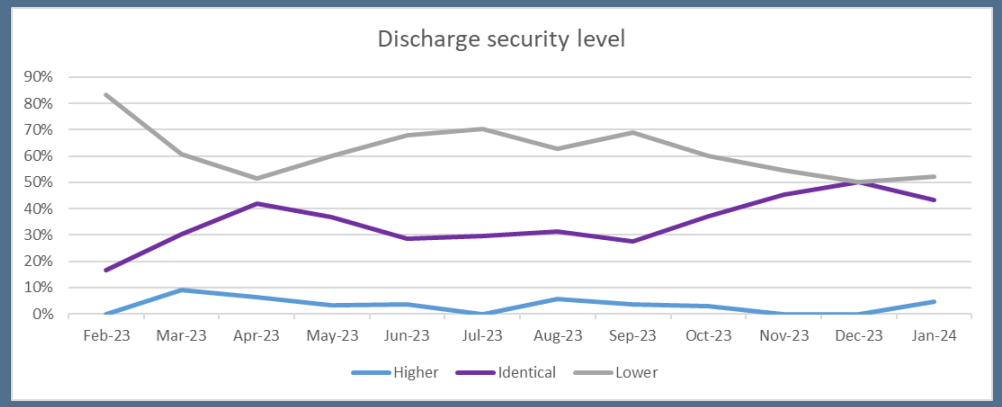


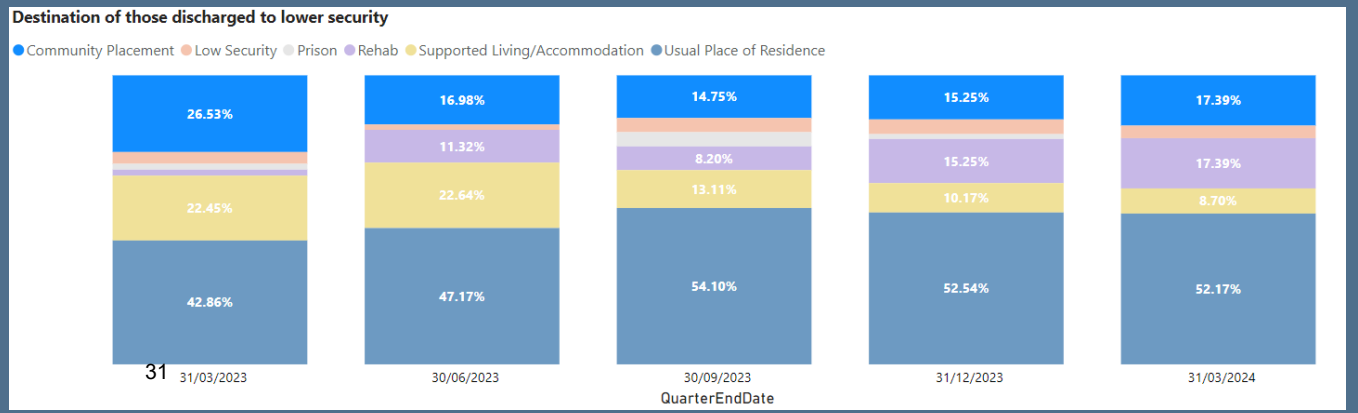
My Voice:

- IT issues meant the survey was unavailable for a period of time in December, hence the reduced completion
- Feedback scores are currently below average with an adverse trend, with this in mind there is a focus on utilising the verbatim comments that accompany the scores. This insight supports discussions in Community Meetings with actions reflected in the 'You said, we did' boards
- New procedure for My Voice reinforces the assurance from ward to Therapies Advisory Group (TAG) and Clinical Services SLT. This will enable oversight of the progress
- One of our 24/25 strategic milestones is to develop new ways of hearing our patients and cared

Discharges:

The majority of patients continue to be discharged to a lower level of security, with the majority returning to their usual place of residence. Of those remaining at an identical security level 97% have moved closer to home. Individuals moving to a higher security level have transitioned to prison.





Quality – Safety and Outcome Indicators

-	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
Clinical Services																

-	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			1													2
LDA								3								
Low Secure & Specialist Rehab																
Medium Secure											4				5	
Neuro																

How to use the above table:

Statistical concern requiring review. Review of each is on the following pages. Review conclusion requires no additional actions means further actions being taken.

Statistical improvement

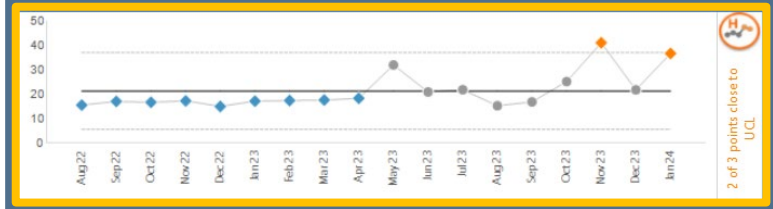
Improvements

Clusters of improvement are apparent across CAHMS and Medium Secure – these have supported Charity wide sustained statistical improvements across: overall incidents, incidents of violence, level 1 and 2 incidents and restraint

Clinical Exceptions - Divisions

1. Essex – Incidents L1

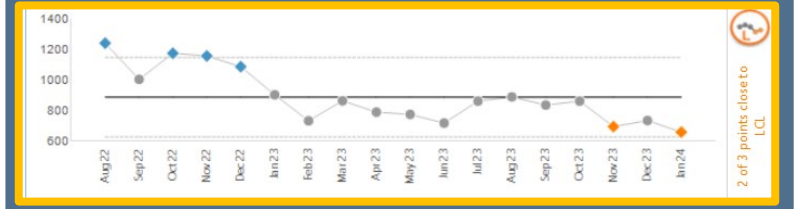
2 of 3 points close to upper control limit



An increase in incidents across the unit.
This is due to increase acuity on several wards – level 1 incidents returned closer to the mean in February and is back in common control.

2. Essex – Patient Leave

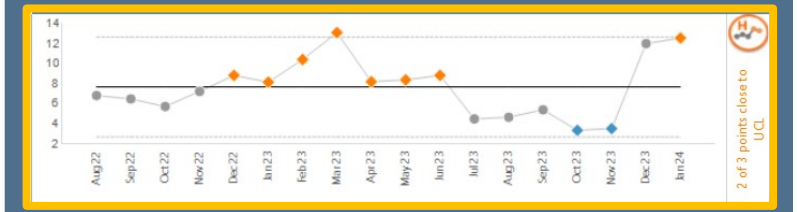
2 of 3 points close to lower control limit



Reduction on PICU due to acuity of patients. For February episodes of leave is closer to the mean and is back in common control.

3. LDA – Seclusion Events

2 of 3 points close to upper control limit

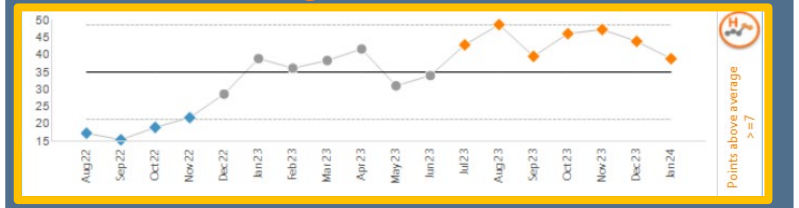


Peaks in acuity on Sycamore and Hawkins have led to an increase in use of seclusion. Plus periods of challenges for individual patients on Oak and Acorn also requiring seclusion.

Seclusion events returned to the mean in February and are back in common control.

4. MSU – Days in Long Term Segregation

Points above average >=7

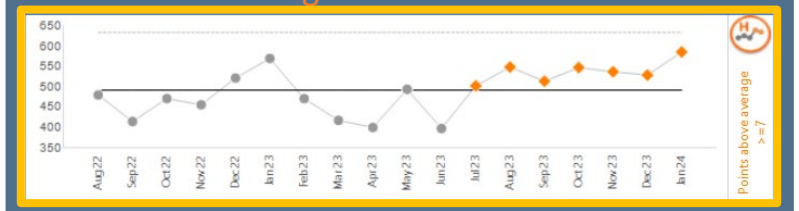


We continue to have high levels of LTS as we have been referred patients who need LTS. As we terminate LTS we are often admitting new patients into LTS.

All LTS patients have plans and were externally reviewed by Arnold Lodge in Jan.

5. MSU – Enhanced Support WTE

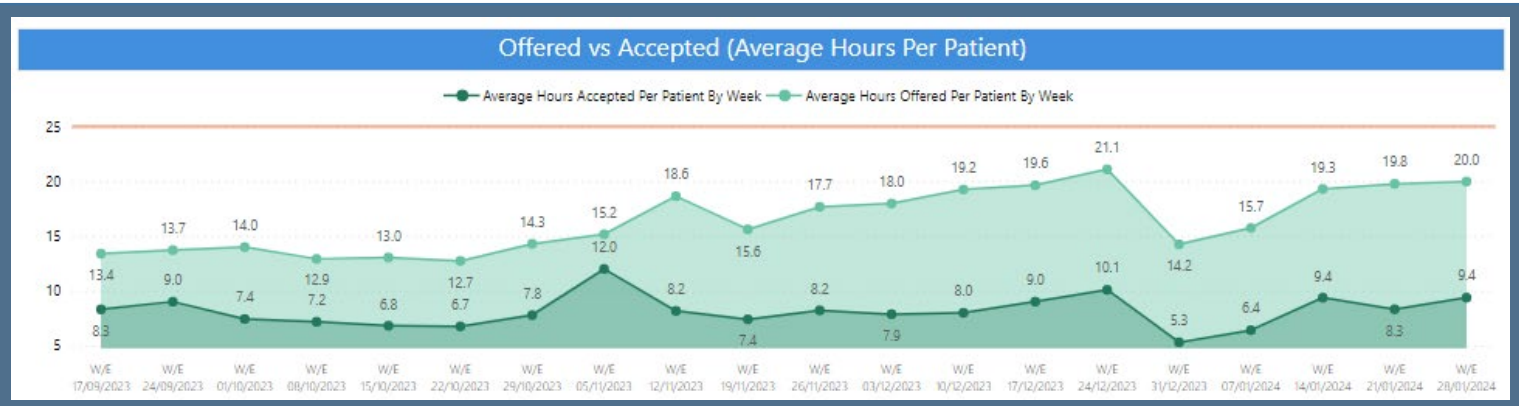
Points above average >=7

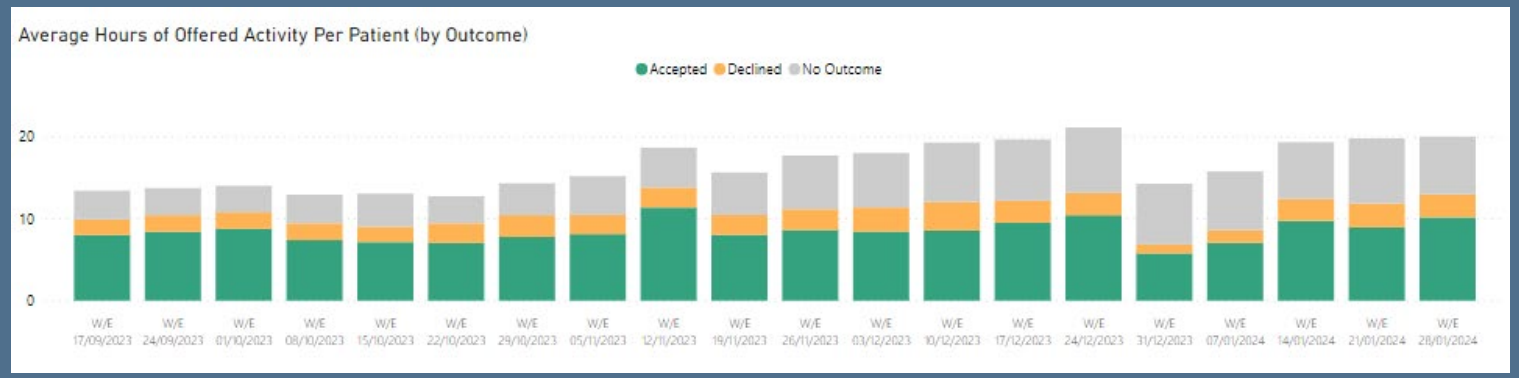


High levels of chronic enhanced support at present. This is reviewed weekly at divisional meeting.

QI project to reduce ES is in progress.

Quality Drivers – Meaningful activity

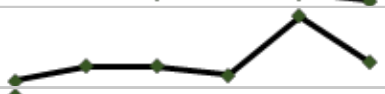




Meaningful activity:

- Overall there is an increase in offered activity across the Charity indicating teams are continuing to engage and improve their processes. There continues to be a discrepancy in the uptake of activity (whether the patient declines, the activity is cancelled or whether it is outcomed by the facilitator)
- In January 2024, 87% of activity was planned, compared with 13% ad-hoc, 13% of ad-hoc activity is a relatively small percentage when we consider the amount of spontaneous opportunities staff have to meaningfully engage patients
- 25% of planned activity was cancelled and the majority of cancellations are due to errors, rescheduling, reprioritisation and change in priority. TAG are reviewing cancellation options as it is felt current options are not giving the clarity needed. SLT discussed the need to understand when activity is cancelled due to staffing/ safety concerns; particularly in LDA where wider clinical teams have been deployed to support the wards
- 16% of activity is happening at the weekend and 27% outside of 9-5pm
- Continued focus required on ensuring activity is outcomed
- Lead OT in LSC is running CPDs for nursing teams on PICU to imbed the MA tool; specifically the importance of recording and outcoming sessions with the aim of rolling this out across LSS and across the other division

People

Measure	Target	St Andrews		
		Jan-24	6 month trend	SPC
Voluntary Turnover In Year	13%	13.0%		Improvement
Voluntary Turnover In Month	1.1%	1.3%		In control
Vacancy Rate		19.0%		
Mandatory Training	90%	90.0%		Improvement
Mandatory Training (Perm)		90.0%		
Sickness % In Month	7.7%	7.0%		In control
Non Patient Facing Shifts (Headroom Shifts)	Budget 28%	25.6%		

How to use above table chart:
Actual results are colour coded red for adverse to target, green for favourable to target or black where there is no target. This is complimented by a spark line that shows the actuals across the last six months. SPC status added where this is measured.

Adverse to target or statistical concern requiring review, noted below

People Performance:

- Voluntary turnover in year remains in target and represents a statistical improvement – in month however the result was marginally above target
- Vacancy rate will be rebased in line with the new financial year and is anticipated to improve
- Mandatory training, whilst within target and showing a statistical improvement, the trend indicates a decline and rectifying this is currently in focus
- Sickness is favourable to target and in control following a seasonal increase
- Non Patient Facing Shifts are within budget, some increase is forecast for the close of the annual leave year, this should also correlate to an increase in mandatory training
- Nursing establishment levels are being reset as per the establishment review – these go live late April and will be shared in the following reports

Your Voice staff engagement survey planned for the end of Quarter 1.

Divisional integrated performance summary

	Measure	Community Services	LDA	LSSR	CAMHS	Medium Secure	Neuro	Birmingham	Essex	Community Partnerships	Divisional Average
Safety	Ward level SPC Concerns	3%	5%	3%	0%	2%	2%	3%	4%	N/A	3%
	Ward level SPC Improvements	0%	5%	3%	8%	4%	2%	0%	1%	N/A	3%
	My Voice Responses (Nov 23 – Jan 24)	N/A	13	5	0	53	2	0	22	N/A	14
	Positive My Voice (Nov 23 – Jan 24)	N/A	74%	78%	50%	62%	79%	N/A	63%	N/A	68%
Workforce	Voluntary Turnover In Year (13%)	12.1% Improvement	12.9% Improvement	13.6% Improvement	33.3% Concern	12.0%	10.2% Improvement	11.9%	14.7% Improvement	8.9%*	14.4%
	Voluntary Turnover in Month (1.1%)	0.0%	1.8%	1.5%	4.0%	2.2%	1.1%	1.5%	0.6%	2.2%*	1.7%
	Training (90%)	92.6% Improvement	85.8% Concern	91.1%	93.3% Improvement	90.6% Improvement	89.9%	87.7%	91.6% Improvement	86.2% Concern	89.9%
	Sickness % In Month (7.7%)	5.2%	11.23% Concern	6.6%	8.0%	7.9%	9.0% Concern	5.8%	7.2%	1.7%	7.0%
	Non Patient Facing Headroom (26.0%)	N/A	28.5%	24.4%	Included in LSSR	24.7%	25.9%	22.4%	25.7%	N/A	25.3%
Safer Staffing	Shifts <80%	1%	15%	22%	60%	12%	22%	14%	17%	N/A	20.4%
Finance	Shifts >100%	83%	30%	15%	5%	30%	22%	13%	22%	N/A	27.5%
	Mth Net contribution vs budget % (100%)	Included in LSSR	63.8%	143.4%	Included in LSSR	99.9%	150.6%	95.0%	58.7%	291.8%	
Focus wards	9C review wards		Under review			Willow	Fenwick	Edgbaston			

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

Friday 17th May 2024 9.30am

(Paul Burstow - Verbal)

Annexes

Annex A

Quality & Safety Committee

Mechanical Restraint Report - Dec & Feb

MHLSG Report - Dec & Feb

QSG Report - Feb

QIP - Feb

Safer Staffing Report - Feb

Paper for Quality and Safety Committee	
Topic	Mechanical Restraint Report
Date of Meeting	Tuesday, 19 December 2023
Agenda Item	**8**
Author	Ash Roychowdhury
Responsible Executive	Ash Roychowdhury
Discussed at Previous QSC Meeting	Yes
Patient and Carer Involvement	This is an assurance report about patient care and part of meeting the requirement for Board approval of mechanical restraint
Staff Involvement	Staff note use of MR on DATIX that serves as the information source for the paper; Staff use MR care plans
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☒ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Voice ☐ Community ☐ Quality ☒ Service Development ☐ Workforce ☐ Learning and Research ☐ Financial Sustainability ☐
Committee meetings where this item has been considered	RPMG- being re-established after appointment of new Patient Safety Lead

Report Summary and Key Points to Note

This paper provides an overview of the use of Mechanical Restraint to the Board, which is a regulatory and Code of Practice expectation

A MR dashboard has been created on DATIX and a BI request is in place to add MR to the IPR and is in the development pipeline, appropriately triaged.

