CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Thursday 24 March 2022 at 9.30 am

Great Hall, Main Building
St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG

		Info / Dec	LEAD		Page No.	Timing
1.	Welcome and Apologies	Information	Paul Burstow		*3*	*09.30*
Administration						
2.	Declarations of Interest	Information	Paul Burstow		*4*	*09.31*
3.	Minutes from the Board of Directors Meeting in Public on 27 January 2022	Decision	Paul Burstow	✓	*5-13*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*14-15*	*09.35*
Chair's Update						
5.	Chair Update	Information	Paul Burstow		*16*	*09.40*
Executive Update						
6.	CEO Report	Information	Jess Lievesley	✓	*17-23*	*09.45*
7.	East Midlands Board Paper in Common	Information & Decision	Jess Lievesley	✓	*24-40*	*10.00*
Finance						
8.	NHS Improvement Annual Solvency Commitment	Decision	Alex Owen	✓	*41-45*	*10.05*
Quality						
9.	Quality Improvement System Support and Buddying Workstreams Update	Information	Andy Brogan & Julie Shepherd	✓	*46-47*	*10.10*
10.	CQC Report and Action - Progress Update	Information	Andy Brogan	✓	*48-51*	*10.25*
11.	Safer Staffing Report	Information	Andy Brogan	✓	*52-64*	*10.35*
Matters Arising / Discussion Topic						
12.	Workbridge Strategy	Information & Comment	Martin Kersey (Holly Taylor & Laura Agnew)	✓	*65-65*	*10.45*
Break 11.00 am to 11.10 am						
Assurance						
13.	**Committee Updates** • Pension Trustees • Quality & Safety Committee • People Committee	 Information Information Information	 Martin Kersey David Sallah Paul Burstow	 ✓ ✓ ✓	 *67-69* *70-73* *74-76*	*11.10*

14.	Governance Oversight Group Update and Decisions for the Board	Assurance	Alex Owen	✓	*77-82*	*11.20*
Operations						
15.	Integrated Quality & Performance Report, incorporating: • Divisional Performance • Finance update • Covid response and update • Information Security Metrics	Review & Comment	Anna Williams, Kevin Mulhearn, Dr Sanjith Kamath & John Clarke	✓	*83-106*	*11.30*
Patient / Carer Voice						
16.	Divisional Presentation (including patient voice): Medium Secure Division – Women's Services	Information	Dr Sanjith Kamath (Alex Hamilton and patient)	✓	*107*	*11.50*
People						
17.	Lead the Change	Information	Martin Kersey (Tom Bingham)		*108*	*12.20*
Any Other Business						
18.	Questions from the Public for the Board	Information	Paul Burstow		*109*	*12.40*
19.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*110*	*12.43*
20.	Date of Next Meeting – Friday 27 May 2022	Information	Paul Burstow		*111*	*12.45*
Meeting Closes at 12.45 pm						

Welcome and Apologies

(Paul Burstow – Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 27 January 2022

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

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

Thursday 27 January 2022 at 09.15 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Jess Lievesley (JL)	Interim Chief Executive Officer
Alex Owen (AO)	Chief Finance Officer
Andy Brogan (AB)	Chief Nurse
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director
In Attendance:	
John Clarke (JC)	Chief Information Officer
Duncan Long (DL)	Company Secretary
Rupert Perry (RP)	Lead Governor
Anna Williams (AW)	Director of Performance
Alex Trigg (AT)	Director of Estates and Facilities
Oliver Shanley (OS)	Advisor to the Board
Dr Peter McAllister (PMc) Item 7	Assoc. Medical Director for Education
Dr Deborah Morris (DM) Item 7	Director, Centre for Developmental and Complex Trauma
Holly Taylor (HT) Item 7	Director of Learning and Development
Cheryl Smith (CS) Item 7	Head Teacher, St Andrew's College
Dr Muthu Natarajan (MN) Item 15	Clinical Director
Melanie Duncan (Minutes)	Board Secretary
Apologies Received:	
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
David Sallah (DS)	Non-Executive Director

Agenda Item No		Owner	Deadline
1.	**Welcome** PB (Chair) welcomed everyone to the first part of the Board of Directors (Board) meeting, which is a meeting held in public. Apologies received from Andrew Lee, Elena Lokteva and David Sallah were noted. JL welcomed Oliver Shanley and Alex Trigg to the meeting.		
ADMINISTRATION			
2.	**Declarations Of Interest** All members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose.		
3.	**Minutes Of The Board