Division	No. of patients with MR care plan, in RiO	No. of times MR-handcuffs used in October and Nov	No of times MR-SRE used in October and Nov 23
CAMHS	1	0	0
LD ASD	27	0	0
MS	75	7	4
LSSR	12	1	0
NPS	2	0	0
Bham	44	5	0
Essex	0	0	0

Heygate- police used to return an AWOL patient

Mackaness- planned dental treatment- MOJ requirement

SRE x 4 to help relocate a patient from seclusion to allow cleaning of the seclusion room

Bracken x 2 for MOJ required use of cuff for treatment at NGH

Birmingham- all on one patient to assist A & E treatment

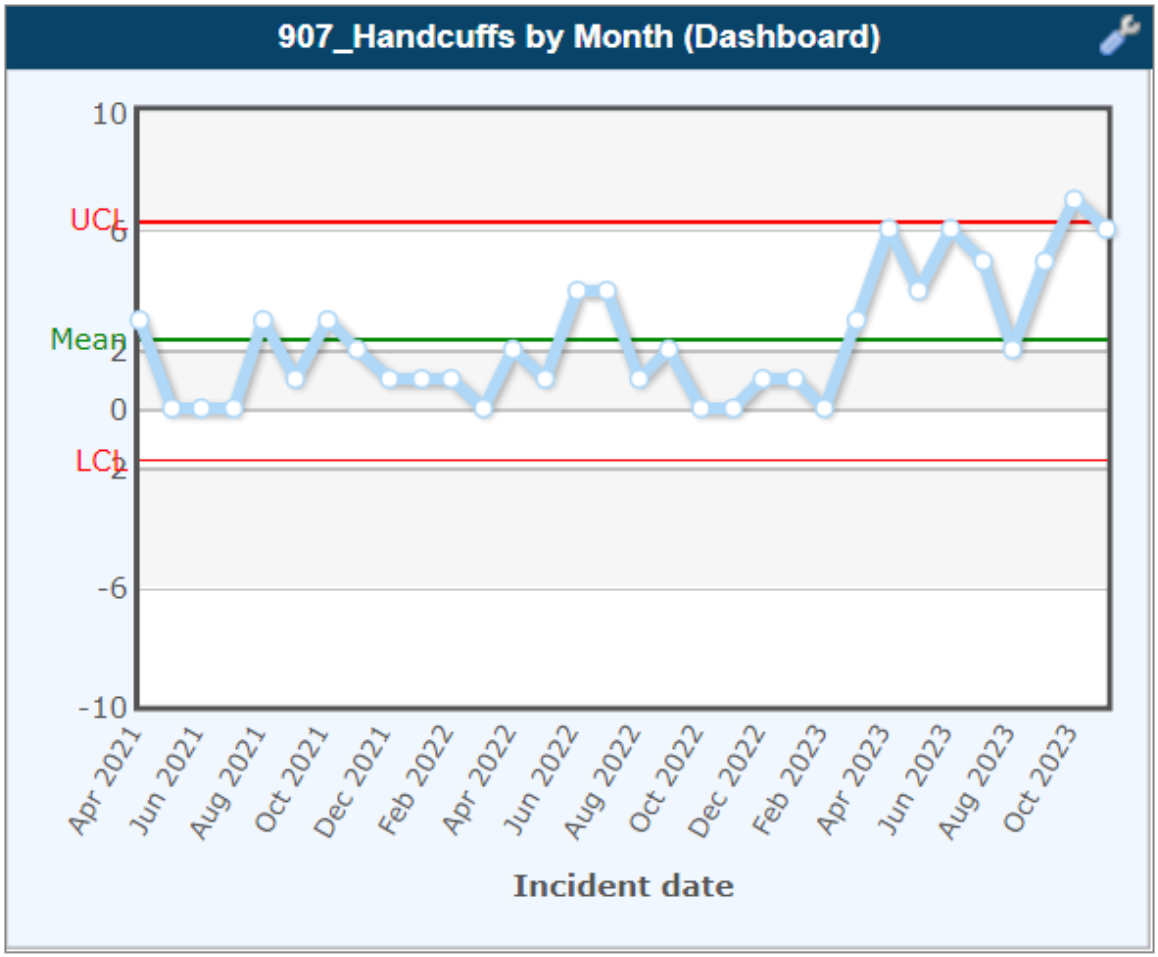
MS - 3 for MOJ stipulated or care planned use outside of a secure building for a medical appointment on site or at NGH

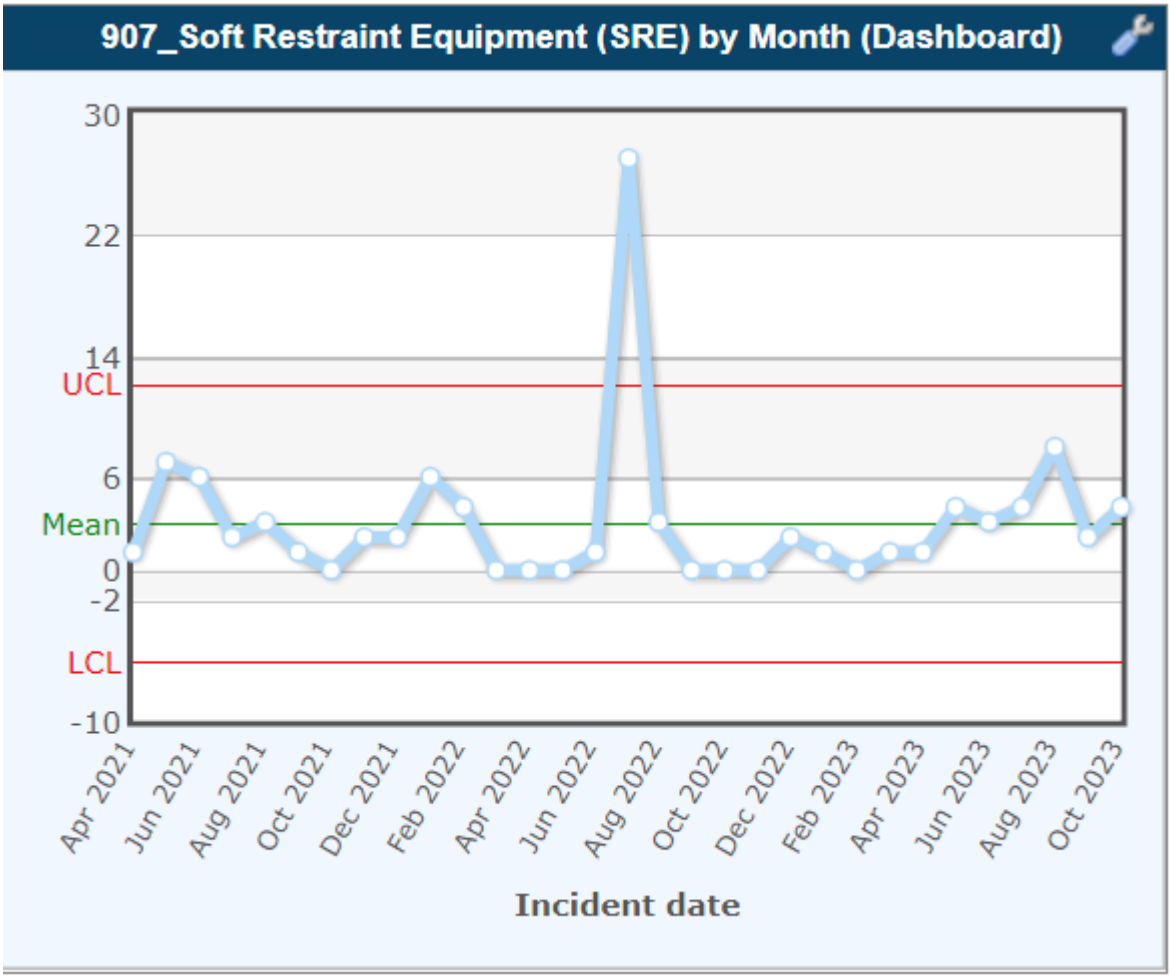
3 use of SRE to help relocate a patient to a different seclusion room to allow cleaning – this patient has been accepted for high secure care

Birmingham – 1 applied by the police to manage an incident and 1 for planned dental leave (legally stipulated)

CAMHS – all for care planned NG feeding

Rates back to the mean


907_Handcuffs by Month (Dashboard)
10
UCL
6
Mean
2
0
LCL
-2
-6
-10
Apr 2021
Jun 2021
Aug 2021
Oct 2021
Dec 2021
Feb 2022
Apr 2022
Jun 2022
Aug 2022
Oct 2022
Dec 2022
Feb 2023
Apr 2023
Jun 2023
Aug 2023
Oct 2023
Incident date


907_Soft Restraint Equipment (SRE) by Month (Dashboard)
30
22
14
UCL
6
Mean
0
-2
LCL
-10
Apr 2021
Jun 2021
Aug 2021
Oct 2021
Dec 2021
Feb 2022
Apr 2022
Jun 2022
Aug 2022
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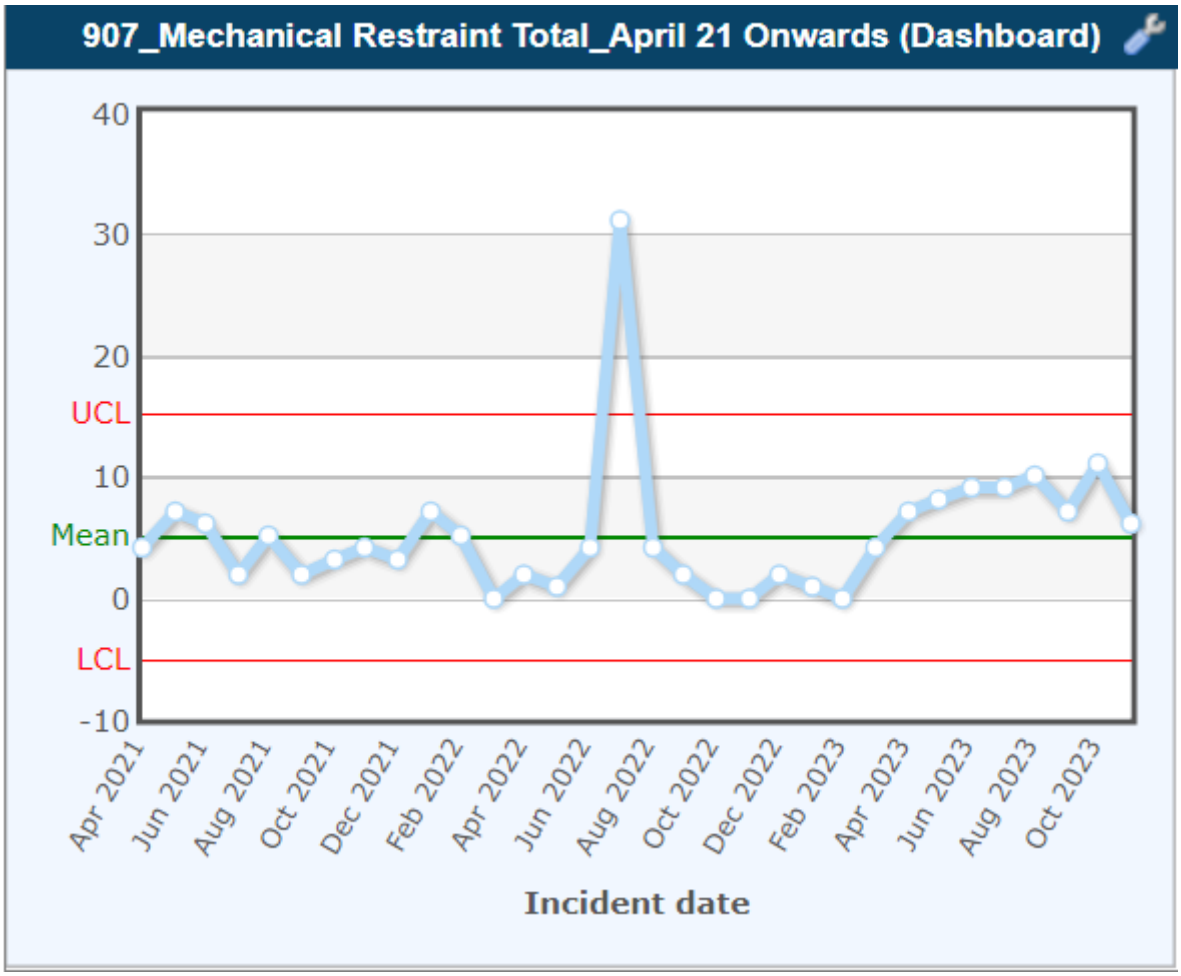
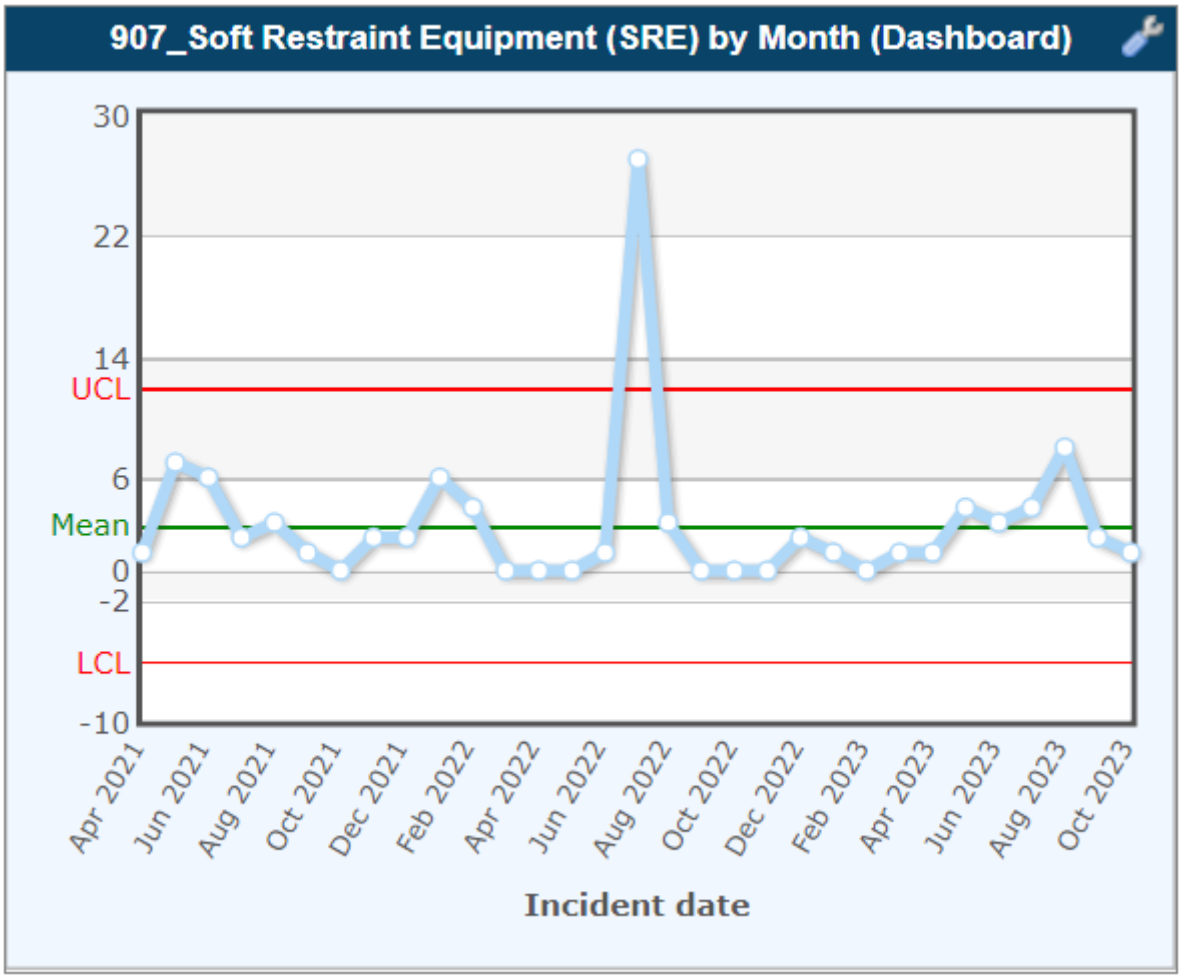


Overall use above the mean, but a large part of this is much more robust recording as part of embedding the overall MR policy

Vast majority of use is required by the MOJ and safely enables physical healthcare treatment



In SPC limits

Compared to the previous 2 months, there has been only 1 use by police compared to 7

MR forms only 1% or less of total UoF

Actions from the MR audit are being enacted and we will plan a re-audit in due course, focussing on an improvement in evidence of qualified nursing observations - the requirements of policy have been recirculated and MR obs forms are now part of the hospital transfer pack.

Paper for Quality and Safety Committee	
Topic	Mechanical Restraint Report
Date of Meeting	Tuesday, 27 February 2024
Agenda Item	**9**
Author	Ash Roychowdhury
Responsible Executive	Ash Roychowdhury
Discussed at Previous QSC Meeting	Discussed at every Committee meeting
Patient and Carer Involvement	This is an assurance report about patient care and part of meeting the requirement for Board approval of mechanical restraint
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Appendices – None

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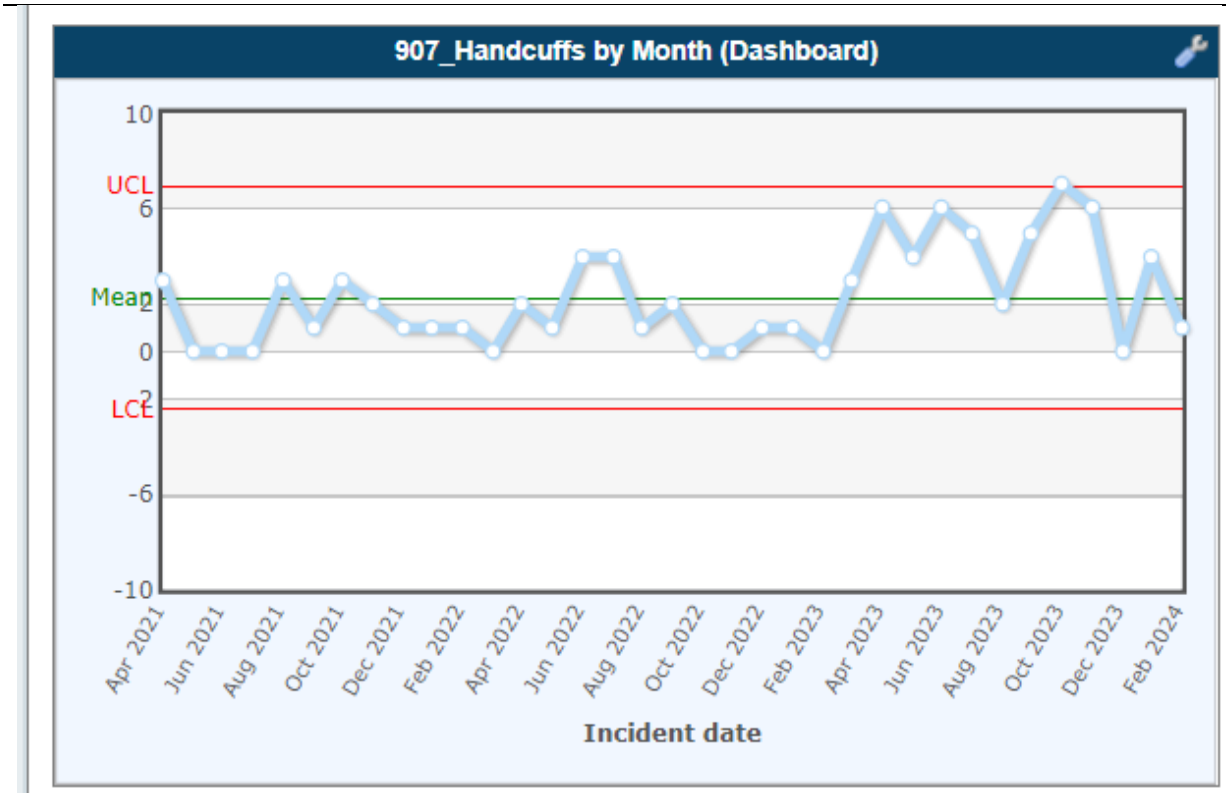
CAMHS	1	0	0
LD ASD	24	2	2
MS	71	10	3
LSSR	8	1	0
NPS	2	0	0
Bham	43	1	1
Essex	1	0	0
	149	17	6

Medium Secure- majority of handcuff use was to support leave for dental or hospital treatment, stipulated by the MOJ or to manage risk; use of SRE was to help relocate to seclusion or to move between seclusion rooms

LDA – to help relocate to seclusion, assit a dental extraction and police assistance to return a patient who was AWOL from escorted leave

Birmingham- for medical treatment externally subject to legal stipulations (both metal handcuffs and soft cuffs)

LSSR- police assisted in returning an AWOL patient from Heygate PICU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UCL
6
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Apr 2021
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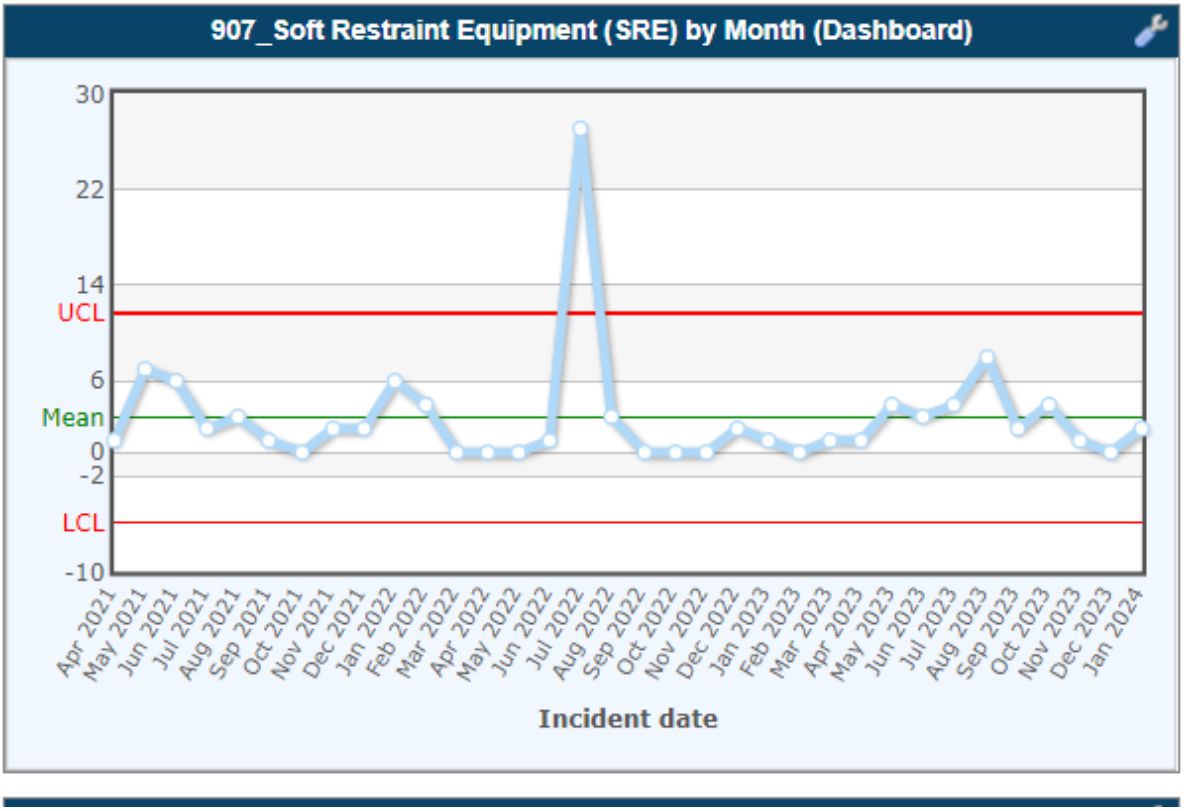
Feb 2024
Incident date


907_Soft Restraint Equipment (SRE) by Month (Dashboard)
30
22
14
UCL
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Apr 2021
May 2021
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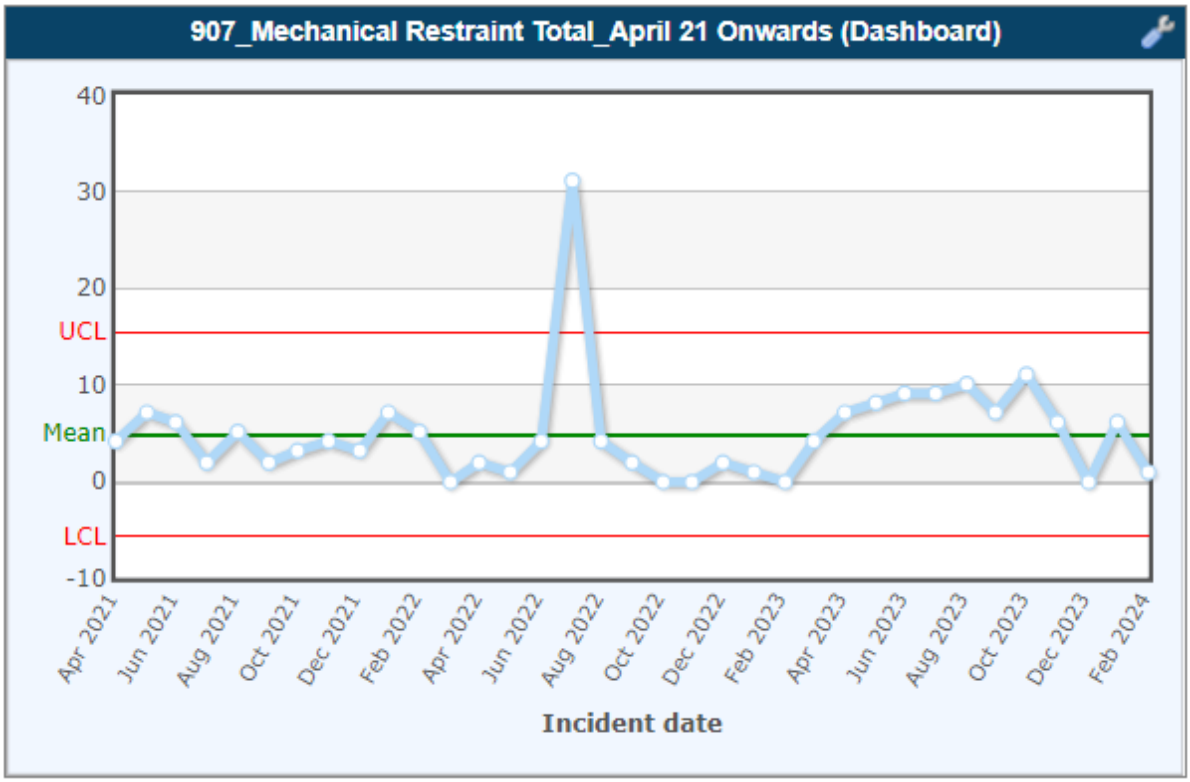


Rates of use near or below the mean, within control

All use of MR has appeared valid and proportionate to the need.

Group Report to Quality and Safety Committee

Name of Group/Meeting:
Mental Health Law Steering Group

Dates of Group/Meeting:
19 October 2023 and 16 November 2023 (both meetings were quorate)

Chairs of Group/Meeting:
Dr Alex Hamilton and Stuart Wallace

Report Author:
Dr Alex Hamilton and Stuart Wallace

Key Topics and Matters Discussed:

1. MHLSG work plan – The MHLSG work plan is being progressed.

2. Structure and role of the MHLSG. The October MHLSG was the first of the restructured MHLSG with a much wider representation from across the charity. The ToR for the group were reviewed and updated to reflect the new group structure. The November meeting was the first routine meeting in this format, and the expectation is that after the January meeting, the new structure will be BAU.

3. The restructured MHLSG has identified two working groups, one to propose updates to the MHA policies and procedures, and the other to do the same for the MCA policies and procedures. The draft changes are to be reviewed at the January MHLSG meeting

4. Planning for changes to the MHA has been suspended as the changes were not in the King's speech and therefore are not going to go forward at present.

5. The MHLSG dashboard is now in a prototype stage and will be going live shortly. This gives information on what legal orders patients are detained under, the demographics of patients under different legal orders and vice versa, legal report and hearing status, and compliance with Section 132 rights. We are working to get Consent to treatment compliance on the dashboard but there are challenges to making this meaningful.

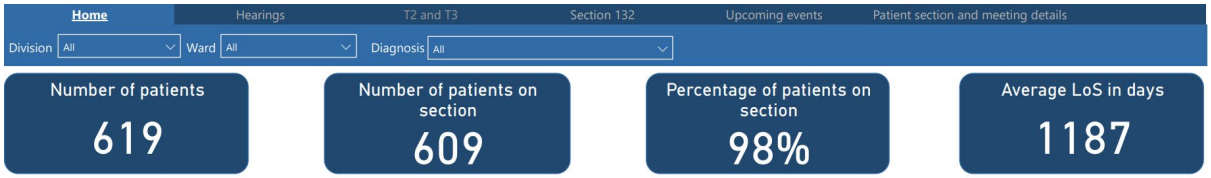
Decisions Made by the Group:

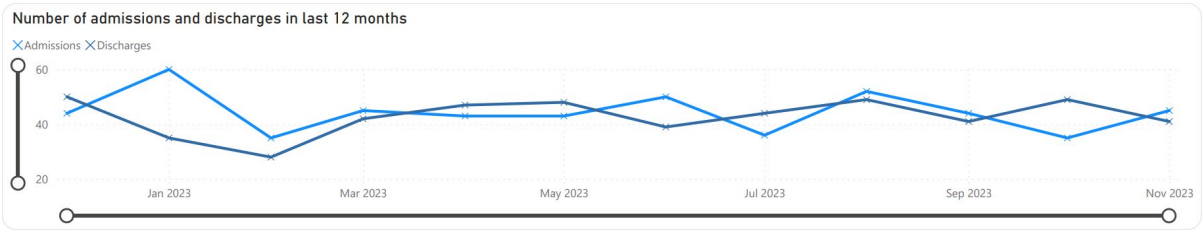
- The MHLSG agreed that as the proposed MHA changes were not included in the King's speech, preparatory work for these changes will be suspended.
- The MHLSG agreed that if the consent to treatment data for the MHSLG dashboard can be easily incorporated meaningfully, then when this is done the dashboard will go live. If they cannot, the dashboard will go live without this data.
- Key lines of assurance document reviewed and agreed by the MHSLG. The questions for front line controls are:
    1. Are any patients unlawfully deprived of their liberty?
    2. Do all detained patients have appropriate and accurate consent to treatment paperwork?
    3. Have all detained patients been read their 132 rights?
    4. Do all clinical staff know the principles of the MHA/MCA and where to find information on MHA/MCA?

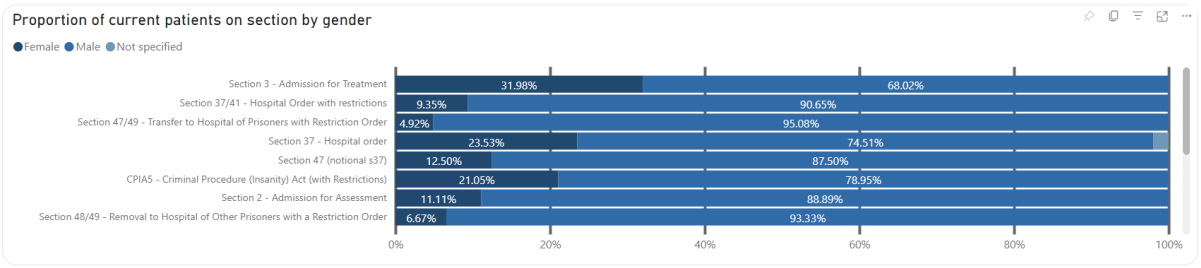
5. Are all clinical staff up to date on MHA/MCA training?
Significant Risks and Issues for Escalation: 1. Nil currently.
Decisions/Approvals required: • Nil.

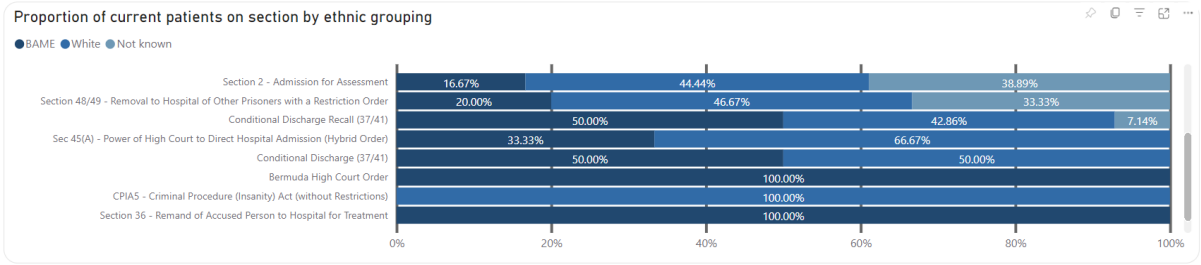
Appendix 1:

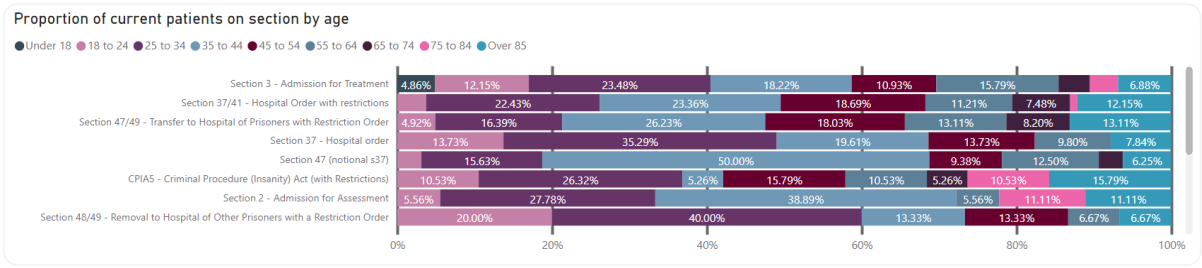
Prototype MHLSG dashboard (not live data):

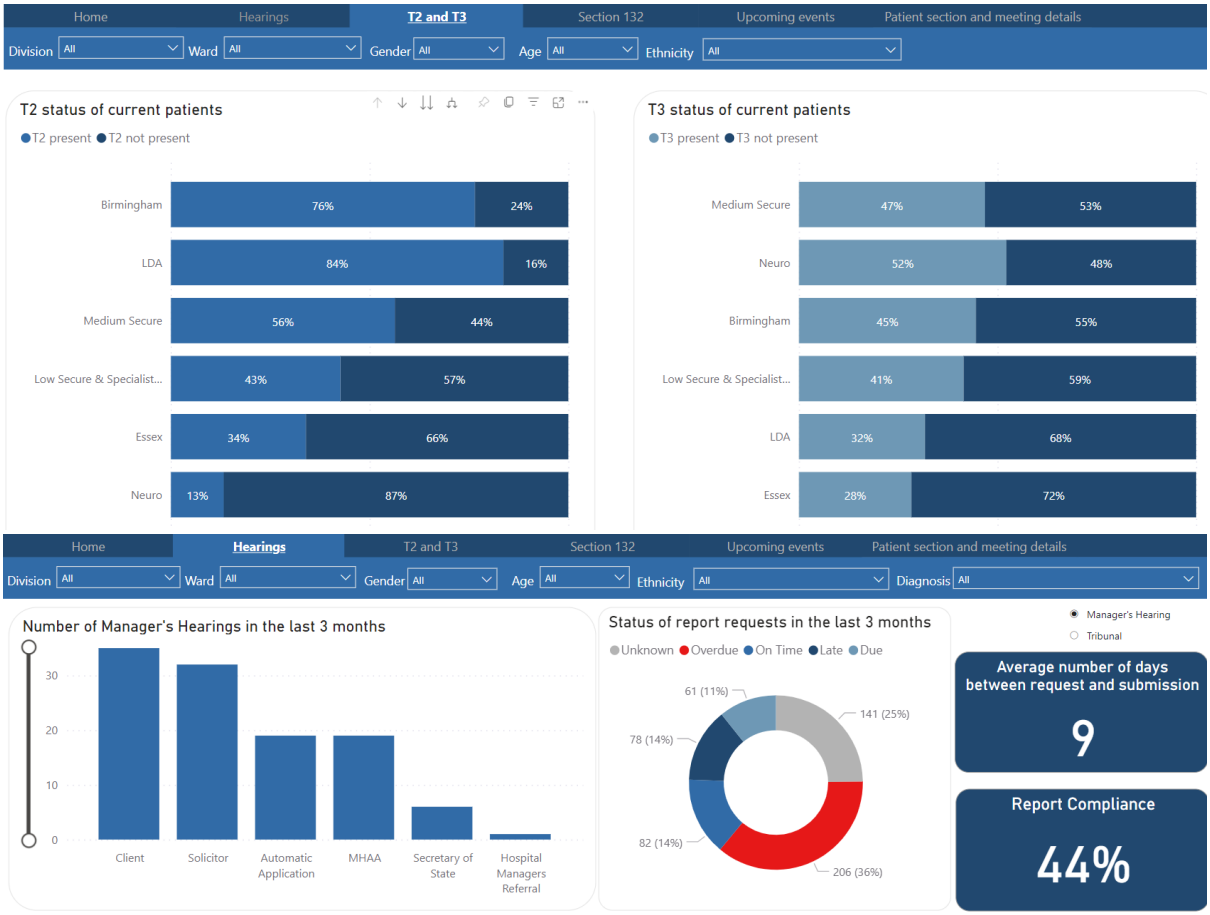












Requested reports

Rio number	Ward	Meeting type	Meeting date	Report due date	Requested from	Report status	Report received date	Meeting outcome
000701140	WMH Moor Green	Renewal	18/11/2022 10:30:00		Cheryl Ford	Unknown		Meeting Cancelled - Patient Withdrew
000701140	WMH Moor Green	Renewal	18/11/2022 10:30:00		Dr M Viveier	Unknown		Meeting Cancelled - Patient Withdrew
000701140	WMH Moor Green	Renewal	18/11/2022 10:30:00		Naddina Morrisen Fraser	Unknown		Meeting Cancelled - Patient Withdrew
020010004	NPS Redwood	Renewal		22/09/2023	D Beech/B Bhatal	Overdue		

Section 132 Status Detail

Division	Ward	Rio number	AssessmentDate	S132Status
Birmingham	MMH Edgbaston	020220142	06/10/2023 18:33:00	Error
Birmingham	MMH Hurst	020190401	14/09/2023 11:54:00	Error
Birmingham	MMH Northfield (Old Lifford)	020210018	31/07/2023 14:50:00	Error
Birmingham	MMH Northfield (Old Lifford)	020190607	06/10/2023 18:30:00	Error
Birmingham	WMH Moor Green	020180950	08/06/2023 18:00:00	Error

Patient section review dates and meeting outcomes

Rio number	Ward	Section	Section start date	Next review date	Meeting date	Outcome	Date meeting created	Meeting made by
020220362	MMH Danbury	Section 37/41 - Hospital Order with restrictions	16/01/2012 00:01:00	15/12/2012 23:59:00				
020120589	NPS Allitsen	Informal	12/11/2013 19:31:00	11/11/2013 23:59:00				
020220644	NPS Tallis	Section 48/49 - Removal to Hospital of Other Prisoners with a Restriction Order	18/05/2015 12:00:00	17/04/2016 23:59:00				
020220223	MMH 23a The Avenue	Section 47/49 - Transfer to Hospital of Prisoners with Restriction Order	17/03/2016 00:01:00	16/02/2017 23:59:00				
020230629	MMH Heygate	Conditional Discharge (37/41)	31/05/2016 00:01:00	30/05/2018 23:59:00				
020160525	NPS Sinclair	Irish High Court Order (undefined length)	14/12/2017 00:00:00	13/12/2019 23:59:00				

Group/Meeting Report to Quality and Safety Committee

Name of Group/Meeting:
Mental Health Law Steering Group

Dates of Group/Meeting:
11 January 2024 - this meeting was quorate

Chairs of Group/Meeting:
Dr Alex Hamilton and Stuart Wallace

Report Author:
Dr Alex Hamilton and Stuart Wallace

Key Topics and Matters Discussed:

1. MHLSG work plan – The MHLSG work plan is being progressed.

2. Structure and role of the MHLSG. The new format and agenda of the MHLSG is now BAU.

3. The MHLSG dashboard is now live. This gives information on what legal orders patients are detained under, the demographics of patients under different legal orders and vice versa, legal report and hearing status, and compliance with Section 132 rights. There is ongoing work to get Consent to Treatment compliance on the dashboard but there are challenges to making this meaningful.

   The dashboard gives very helpful information, particularly around demographics and use of the Mental Health Act (MHA). The MHLSG noted that there is not a significant difference in the proportion of patients detained on civil vs forensic sections between white and BAME patients at St. Andrew's, whereas nationally there is evidence that suggests that a higher proportion of BAME patients would be detained under forensic sections.

   In terms of the proportion of BAME patients detained under the MHA within the Charity, this appears to follow the national average, with a higher proportion of unknown ethnicity. The national data from the NHS for 2021/22 shows that 65% of people detained under the MHA in 2021/22 were white, 28% were BAME, and 7% were of unknown ethnicity. For St Andrews's in February 2024 those proportions are 63% white, 28% BAME, and 12% unknown ethnicity.

4. Compliance with MoJ reports. The MoJ has shared a spreadsheet with St Andrew's detailing each restricted patient and any reports which are outstanding. This information has been passed on to the Responsible Clinician (RC) for each patient who is addressing any gaps [which will be monitored as usual]. Not all gaps are due to St Andrew's failings, some are patients who have been in the community and recalled to hospital recently, and others appear to have been sent to the MoJ but not recorded by the MoJ.

5. MAPPA policy review. As a review of MAPPA is being undertaken by Suzi Mellis, the updating of the MAPPA policy is being paused until the review has taken place, when we can ensure the correct people are part of the process.

Decisions Made by the Group:

1. MAPPA policy review. As a review of MAPPA is being undertaken by Suzi Mellis, the updating of the MAPPA policy is being paused until the review has taken place, when we can ensure the correct people are part of the process.

Significant Risks and Issues for Escalation:

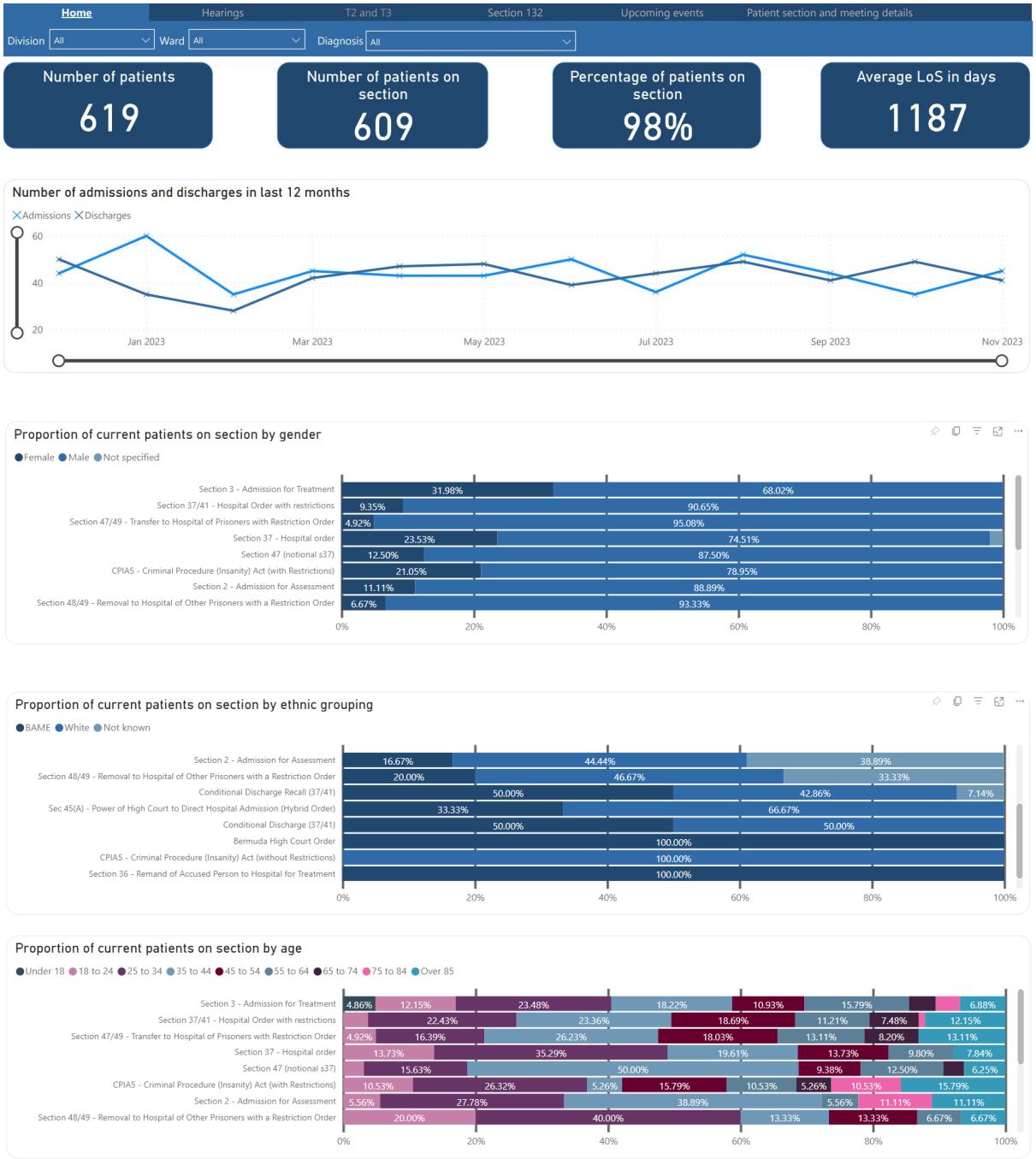
1. The MHLSG dashboard data on overdue reports was reviewed and a number of reports that had been submitted by members of the MHLSG were recorded as being several months overdue. As the dashboard pulls through data from the MHA Office noting on Rio that the reports have been received, there were concerns that this could be an indicator that the MHA office is currently finding difficulty in fulfilling all of their functions. This will be further explored with the MHA Office to understand what the issues are and what action/s is needed.

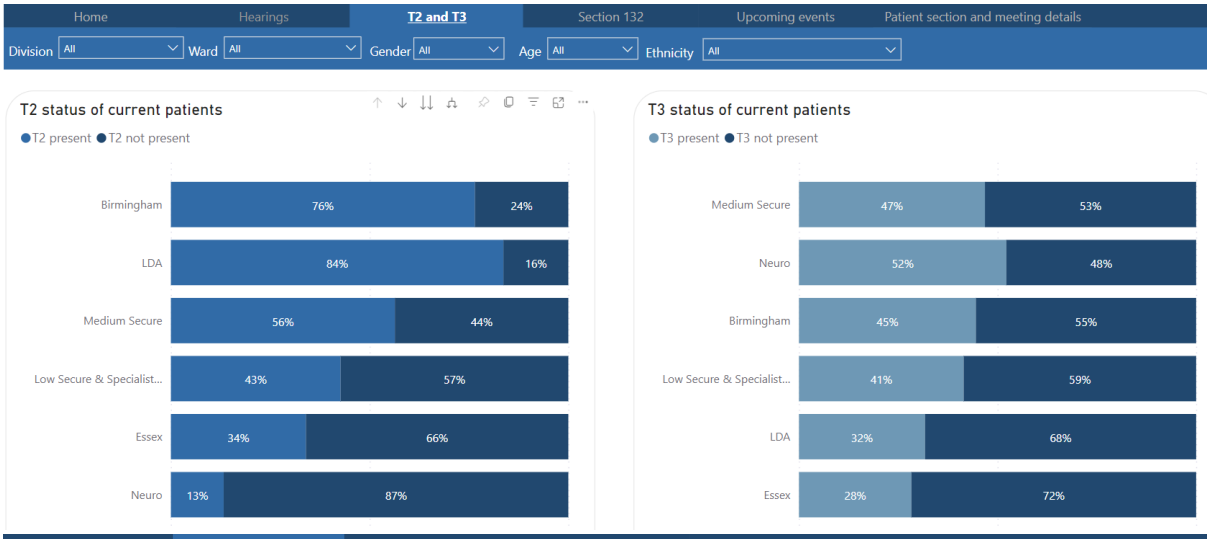
Decisions/Approvals required:

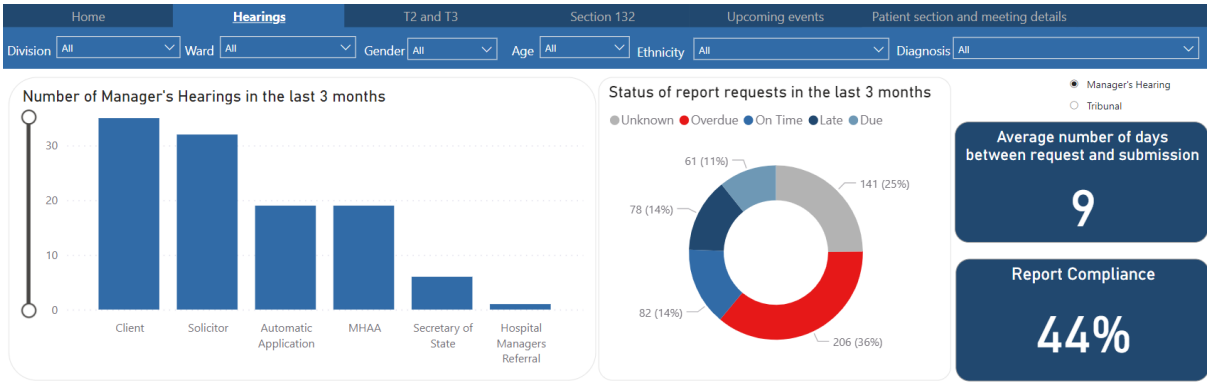
- Nil.

Appendix 1:

Prototype MHLSG dashboard (not live data):







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Group Report to Quality and Safety Committee

Name of Group:

QSG – Safety and Patient Experience (QSG-SPE)

QSG – Compliance and Effectiveness (QSG-CE)

Date of Group:

QSG-SPE – 6 February 2024

QSG-CE – 8 February 2024

Chair of Group:

QSG-SPE – Ash Roychowdhury/Muthu Natarajan

QSG-CE – Ash Roychowdhury/Muthu Natarajan

Report Author: Muthu Natarajan

Key Topics and Matters Discussed:

SIs

There have been five new SI's in this reporting period. A particular theme that was reviewed by the patient safety group was self-harm by ingestion of objects such as batteries, vape. These have required escalation to the acute hospital. However, we are overall seeing a downward trend in self-harm incidents through ingestion, though this is slightly confounded by the reduction in CAMHS beds.

PSIRF methodology is now being used. Increased data analysis allows better learning, and this will be embedded in the coming months. Areas for further analysis and learning include e.g., quality of handovers and staff understanding of care plans. It was agreed that this should be the subject of a thematic review. This and other aspects in this discussion will be taken to the Patient Safety Group.

Noted use of dashboard data should be wider and clinicians reminded so that it informs their practice and decision making.

Safeguarding

Safeguarding numbers have overall remained static in this reporting period. Backlog of S42 reports has been addressed. Safeguarding practitioners working closely with divisions. Local Authority and divisions engaging well together, which has led to a reduction in S42 requests as they are gaining assurance directly from divisions.

89 Safeguarding Navigators across Charity: these are mainly HCA's and adds to the SG capability at local level. Check number parity across divisions. S42 training continuing with increasing numbers of trained staff.

Closed cultures – SG team do ad hoc training when required. Ward governance should entail a ward considering its culture and supported by QM visits and feedback. Training forms a significant component of assurance. Agreed to look at how this is reported through to QSG.

Key safeguarding themes include physical aggression, self-harm and allegations of abuse by staff (which are appropriately investigated).

West Northamptonshire Council have been positive about the improvement in processes and communication and the quality of S42 reports.

Patient and Carer Experience
Overall reduction in complaints; though there is a static number of overdue complaints with majority in LDA. Overall feedback from patient and carers is around poor feedback.

Governors will be provided up to date information by Katie Bayliss ahead of their visit to a ward.

Quality and timeliness of draft complaint letters was discussed again at this month's QSG; which is being reviewed for improvement. Training on this process is being delivered; noted that all QM and GM have had training. Agreed that we need to get to a point of doing good investigations and good complaint letters.

Restrictive Practice Monitoring Group
Update to be provided at next QSG.

Pharmacy
Reduction in medication/controlled drug errors. Ongoing actions are in place.

Regulatory changes to prescribing of Sodium Valproate due to teratogenic effect; requiring 2 experts to agree to prescription. Charity has procedure in place.

Mortality Surveillance Group (MSG)
Six deaths discussed in MSG. Examples of good care reported. Areas of learning includes capacity assessments; agreed that this would be reviewed further, including further teaching/training.

Learning and Development
Mandatory training compliance overall at 91% in the organisation (which is above the NHS threshold), however there are some areas below the threshold i.e., life support, SIT, safeguarding, disengagements. Agreed that further analysis to be undertaken at divisional level.

Co-Production Network
Co-production Framework – developed work has progressed well and various elements are being implemented in relation to enablement. Agreed further discussion around approach to Experts by Experience.

John's Campaign
Person-Centred Care approach to involving carers/relatives in their loved ones care on the ward. Discussed and agreed policy.

Physical Healthcare
Compliance with physical healthcare assessments remains high. Long-term condition review compliance at 96%. Dashboard information has been a significant help

Area of focus is on implementing correct frequency of monitoring for patients who score 1-4 on NEWS2 tool. This is on the QIP.

Epilepsy procedure and VTE procedures agreed for update.

Physical health observations training – action agreed to look at future delivery of this training.

Infection Prevention and Control (IPC)
Head of IPC has noted that IT solution for infection reporting and surveillance has progressed, however further work to implement is required. This is on the risk register.

Mattress audit process map and procedure will be go to March POG for ratification.

IPC audit completion will be reviewed at divisional level and quality control strengthened. IPC training videos will be available soon for staff.

There were no Covid-19 outbreaks in this reporting period.

Therapies Advisory Group (TAG)
Meaningful activity 25 hours per patient per week – capturing of information remains a challenge due to the number of options available. Work is being done to simplify the options list to encourage outcoming. There is also a gap with offered vs completed hours. This is being reviewed and discussed at TAG. Lead OT's are responsible and REDS academy and Recovery College will soon be able to also use the system.

Outcome measures agreed will be in RiO.

Peer Reviews, Clinical Audit and Effectiveness
Clinical Peer Review Tranche 7 completion low. Agreed that timeline would be extended to February end.

DNACPR audit to be completed initially in Birmingham.

Divisions have been asked to look at local audit planning, looking at areas of focus and interest. Once agreed by Clinical Directors, these can be added to the audit plan.

National Clinical Audits – no new information.

NICE guidance – 12 guidelines applicable to Charity; and table provided in QSG documents.

Completed audits; nutritional screening, use of PRN medication, consent to treatment.

Procedure for 'Patient Involvement in Clinical Audit' agreed.

CCIO update
Rio upgrade is on track, and likely to be ready end February/beginning of March.

Referrals to admissions process being developed on Rio, which will significant assist and improve this process. Trial in Neuro likely at end of February and Charity-wide roll out in March.

Patient journey dashboard nearing completion and readiness for testing.

CQI
There are currently 17 active projects and 16 projects have been completed.

QSIR training ongoing with aim of 30-35% of all Charity trained by 26/27

New CQI – 'Improvements in quality and recordings of nursing entries and patient progress notes in Rio'.

Areas of focus include 'Improving Searches', 'Sexual Safety' and 'Enhanced Support Observations (ESO)'. Some evidence of reduction in use of ESO since start of CQI.

Quality Planning / Design for Quality (divisional updates)
LDA – focus on least restrictive practice (Baroness Hollins report) at next leadership day. Focus will be on LDA regulation and principles in 'Right Support, Right Care, Right Culture'.

Medium Secure – improvement in meaningful activity delivered. Area of focus will be use of leave by patients.

Birmingham – highlights from recent CQC inspection, positives around community meetings, seclusion reviews, areas for further review include patient voice and care plans.

Decisions Made by the Group:

- Approach to use of PSIRF to be discussed at Patient Safety Group.
- Review understanding of closed cultures and map key controls and assurance
- Further review of complaints process in relation to quality and timeliness.
- John's Campaign policy agreed.

Significant Risks and Issues for Escalation:

- None.

Decisions/Approvals required:

- None.

Date identified	Source	What is the issue	Theme	9C	Action required (SMART Actions)	How will this be evidenced?	Owner	Target date	Comments/progress notes	Sustaining Improvement Timescale	Action Status
29/09/2023	Clinical Audit;IMPACT (Provider Collaborative)	Audit found lack of consistency in search practice across the charity. Examples of poor practice included: no pre and post leave search, contraband not being recorded in Datix, lack of evidence that patients privacy and dignity is protected during search, use of paper forms, lack of evidence of patients property checks. Recommendations were classed as High priority.	Improving Search Practice	Correct Recording;#Care planning	To scale the interventions from the Search CQI to all wards to improve adherence to core standards of the current policy: individual care planning in RiO and S17 sections; use of wall planners and use of standard RiO templates	Internal local follow up audit sample to cofirm RiO entries, Wall planners visible to staff.	Keira WhitePheon SilauleJennifer MyttonDean RobinsonElizabeth PhillipsGerard Fogarty	31/01/2024	19/02/2024 - Closed charity wide action. Transferring to divisional QIP's where agreed action has not yet been implemented. 04/01/2024 - Neuro - Search care plans in place. Search CQI outcomes have been shared divisionally wide 29/12/2023 (KA) Agreed at SQH to extend action to 31/01/2024 to allow Divs to progress. 5.12.23 (AR) Items to be added to divisional QIP's and there is active engagement of the divisions in the new security forum 24/11/2023 - (AR) Clinical Audit found use of wall planner and progress note template limited to use within MSH only as per original CQI scope 02/11/2023 - Essex - To agree a timetable to spot check current searches to determine issues. Review the search interventions from the CQI and discuss with Ward Managers to embed 12/10/2023 MS - DR - Search CQI on Prichard/Robinson. Currently being delivered to all remaining wards. Target by Dec 23.	Security and Patient Safety Groups will review incidents to seek assurance utilising the Search Dashboard.	Action Complete
29/09/2023	Clinical Audit;Patient Safety (Incident)	Lack of consistency in search practice across the charity. Audit also found lack of clarity within the procedure over various requirements e.g.: recording, training frequency, S17 Leave conditions. Recommendations were classed as High priority.	Improving Search Practice	Correct Recording	Review current policy, procedure and training and make recommendations to ensure these are simple, with robust control and assurance	Proposal to PoG and subsequent approval	Angela Shaw	31/01/2024	22/01/2024 - Policy and Procedure been to PoG - awaiting required updates but approved 22/12/2023 - Policy and procedure is due for January POG 06/12/23 - Policy and procedures have been through consultation and are ready for POG now. 06/12/23 - Training reviewed and updated (classroom and e-learning), based on feedback from lessons learnt and recent incidents. This is now sitting with the security forum for consultation and further review from others,. 5.12.23 Draft policy is in consultation 9.10.23: classroom and e-learning training for searches has been reviewed and in the process of update via L+D ; policy and procedure, in the process of review with security and divisions who have carried out CQI	Depends on recording system but RiO based or DATIX based dashboards. Security & Patient Safety Groups	Action Complete
29/09/2023	Quality Priorities;Peer Review;CQC Inspection	Improvements required to handover process across the charity.	Improving Nursing Handover	CQI	Complete handover CQI with appropriate recommendations taken to QSG	A completed CQI handover document prepared for QSG	Keira White	29/02/2024	16/02/24 - This handover CQI has been closed on the QI dashboard and was approved at QSG to close. 06/12/2023- CQI scope now reduced to QI through a simple handover guidance document while awaiting hospital wide changes that'll impact on handover times and use of ward boards. Handover policy will need re-writing and re-launching in line with these changes rather than taking a CQI approach. 14.10.23 Collation of learning being done with the CQI team to then allow sharing 28/06/23 - Projects ongoing around Handover processes. CQI has led to optimisation of current process that will be reflected in policy; shift pattern work and ward screen initiatives being scoped6/	Handover audits as part of local or central programme feeds into: BAU Ward to Board Governance	Action Complete
29/09/2023	Quality Priorities	Delivery of Patient and Carer Experience Strategy	Improve Patient and Carer Experience	Clinical Modelling	Approve the 23/28 Patient and Carer experience strategy and then add 12 month deliverables to the workplan of the Patient and Carer Experience team and/or the Charity QIP.	Strategy documents, Improved PREMS/My Voice, Developing Carers' Voice system, Progression of the co-production ladder, Improved timeliness in response to complaints and system for carers feedback.	Katie Bayliss	31/01/2024	09.10.23 - Patient and Carer Experience Strategy being drafted (due 25.10.2023) . Now being co-ordinated with the Quality Strategy and these will set out the specific 12 month deliverables.. 19.12.23- Patient and Carer Experience Strategy reviewed by Non Executives at QSC for assurance. QSC wishes to review Quality and Voice strategy to see how all three align. 31.12.23 Strategy approved by Exec and QSC. Date extended to allow specific deliverables to be added to the QIP once a co-ordination meeting has been held with the Voice strategy in Jan 22.01.24 Strategy to go to the Board for information/review - earliest Board date possible MAR 2024. Strategy considered completed and has been approved by QSC.	Patient and Carer Experience Team will report into QSG on progress of the strategy and BAU KPI's and this will then have Board oversight via the QSC and Exec	Action Complete
10/02/2023	Quality Priorities	Improve the support provided and listen to staff	Support for staff	Clinical Modelling;#CARE Values;#Culture	-Focus on high quality Clinical and Management supervision delivery to all eligible staff ensuring that contractual targets are achieved. -Implementation of management supervision trees. -Delivery of supervision training (HR led) to priority areas.	Clinical Supervision rates of 90% Management Supervision rates in line with policy	Keira WhitePheon SilauleJennifer MyttonDean RobinsonElizabeth PhillipsGerard Fogarty	31/03/2024	16/02/24 - Charity wide action closed. All divisions, with the exception of LDA, have consistently achieved total supervision levels of over 90% across the last few months and have implemented management supervision trees. Action transferred to LDA QIP. Feb 2024 - Essex, Neuro, CAMHS & Notts community services - all implemented management supervision trees & correctly aligned on SAP. Remaining divisions to implement by end of March 24. Supervision training scheduled for end of Feb. 04/01/2023 - Neuro - December CS rates - One ward is below 90% however this is due to challenges on the ward/acuity. OOO visits continue across the division. ADN to continue to support the wards to maintain consistency. 06/12/2023- LSC- clinical supervision rates for division above 90% consistently however 3 ward areas are consistently below KPI. Supervision trees completed to mitigate risk of staff being unable to attend specialist supervision offered in these areas. QM's checking in with staff with regards to quality of supervision due to occasional sudden increase in completion rates at the end of the month raising professional curiosity. 02/11/23 - Essex - Continuing with actions as below, positive feedback received from staff. 13.10.23 Charity level of CS for Sep 23 was 88%; MS under review and next quarter figures pending 12/10/23 MS DR - Sept 96%, Aug 97%, July 90% - Willow remains a potential outlier but showing signs of improvement. 11.10.23 - Essex - Last 3 months Clinical Supervision has been above 90%, September Management Supervision was over 95%. Staff Engagement, Development and Wellbeing sessions are occurring weekly, rotated across the five wards. OOO rota in place, one visit per month. 18.9.23 CS at 80% - supervision trees behind designed operationally to support	IQPR, Out of Hours and staff feedback	Action Complete
10/02/2023	CQC Inspection	Availability of patient call bells	Improving Patient Safety, Culture and Practice	Clear Risk Assessment	Patient call system to be installed in bedrooms and areas that patients may be unobserved across Charity.	Implementation Plan and delivery programme.	Dawn Chamberlain	31/12/2023	06/12/2023 (KA) - CLOSED at request of DC as per email dated 06/12/2023. 18.9.23- On track for early Dec 23 completion 28/06/2023 - Paper has gone to board, further work to be done on this, Dawn is leading on this with Simon and we will have an outcome in around 2-3 weeks. 21/06/2023 - Paper due to go to CEC today for decision. 14/06/2023 - Paper will be presented to Execs next week, last few bits to finalise on this. 29.8.23 Estimated completion by early Dec- on track 31/05/2023 - This action to close when agreement sought on permanent solution, following completion of proposal paper by Simon Callow. 17/05/23 - Concerns raised about effectiveness and possible ligature/self-harm risk for the temporary alarms being used in some wards until the call bells have been installed everywhere. Ligature risk assessments to be reviewed/updated in relation to this. 15/05/2023 (AB) - Procedure now complete Further meeting to be held this week and design options yet to be finalised. 16/02/23 - Call Bells installed in all wards in Essex.	Oversight through OPComm and Charity QIP progress that goes to QSG, QSC and Exec	Action Complete

01/01/2024	Patient Experience;Clinical Audit	Outstanding actions from 2022-2023 advocacy audit.	Improve advocacy service	Communication;#Correct Recording;#Care planning	Action 1- 4.1.1 Evidence Awareness of and access to the service - Keeping patients informed and ensuring access to advocacy services. Action 2 - 4.2.2 Evidence improved quality of the advocacy service.	- Outcomes/evidence reported by advocacy - Increase in patient/carer satisfaction	Katie Bayliss	31/03/2024	13.07.2023 - CAAT shared actions with patient and carer experience team who liaised with Advocacy re outstanding actions. Audit discussed via contract monitoring meetings 17.07.2023 - Audit shared with Project Manager, OPS Manager and General Manager 21.07.2023 - Response to outstanding audit actions attached 21.08.2023 - Plans to move actions to QIPs 08.12.2023 - Audit team requesting further update on actions *Review of current advocacy contract underway during this time 10.01.2024 - Further actions requested by STAH to Together 29.01.2023 - All outstanding actions accounted for (see attached docs)	-Add a question to My Voice to help monitor in the future -Feedback monitored/escalated via QUA meeting structure	Action Complete
29/09/2023	Clinical Audit;Internal KLOE Inspection	Consistency and quality of enhanced support reviews to be improved. Inconsistent quality of enhanced support care plans, specifically in relation to considerations around privacy & dignity. Recommendations were classed as Medium priority.	Improving Enhanced Support Practice	Correct Recording	1. Add reminders to the WardBoard for the weekly MDT reviews and add data to existing ES dashboard	Screen shot of dashboard	Nadeem Mazi Kotwal	02/02/2024	12/10/2023 – Completed – the Rio ward board now provides alerts for long-term segregation and enhanced support care plan reviews and MDT/AC progress note reviews. 05/12/2023 - Pending – dashboard visualisation of enhanced support MDT review, enhanced support care plan review, long-term segregation daily AC review, long-term segregation MDT review, long-term segregation care plan review is pending dataset development. 07/02/2024 – pending – data and analysis team have started work on a prototype and is being checked for any errors. 18.2.24 Completion imminent subject to data quality checks- ward board reminders are now live- it is the ES dashboard data that is waiting	ES Dashboard is reviewed in ward, divisional and IQPR governance Aim is to consistently achieve at least 95% completion of weekly MDT reviews done at a required quality assured through audit	Delayed
29/09/2023	Quality Priorities	The charity is experiencing unnecessary use of Enhance Support across the Charity, and lack understanding of the drivers.	Improving Enhanced Support Practice	CQI	Charity wide CQI to reduce ES by 20% by Nov 24	LifeQI reports	Michaela Roberts	30/11/2024	18.2.24 First collaboration meeting took place in Jan and early learning collated. Second PDSA cycle from 3ed week of Feb. Overall ES WTE now back in control. 06.12.23 - MR CQI Team are meeting with Divisional teams undertaking the trial to look at findings of first PDSA cycle, and data captured during the period. Initial data look positive which indicates an overall reduction, but this needs to be discussed in the context of the changes tested, and increase in balancing measures and the sustainability of the change. Workshop #2 planned for 14 January to collaborative to come together to share learnings, and identify changes for next PDSA cycle. 5.12.23 Wards have already achieved greater than 20% reduction, mainly in LSC 12.10.23 - MR 13 Wards are taking part in the first PDSA cycle. Data is being captured on progress from the IPR, PSF and local ward measures. Wards to deliver findings at CQI Forum on 16 November. 18.9.23 14 ward enrolled and on track for first PDSA cycles to complete and report back in Dec 23 29.08.23- CQI set up[on LifeQI- divisions engaged- PDSA cycles on wards and charters to start 3rd week of September 03/07/23 - Senior Leaders away day focussed on Enhanced support completed on the 27/06/23 with a number of actions being co-ordinated by the CQI team. Looking at clarifications of language and expectations, escalation and usage of additional support needs, monitoring of compliance and new ways of working. 28/06/23 - JK/AR/AB to review this action. Actions needed around enhanced support practice. It was suggested that this may be monitored through Quality Matron standards of practice.	IPR ES WTE metric	Open
29/09/2023	Quality Priorities	Lack of digital seclusion for seclusion recording, performance and assurance oversight.	Improving Seclusion Practice	Correct Recording	1. To digitise the end to end process and remove paper packs 2. Develop a QC and assurance dashboard that can replace the current seclusion audit process	New RiO Process	Nadeem Mazi Kotwal	30/06/2024	12/10/2023 - Initial Rio development requirements being scoped out; dashboard development requests made 08/12/2023 - Current Rio resources diverted to upgrade of Rio and to streamline referral process. Work on seclusion digitisation to be fully scoped out from March after the completion of Rio upgrade 18.2.24 RiO upgrade imminent- this will help deliver some of the functionality required and process can be scooped. We have content sheet shared from BSMHT	Dashboard data in ward, divisional governance feeds into IQPR and Board oversight through QSG, QSC and Exec IQPR reports	Open
29/09/2023	Quality Priorities;Peer Review	Lack of process and embedded practice in relation to Quality Impact Assessments	Quality Impact Assessments	Clear Risk Assessment	Develop a procedure and template for the use of QIA's for large change initiatives	QIA procedure and templates	Chloe Annan	23/02/2024	26.1.24 Target date extended to allow POG approval in Feb 08/12/2023: QIA template agreed and in place. Currently being trialled and used as part of 2 big change projects. Following feedback from this trial, procedure to be finalised and go through to POG - target date of Feb 2024. 25/10/23: Triggers for use under review, but will include all major operational projects, ward moves 08/08/23 QIA template and process drafted. Ongoing work to agree criteria for consideration 28/06/23 - JK/AR/AB to review this action. Quality Impact Assessment for Workforce Standards has been completed by CA. Need to agree standard template for QIA going forward and embed use.	QIA process embedded through change and transformation programmes.	Open
29/09/2023	Quality Priorities;CQC Inspection	Improvements required to handover process across the charity	Improving Nursing Handover	Collaborative Team Working	Pilot in two wards ward screens that can show critical information that supports handover and quality control activity	Pilot feedback report and business case	Dawn Chamberlain	31/03/2024	5.12.23 Requirements still being scoped with a focus on handover and quality control data -this will then determine the technology trialled Two wards identified for pilot - Aspen in Neuro and Audley in Essex. Project group to be established in November and pilot to run through Q4.	Op Comm- will oversee the pilot findings and approve the business case Please see attached progress report below as of 20/12/23	Open
29/09/2023	Quality Priorities;CQC Inspection	Inconsistent escalation and follow up of abnormal NEWs2	Physical Health	Clinical Modelling	Development of Physical Health dashboard to show data on follow through recording of NEWS 2	Dashboard availability via safety huddles and through governance, appropriate and evidenced response to physical health concerns	Nadeem Mazi Kotwal	31/03/2024	12/10/2023 – existing NEWS2 dashboard is being strengthened to show if NEWS2 is overdue and how long it has been overdue for. Dashboards are in the development pipeline for - Proportion of abnormal news2 scores that were repeated within the recommended time interval(daily, weekly, monthly) 08/12/2023 - gradual progress in place and remains on track. Alerts are now available on the NEWS2 dashboard that show when the last NEWS2 was completed 18.2.24 On BI work plan to deliver last phases- can link in with digital handover work	BAU Ward to Board Governance	Open
29/09/2023	Quality Priorities;National Guidance/Publications	PSIRF Implementation	Improving Patient Safety, Culture and Practice	Clinical Modelling	PSIRF Policy and Plan to be developed and socialised through commissioning network.	Policy and Plan	Cath Marshall	29/03/2024	18.2.24 Policy at Feb QSC - drafts have taken into account stakeholders feedback 08/12/2023 (CM) Working with external stakeholders to gain agreement for official sign off. Yet to be confirmed. 14.10,23 Draft policy and plan complete. Is to be socialised with IMPACT. 18.9.23 PSIRF GANTT chart created; PSIRF policy and action plan on track for Oct 23; training being delivered; providers are moving to PSIRF at differential rates across the next 6 months 17/11/2023: AW commencing with conference planning.	Patient Safety Group will oversee the change and report into QSG and QSC	Open
29/09/2023	Quality Priorities;National Guidance/Publications	PSIRF Implementation	Improving Patient Safety, Culture and Practice	Clinical Modelling	Transition to PSIRF learning templates following socialisation of policy/procedure with commissioning network.	New Templates	Cath Marshall	29/03/2024	18.2.24 PSIRF templates all done- waiting for Board and commissioning sign off. Templates in use sheet and there is a current local training plan to ensure competence 08/12/2023 (CM) Awaiting Policy/plan approval 14.10.23 Draft templates created for different learning responses and are being consulted upon 17/11/2023; AW leading on conference planning.	Patient Safety Group	Open
29/09/2023	Quality Priorities;National Guidance/Publications	PSIRF Implementation	Improving Patient Safety, Culture and Practice	Clinical Modelling	Oversight, engagement and learning response lead training based on an approved and funded training plan	Training plan and data	Cath Marshall	31/03/2024	08/12/2023 (CM) - 2nd wave of training will commence is January 2024 Second wave of PSIRF (accredited) training, secured. Key personnel identified to be provided in December 2023	TNA refreshed annually and use of approved providers	Open

29/09/2023	Quality Priorities	Reducing Restrictive Practices	Reducing Restrictive Practices	Clinical Modelling	RPMG to create and QSG to approve key focus areas for the next 12 months	24/25 REDUCE action plan	Cath Marshall	31/03/2024	18.2.24 RPMG ToR agreed and programmed of work will be agreed by deadline date 08/12/2023 (CM) No further update. 14.10.23 RPMG to restart in October 23 and set priorities that will be followed through in the group's action log	RPMG, QSG & BAU Gov	Open
29/09/2023	Quality Priorities;IMPACT (Provider Collaborative);Lessons Learned;Patient Safety (Safeguarding);Patient Safety (Incident)	Clinical security review and improvements	Management of Contraband and Restricted items	Clinical Modelling	A review of the relevant key systems, processes, training and assurance - including contraband lists, Physical Security documents, reception practice, interface with clinical search practice and management of patient possessions	Review findings document with recommendations and actions	Jacqueline Liveras	31/03/2024	13.10.23 - A cross functional expert group has been set up including an SD, CD, Estates, security, nursing to lead this work 11/12/23- meetings are ongoing and good progress on overall security procedures. 26.1.24 Group is working on a number of areas and has recently proposed a revised security competency framework that will drive the offered training to staff 18.2.24 Competency framework to be reviewed at new L&D group and appropriately prioritised	Security Group will have direct oversight and feedback through OPComm and monthly review of the Charity QIP	Open
10/04/2023	Clinical Audit;Internal KLOE Inspection;Lessons Learned;Patient Safety (Safeguarding)	Consistency and quality of enhanced support reviews to be improved. Inconsistent quality of enhanced support care plans, specifically in relation to considerations around privacy & dignity. Recommendations were classed as Medium priority.	Improving Enhanced Support Practice	Correct Recording	Develop and commence an audit led by QM's to review the quality of ESCP's and MDT reviews, with a focus on privacy and dignity	audit tool	Chloe Annan	29/02/2024	16.02.24 - Agreed process (adapted from LSC) being shared at QM forum on the 28.02.24, On track to close by due date. 04.02.24 - Divisions confirming their current processes for auditing ES care plans, variances and good practices being shared at the next QM forum mid Feb. Agreement of single audit process to commence from March. 14.10.23 QM /GM tasks/ roles now set out. Audits required of them for frontline assurance are being designed so as to complement those done by second line and central audit team but care planning is to be a priority.	Audits feeding into governance, RPMG and LLG - outcomes feeding in to QIP process at ward/divisional level.	Open
21/11/2023	IPC Audit;National Guidance/Publications;Lessons Learned;Environmental Audit;Internal Audit;Clinical Audit	lack of process and embedded practice to complete and act on mattress audits	IPC practice	Clear Risk Assessment;#Cleanliness;#Culture	1, Task and finish group to develop process 2, Mattress audit to be added to IPC ICAT system 3, Embed new procedure into clinical practice 4, Re-audit following introduction of procedure	IPC ICAT audits with 1st line assurance with Quality Matrons and 2nd Line assurance with IPC team	Pixy Strazds	29/03/2024	18.2.24 Draft mattress procedure now out for consultation and basic structure reviewed at Feb QSG 5.12.23 Task and Finish group identified and meeting arranged for January 2024. Process map for the Task and Finish group created. 22.12.23 Initial process map developed for discussion with task and finish group in Jan 2024 22.12.23 Shared work with Betsi Cadwaladr University Health Board who are also developing a mattress protocol so we are working in collaboration 16/01/24 The first task and finish group meeting was held and a draft process will be shared with members of the group and then be shared for consultation across the wider Charity. The IPC team are creating a training video demonstrating how to audit a mattress correctly 22/01/24 Draft process shared with task and finish group for comment prior to sharing at IPCG and QSG for approval	Adherence will be via monthly mattress audits monitored by ICAT and through IPC group to QSG	Open
27/12/2023	Lessons Learned;Internal KLOE Inspection;Patient Safety (Incident);Quality Priorities;Prevention of Future Deaths Order;CQC Inspection	Inconsistent quality, content and accuracy of nursing handover notes	Improving Nursing Handover	Communication;#Correct Recording	1. Create an automated handover note that draws in key information from multiple systems- RiO, DATIX (incidents), EPMA (Detailing medication accepted, declined & omitted). 2. Pilot its use in at least 1 service and iterate	Results and recommendations from pilot	Nadeem Mazi KotwalChloe Annan	29/03/2024	Dec 23 Initial requirements being scoped - links with other handover projects Jan 24 - Discussed at Senior Quality Huddle and being progressed with clinicians & BI team. Also re-starting the charity wide handover CQI work which this will feed into. 17.2.24 Part of responding to PFD and CQC action	Patient Safety Governance structure will review the effects of this in practice	Open
19/01/2024	External Surveillance (CQC Reports);National Guidance/Publications;Clinical Audit	Evidencing and implementing AIS procedures.	Meeting patient/carer communication needs	Communication;#Care planning;#Correct Recording	-AIS procedure to be outlined in Admissions/EDI policy. -AIS form to be reviewed/updated appropriately. -AIS needs to be added to front view of patients' case records. -E-learning to be reviewed/updated appropriately.	AIS procedure outlined in admissions and EDI policy. RiO case records will outline patient and carers' AIS needs. Patients' AIS forms completed.	Katie Bayliss	31/03/2024	- (22.01.2024) Email sent to Nadeem, Richard Burrows, Ria Stayner and Mat Ward to clarify actions. -(22.01.2024) Nadeem followed up to inform that a request must be submitted to change AIS form on RiO. Richard confirmed addition of AIS procedure can be added to Admissions Policy. *Note: Responsibility of this policy may require change of hands.	Review themes of complaints Review having enough information question in MyVoice Reports through QSG to QSC	Open
29/01/2024	Patient Experience	Year 1/Year 2 Patient and Carer Experience Strategy deliverables.	Improving Patient and Carer Experience	Communication;#Care planning;#Culture;#Collaborative Team Working	- To explore and establish direct communication pathways with patients, families and carers. - To increase patient and carer engagement at forums, meeting and events etc. - To develop Expert by Experience 'roles and responsibilities' opportunities. - To ensure patient engagement/activity timetables are visible on all wards.	- Communication pathways established. - Patient timetables reflect increased attendance/activity. - Increase in numbers attending local and charity wide opportunities (meeting minutes). - Patient opportunity timetables displayed on wards. - Patient and carer roles expanded with clear governance/process.	Katie Bayliss	01/04/2024	18.2.24 Meetings for all listed actions established.	- Oversight/monitoring via QSG, QSC & Exec. - Charity QIP progress. - RiO outcomes. - My Voice/Carers' Voice data	Open
08/02/2024	Patient Experience;Co-Production;Lessons Learned	No system currently in place for Carers to feedback their experiences.	Improving Patient and Carer Experience	Communication;#Collaborative Team Working;#CARE Values;#Culture	-My Voice system to be mimicked to create a 'Carers' Voice' system. -Carers questions to be developed by Carers.	-Carers system created -Carers feedback received	Katie Bayliss	30/09/2024	-Carers Voice system requested with Business Intelligence team via new form: 08/02/2024 -Questions developed by Carers: 05/02/2024	-Divisional oversight via system -Oversight/reportable by patient and carer experience team -QSG/QSC oversight -Internal audits	Open
16/02/2024	CQC Inspection;IMPACT (Provider Collaborative);Internal KLOE Inspection	Inconsistent shift planning at ward level, on a shift by shift basis. Manual, paper process is time consuming and means staff aren't always being deployed to tasks effectively and in line with policies.	Shift Planning	Collaborative Team Working;#Correct Recording	To launch a shift planning working group to explore digitalisation and automation of a shift planning tool, by the end of March 24.	Meeting minutes from working group - MOSCOW form and action log Development of a shift planning tool/app.	Julya Huntley-WelsenaerHannah Lavender	01/04/2024	18.2.24 Scoping work to be done to allow complexity of work to be understood and further timescales agreed		Open
05/01/2024	National Guidance/Publications	Freedom to Speak up requires development and improvement	Freedom to Speak Up	CARE Values;#Culture	All staff to have access to FTSU training via SAP Reach FTSU groups who don't often speak up Report themes and link in nationally to ensure learning and standards via the NGO Raise the profile of FTSU via comms	FTSU data reported to execs quarterly updates of progress plans via FTSU lead national reporting will be recognised via CQC	Angela Shaw	01/03/2024	18.2.24 Comms poster complete - circulated within divisions intranet page updated but needs to add in poster Met with clinical inequalities lead to discuss recruitment to roles and comms amongst charity groups FTSU training has been agreed - waiting with L+D to be put on staff profiles FTSU data reported on NGO website - complete Advisory internal audit completed in Feb24		

Paper for Quality and Safety Committee	
Topic	Safer Staffing and Establishment Review
Date of Meeting	Tuesday, 27 February 2024
Agenda Item	**11**
Author	Chloe Annan
Responsible Executive	Dawn Chamberlain
Discussed at Previous QSC Meeting	This is a consistent agenda item at QSC, and was last discussed in December 2023.
Patient and Carer Involvement	Aspects of Safer Staffing have been discussed with patients, where appropriate to do so, within community meetings on the ward.
Staff Involvement	Divisions and ward clinical nursing and operational teams have been fully engaged as have other lead members for Psychology and Occupational Therapy.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Focus Area	Voice ☐ Community ☐ Quality ☒ Service Development ☐ Workforce ☒ Learning and Research ☐ Financial Sustainability ☐
Committee meetings where this item has been considered	

Report Summary and Key Points to Note

This report provides an overview of Safer Staffing & our annual Establishment Review to the Committee and summarises our progress and improvement within the last few months.

The CIS dashboard was softly launched in January 2024, and has been running in parallel with the previous Operational Staffing Dashboard. This has allowed us time to collect feedback from divisions on its use, and deal with any quality issues. Its official release has now been agreed as the 21st February, at which point the Operational Staffing Dashboard will be removed. This new dashboard pulls information directly from patients care plans on RIO and acts as another assurance mechanism for divisions to review daily and ensure good quality and accuracy of this data.

Our annual establishment review concluded in January 2024 and will come into effect in April 2024, in line with the new financial year. This is with the exception of the rehab and other 'houses' which will conclude by March 2024. This annual review has been the most comprehensive St Andrews has carried out.

The review has concluded with a realignment of registered nurses and HCAs to benchmark informed levels. For our Qualified nurses, although previous reviews were well intended the investment in qualified nursing was not achievable due to market pressures or in line with best practice for thriving wards. For our HCA's, St Andrews commissioned an NHS benchmarking study which clearly stated a high level of HCA's and a lack of other multidisciplinary roles. This, combined with a re baseline of the levels of enhanced support built into each ward has seen our HCA numbers change. We will also be protecting the Occupational Therapy and Psychology staff outside the care hours and ward rosters to ensure their dedication to meaningful activity and therapies for our patients.

Appendices:

Appendix 1 – Day snapshot
Appendix 2 – Night snapshot

Safer Staffing Update –
Staffing Dashboards
Clinically Informed Staffing (CIS) Dashboard
Establishment Reviews
Nursing Workforce Standards Benchmarking

Our Staffing Dashboards continue to be available to help inform the right staffing adjustments to the baseline based on both occupancy and levels of enhanced observations, escorting needs or extra-care packages. These continue to be used daily in various divisional meetings and groups to closely monitor staffing levels, and ensure any areas of concern are quickly escalated and actioned. Over the last 4 weeks, we have been progressing a move from our previous Operational Staffing Dashboard, to our new Clinically Informed Staffing Dashboard (CIS). The final release of the new CIS dashboard is planned for the 21/02/24, which is when the old dashboard will be removed from circulation.

Operational Staffing Dashboard

Day shift snapshot:
(Appendix 1)

	Occupancy				Enhanced Support				Q-Registered (Q-RN and Q-RP)									U-Unregistered (U-RN)							Totals						
Site-Division-Group-Ward	Baseline	Actual	Var to Baseline	Var to Prev Day	Baseline ES	Actual ES	Var to Baseline	Var to Prev Day	Planned	Adjusted	Planned + Adjusted	Q-RN Actual	Q-RP Actual	Q Actual	Variance	Variance %	Q Unfilled	Planned	Adjusted	Planned + Adjusted	U Actual	Variance	Variance %	U Unfilled	Planned	Adjusted	Planned + Adjusted	Actual	Variance	Variance %	Unfilled
⊞ Birmingham	123	121	-2	1	9.3	7.0	-2.3	0.0	19.5	0.0	19.5	15.7	0.0	15.7	-3.8	80 %	0.0	37.0	2.5	39.5	42.6	3.1	108 %	2.4	56.5	2.5	59.0	58.2	-0.8	99 %	2.4
⊞ Essex	66	52	-14	-1	4.7	3.0	-1.7	-0.7	12.5	0.0	12.5	11.3	0.0	11.3	-1.2	90 %	1.7	23.2	-4.0	19.2	18.8	-0.4	98 %	6.0	35.7	-4.0	31.7	30.0	-1.7	95 %	7.7
⊞ Nottingham	0	9	9	0	0.0	9.0	9.0	0.0	1.0	0.0	1.0	1.3	0.0	1.3	0.3	130 %	0.0	14.0	0.0	14.0	15.2	1.2	108 %	0.0	15.0	0.0	15.0	16.5	1.5	110 %	0.0
⊟ Northampton	425	443	18	1	102.8	116.6	13.8	1.0	98.7	-3.0	95.7	88.4	0.0	88.4	-7.3	92 %	11.9	239.6	49.2	288.8	261.6	-27.2	91 %	45.9	338.3	46.2	384.5	350.0	-34.5	91 %	57.8
⊞ CAMHS	17	10	-7	0	8.0		-8.0		4.0	0.0	4.0	4.2	0.0	4.2	0.2	105 %	1.0	11.0	0.4	11.4	8.9	-2.5	78 %	3.0	15.0	0.4	15.4	13.1	-2.3	85 %	4.0
⊞ LDA	102	106	4	0	41.2	54.8	13.6	0.0	24.7	0.0	24.7	23.6	0.0	23.6	-1.1	96 %	4.0	79.2	18.9	98.1	89.3	-8.8	91 %	22.4	103.9	18.9	122.8	113.0	-9.8	92 %	26.4
⊞ Medium Secure	115	129	14	0	19.7	25.7	6.0	0.0	23.5	0.0	23.5	19.2	0.0	19.2	-4.3	82 %	3.9	55.3	13.5	68.8	65.2	-3.6	95 %	8.1	78.8	13.5	92.3	84.4	-7.9	91 %	12.0
⊞ Neuro	114	117	3	0	25.5	29.4	3.9	-0.8	23.5	-1.0	22.5	22.5	0.0	22.5	0.0	100 %	1.0	58.3	13.2	71.5	64.6	-6.9	90 %	4.8	81.8	12.2	94.0	87.1	-6.9	93 %	5.8
⊞ Low Secure & Specialist Rehab	77	81	4	1	8.5	6.7	-1.8	1.8	23.0	-2.0	21.0	18.9	0.0	18.9	-2.1	90 %	2.0	35.8	3.2	39.0	33.6	-5.4	86 %	7.5	58.8	1.2	60.0	52.5	-7.5	87 %	9.5
Total	614	625	11	1	116.7	135.6	18.9	0.3	131.7	-3.0	128.7	116.6	0.0	116.6	-12.1	91 %	13.6	313.8	47.7	361.5	338.1	-23.4	94 %	54.3	445.5	44.7	490.2	454.7	-35.5	93 %	67.9

This daily staffing dashboard snapshot is from a weekday in January (18/01/24), and reflects fairly positively our overall staffing position at a charity level. Whilst some divisions continue to have challenges in resourcing for qualified nurses, there remains the ability for wards to partially mitigate this by backfilling with HCA's. Whilst this mitigates the shortfall in total numbers, it doesn't fully mitigate the skill mix loss. Skill mix is very closely monitored by divisions, through their divisional bleep holder, with any concerns being escalated through the divisional daily huddle and subsequent redeployments made if required. The presence of Ward Managers on the ward Monday to Friday who are in the majority qualified nurses, as well as the improved senior nursing visibility on wards through our Quality Matrons helps to enhance the skill mix. Divisions continue to focus on trying to obtain consistent scheduling across the week of 2 qualified nurses in the day. This snapshot does show an improved position and balance of skill mix (Qualified vs HCA), compared to last months report.

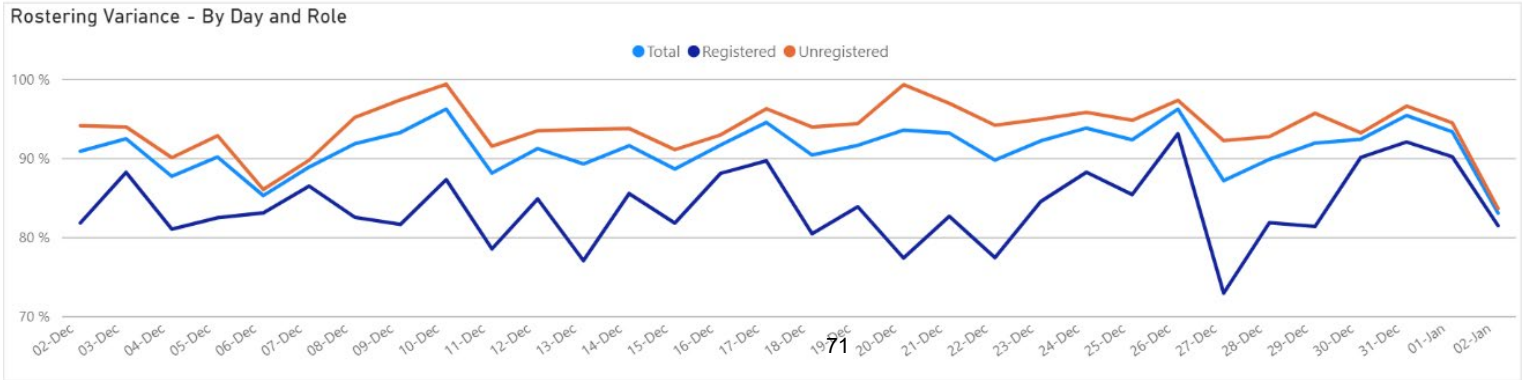
Night shift snapshot
(Appendix 2)

	Occupancy				Enhanced Support				Q-Registered (Q-RN and Q-RP)									U-Unregistered (U-RN)							Totals						
Site-Division-Group-Ward	Baseline	Actual	Var to Baseline	Var to Prev Day	Baseline ES	Actual ES	Var to Baseline	Var to Prev Day	Planned	Adjusted	Planned + Adjusted	Q-RN Actual	Q-RP Actual	Q Actual	Variance	Variance %	Q Unfilled	Planned	Adjusted	Planned + Adjusted	U Actual	Variance	Variance %	U Unfilled	Planned	Adjusted	Planned + Adjusted	Actual	Variance	Variance %	Unfilled
⊟ Northampton	425	442	17	0	92.7	105.7	12.9	-3.7	55.7	0.0	55.7	51.1	0.0	51.1	-4.6	92 %	1.7	218.7	44.8	263.5	255.1	-8.4	97 %	25.0	274.4	44.8	319.2	306.2	-13.0	96 %	26.7
⊞ Low Secure & Specialist Rehab	77	81	4	0	8.6	5.0	-3.6	-2.0	13.5	0.0	13.5	12.0	0.0	12.0	-1.5	89 %	0.0	31.3	1.6	32.9	32.0	-0.9	97 %	5.1	44.8	1.6	46.4	44.0	-2.4	95 %	5.1
⊞ CAMHS	17	10	-7	0	9.5	1.7	-7.9	0.0	4.0	0.0	4.0	3.0	0.0	3.0	-1.0	75 %	0.6	10.0	1.8	11.8	10.7	-1.1	91 %	1.0	14.0	1.8	15.8	13.7	-2.1	87 %	1.6
⊞ LDA	102	106	4	0	36.3	50.5	14.2	0.0	13.4	0.0	13.4	12.8	0.0	12.8	-0.6	96 %	1.2	72.6	19.7	92.3	91.1	-1.2	99 %	10.5	86.0	19.7	105.7	104.0	-1.7	98 %	11.7
⊞ Medium Secure	115	128	13	0	17.8	24.8	7.0	1.3	11.8	0.0	11.8	10.6	0.0	10.6	-1.2	89 %	0.0	54.8	9.4	64.2	63.3	-0.9	99 %	4.1	66.6	9.4	76.0	73.9	-2.1	97 %	4.1
⊞ Neuro	114	117	3	0	20.5	23.7	3.1	-3.0	13.0	0.0	13.0	12.7	0.0	12.7	-0.3	97 %	0.0	50.0	12.3	62.3	57.9	-4.4	93 %	4.4	63.0	12.3	75.3	70.6	-4.7	94 %	4.4
⊞ Birmingham	123	120	-3	0	9.3	7.0	-2.3	-2.0	12.0	0.0	12.0	7.0	0.0	7.0	-5.0	58 %	1.0	22.0	5.0	27.0	31.0	4.0	115 %	0.0	34.0	5.0	39.0	38.0	-1.0	97 %	1.0
⊞ Essex	66	54	-12	0	6.3	4.0	-2.3	0.0	8.0	0.0	8.0	7.0	0.0	7.0	-1.0	88 %	0.0	16.0	-1.0	15.0	15.0	0.0	100 %	2.0	24.0	-1.0	23.0	22.0	-1.0	96 %	2.0
⊞ Nottingham	0	9	9	0	0.0	8.2	8.2	0.0	1.0	0.0	1.0	1.3	0.0	1.3	0.3	130 %	0.0	12.0	0.0	12.0	14.9	2.9	124 %	0.0	13.0	0.0	13.0	16.2	3.2	125 %	0.0
Total	614	625	11	0	108.3	124.8	16.6	-5.7	76.7	0.0	76.7	66.4	0.0	66.4	-10.3	87 %	2.7	268.7	48.8	317.5	316.0	-1.5	100 %	27.0	345.4	48.8	394.2	382.4	-11.8	97 %	29.7

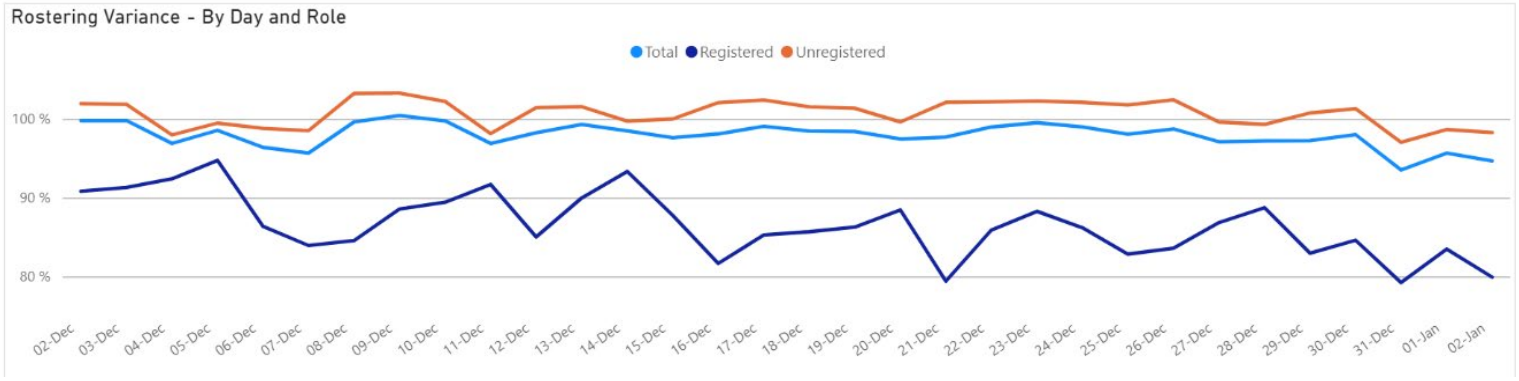
This snapshot is from a weekday night shift in January (15/01/24). Divisions continue to focus on redeploying qualified resource from days onto nights where they can, and where the 2 qualified nurses in the day has been met. There does however remain a challenge where wards that are planned to have 2 qualified nurses at night can rarely get these filled due to some anxieties from these nurses of getting moved to an area that they don't feel confident in, due to sickness or the absence of any qualified nurse in another area. This leads to a very lean qualified nursing picture at night. This is somewhat mitigated by each division have a clinically informed qualified contingency plan at night, as well as the presence of night site co-ordinators who are outside of ward care hours. We are also exploring as part of our charity nurse workforce plan, the rotation of nurses across divisions and additional training required to enhance competence in unfamiliar areas.

In terms of trends and assurance data there are multiple lenses to look through and the following tools continue to be used regularly and are highlighted below. All of these dashboard show our staffing data from the 2nd December to 2st January.

Rostering Trends
Day

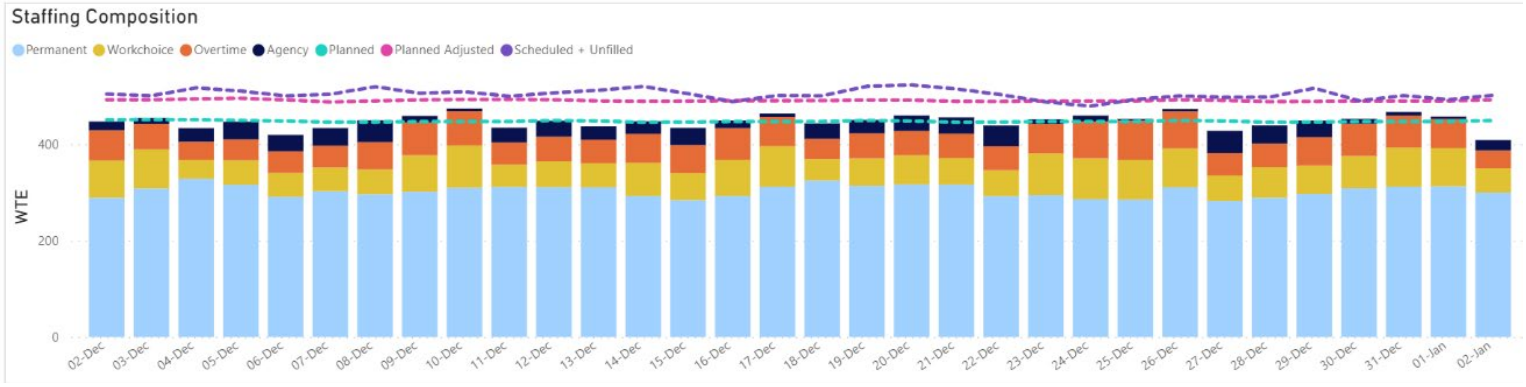


Night



Staffing Composition

Day:



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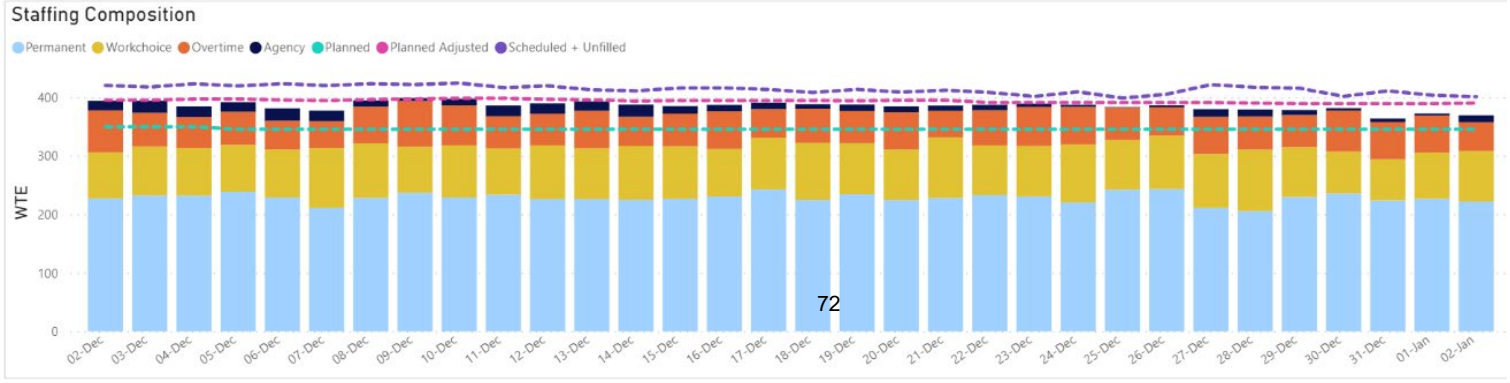


NEW Clinically Informed Staffing Dashboard (CIS)

The CIS dashboard was softly launched in January 2024, and has been running in parallel with the previous Operational Staffing Dashboard. This has allowed us time to collect feedback from divisions on its use, and deal with any quality issues. Its official release has now been agreed as the 21st February, at which point the Operational Staffing Dashboard will be removed.

The new dashboard will reduce the amount of time clinical teams are having to spend on decisions around staffing levels, and give them more time back to spend on the wards and with patients. There will be exceptional occasions whereby a change in acuity on the ward may not be captured in the automatic algorithm (as not related to change in ES/occupancy) and therefore local divisional conversations will continue. The final release on the 21st will allow for manual adjustments to be applied on top of the CIS calculation where clinically required, and approved by the divisional directors.

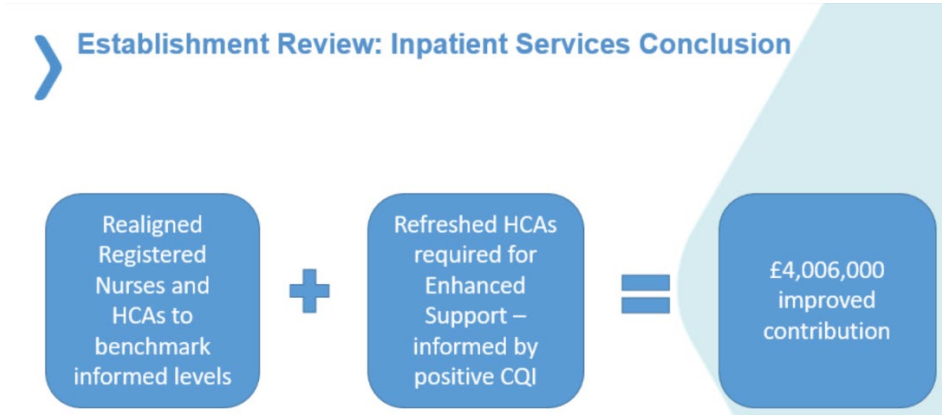
It is also anticipated that this release will positively influence the quality of some of our patient data, including seclusion and ES recordings. The CIS dashboard pulls information on ES, seclusion and LTS directly from RIO patient care plans. Divisions will be able to cross check the information on the dashboard, with their local knowledge of what they know to be happening on the wards, to identify any gaps or inaccuracies in the RIO documentation.

CIS Dashboard

	Q-Registered					U-Unregistered					Totals			
Site-Division-Group-Ward	Planned	Actual	Variance	Shift Fill %	Q Unfilled	Planned	Actual	Variance	Shift Fill %	U Unfilled	Planned	Actual	Variance	Shift Fill %
⊟ Northampton	97.7	79.3	-18.4	81 %	18.4	283.8	264.4	-19.5	93 %	25.7	381.5	343.6	-37.9	90 %
⊞ Low Secure & Specialist Rehab	21.0	15.9	-5.1	76 %	4.1	34.1	37.4	3.4	110 %	1.3	55.1	53.4	-1.7	97 %
⊞ CAMHS	6.0	5.8	-0.2	97 %	1.2	14.4	14.1	-0.3	98 %	1.0	20.4	19.9	-0.5	97 %
⊞ LDA	24.7	17.1	-7.6	69 %	6.5	94.8	80.6	-14.2	85 %	12.1	119.5	97.7	-21.8	82 %
⊞ Medium Secure	23.5	17.2	-6.3	73 %	5.6	66.8	66.6	-0.2	100 %	1.7	90.3	83.8	-6.5	93 %
⊞ Neuro	22.5	23.3	0.8	103 %	1.0	73.8	65.7	-8.1	89 %	9.7	96.3	89.0	-7.3	92 %
⊞ Birmingham	19.5	13.0	-6.5	67 %	5.4	40.8	43.7	2.9	107 %	10.2	60.3	56.7	-3.6	94 %
⊞ Essex	12.5	11.8	-0.7	94 %	0.7	20.8	25.2	4.4	121 %	1.4	33.3	37.0	3.7	111 %
⊞ Nottingham	1.0	1.0	0.0	102 %	0.0	14.0	11.9	-2.1	85 %	0.0	15.0	12.9	-2.1	86 %
Total	130.7	105.1	-25.6	80 %	24.6	359.4	345.2	-14.2	96 %	37.4	490.1	450.2	-39.9	92 %

Establishment reviews

Our annual establishment review concluded in January 2024 and will come into effect in April 2024, in line with the new financial year. This is with the exception of the rehab and other 'houses' which will conclude by March 2024. This annual review has been the most comprehensive St Andrews has carried out and has involved best practice visits to other Good or Outstanding providers, which has helped our Senior leaders learn from these and inform this work. These reviews also used an evidence based national staffing tool (MHOST), triangulated alongside professional judgment and review of quality, safety and workforce data. This is line with the NQB Workforce Safeguards guidance. All reviews were clinically led but advised by the Exec, and included a full review of the multidisciplinary team. This is with the exception of the social work review, which is due to conclude in March 2024.



The review has concluded with a realignment of registered nurses and HCAs to benchmark informed levels. For our Qualified nurses, although previous reviews were well intended with a desire to invest in qualified nursing, this was not achievable due to market pressures or in line with best practice for thriving wards. For our HCA's, St Andrews commissioned an NHS benchmarking study which clearly stated a high level of HCA's and a lack of other multidisciplinary roles. This, combined with a re baseline of the levels of enhanced support built into each ward has seen our HCA numbers change. Another important change is that we will be protecting the Occupational Therapy and Psychology staff outside the care hours and ward rosters to ensure their dedication to meaningful activity and therapies for our patients.

Next steps and enablers

- In order to be ready to launch the new changes from 21st April 2024, we have a coordinated implementation programme involving nursing, ops, HR and project support.
- Dedicated and local comms plans are in place and will launch next week to understand the changes at local level on each ward – no redundancies will take place for our nursing or HCA staff as vacancies were frozen through the design period however some staff will redeployed and wherever possible this will be within their own Clinical Division
- Patients and carers will also be communicated with in terms of how we are working to improve their experience and support the recovery journey by the investment in occupational therapy staff for every ward and tailoring the multi-disciplinary team to the needs of the patient group such as in neuro-rehab
- New templates, rosters and processes are being designed and the clinically-informed staffing dashboard will go live by February 2024

- The cultural change for wards will be such an important part of the success of this change and the Ward Manager and HCA development programmes will also start in Q4 supported by our new Director of Nursing
- Other important enablers include the timetabling of the non-nursing staff back onto the wards in a more visible way; the current CQI programme to reduce unnecessary enhanced observations continuing and the digital huddles, handovers and shift planning projects

Nursing Workforce Standards Benchmarking 2024

	Fully meets the standard
	Partially meets the standard
	Does not meet the standard

Nursing Workforce Standard (NWS)		RAG	Evidence
NWS 1	Senior nurses set nurse staffing and report to Executive Boards.		Annual establishment reviews take place in line with Safer Staffing Policy & Procedure (currently being updated – due April 24 in line with refined process).
	Executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision.		Establishment review template updated & used consistently across all wards. Training took place September 23.
			Annual MHOST acuity & dependency data collection complete as per license (Sep 23)
			Clinically led Division establishment review, informed by exec, concluded January 24 and due for implementation April 24.
NWS 2	Nurse establishments based on service demand and user need		Annual MHOST data collection enables on-going review of acuity and dependency
	Registered nurse and nursing support workers establishments should be set based on service demand and the needs of people using services. This should be reviewed and reported regularly and at least annually. This requires corporate board level accountability		Safecare acuity pilot continues in Essex (daily acuity & dependency collection)
			Quality, Safety & Workforce metrics regularly reviewed in monthly divisional IQPR's, to support safe staffing decision making.
			Allocate enables robust advanced shift planning
			Daily Ward & Divisional Huddles to oversee safe staffing against clinical demand
NWS 3	Business continuity plans enable staffing for safe effective care		Staffing Escalation flowchart & action card procedure sets out the Charity's standard approach to managing challenging staffing levels from day to day, to critical levels.
	Up-to-date business continuity plans must be in place to enable staffing for safe and effective care during		All divisions have Qualified contingency plans in place.

	critical incidents or events.		Regular divisional & Charity review of Datix incidents for use of action cards (no Q on shift) – process is being reviewed and needs to be clarified with ward level staff.
NWS 4	Nursing workforce is recognised and valued		Nursing pay structure is aligned with national guidance and Agenda for Change pay Structure. 5% increase communicated to workforce Sep 23.
	The nursing workforce should be recognised and valued through fair pay, terms and conditions		Charity HR policies and procedures are in place, & recently been reviewed to fairly manage staff within the organisation
			Nursing career development and progression plans are in place. Nursing workforce plan in place but is being reviewed in line with below.
			Recent appointment of Director of Nursing
			Nursing strategy to be developed – led by DON.
			Regular Ward Manager, Quality Matron and ADN huddles in place.
NWS 5	Each nursing embedded service has a Registered Nurse Lead		The Charity has a robust divisional nursing leadership structure, with the recent investment into Associate Director of Nursing & Quality Matron positions in all divisions.
	Each clinical team or service that provides nursing care will have a registered nurse lead.		All Nursing teams have a dedicated Quality Matron, Ward Manager & Deputy Ward Manager.
			A clear Ward to Board structure is set out in the governance Structure.
NWS 6	Nurse leaders receive dedicated workforce planning time		All wards have an identified Ward Manager with 100% supervisory time allotted. This time remains fully protected to support;
	A registered nurse lead must receive sufficient dedicated time and resources to undertake activities to ensure the delivery of safe and effective care.		• Leadership and team management • Improvement and monitoring of care quality service delivery • Workforce monitoring and planning • General ward management • Staff wellbeing support
			MHOST training held throughout August 23 for all Deputy Managers & above, to support annual review process.
			Roster training sessions held for all ward managers across the charity throughout Sept-Dec23. Roster permissions returned to WM's as of Feb 24.
NWS 7	Practice development time considered when defining workforce		The Charity has Practice Educators & a Preceptorship Lead who support post registration nurses during preceptorship and internationally educated nurses to complete the OSCE process and achieve NMC registration at ward level.
	The time needed for all elements of practice development must be taken into consideration when defining the nursing workforce and calculating the nursing requirements and skill mix within the team.		Nursing Protected time pilot started in Essex in September 23. This will be rolled out across divisions in 2024.
			Preceptorship policy reviewed, approved and published end of 2023.
			Clinically informed establishment review, led by ADN's
NWS 8	Apply sufficient uplift when calculating nursing workforce		The Charity uses the MHOST staffing tool for nursing workforce establishment calculations. The tool overlays acuity and dependency data against workforce parameters such as annual leave,

			sickness and study leave.
	When calculating the nursing workforce Whole-Time Equivalent (WTE) uplift will be applied that allows for the management of planned and unplanned leave and absence.		Total Establishment uplift of 25% applied
NWS 9	Substantive nursing workforce below 80% is exceptional		Monthly review of vacancies and staffing at divisional level as part of IQPR.
	If the substantive nursing workforce falls below 80% for a department / team this should be an exception and should be escalated and reported to the board / senior management.		Recruitment files now in place for all wards, with every role having a post reference number – owned by GM's and SD.
			Regular recruitment panel to review requests against vacancies prior to advert.
			Escalation procedure in place, including use of action cards. Incident command structure has been strengthened through the introduction of GM's/QM's as Duty manager (bronze command)
NWS 10	Nursing workforce is prepared and works within scope of practice		All nursing staff working as substantive or bank members of staff undergo a robust induction period and undertake mandatory training as required. Each member of staffs training records are accessible to the individual, & their line manager through SAP.
			Charity wide review of Charity and local induction – and more specifically support for HCA induction.
			Individual training skills (e.g. SIT, ILS, Dysphagia) will be uploaded into Allocate to support with appropriate skill mix deployment & visibility.
	Registered nurses and nursing support workers must be appropriately prepared and work within their scope of practice for the people who use services, their families and the population they are working with.		Mental Health Competency Framework has been developed and approved at QSG to support all our Adult/Child/International Nurses. DON to lead on roll out 2024.
NWS 11	Nursing workforce rostering accounts for safe shift working		Electronic rostering (Allocate) is fully established in all clinical nursing teams across the Charity.
	Rostering patterns for the nursing workforce will take into account best practice on safe shift working. Rostering patterns should be agreed in consultation with staff and their representatives		E rostering policy has recently been reviewed, updated & due to be published.
			Allocate audits & KPI reporting available.
			Roster Performance groups established and taking place.
			New establishment implementation scheduled for April 24 means that all personal patterns and roster builds are currently being reviewed.
			Individual skills & training profiles will be uploaded onto Allocate. Currently only speciality of nursing registration is available.
			Appointment of new Clinical Safer Staffing Lead.
			Shift times being reviewed as part of a large charity wide project.
NWS 12	Nursing workforce is treated with dignity and respect		Staff expect to be treated in accordance with the Charity Values.
	The nursing workforce should be treated with dignity, respect, and enabled to raise concerns without fear or detriment, and to have these concerns responded to.		We have now recruited and have in post a Freedom to Speak up (FTSU) lead, supported by a number of FTSU guardians. We will be advertising for more FTSU guardians. Policy & procedure to support this currently being updated. Re socialization and championing of this service required

			charity wide.
			Regular ward staff meetings being promoted, with staff encouraged to attend. Teams options available.
			PSIRF implementation and a focus on Just Culture & psychological safety. Currently in transition phase and socialization.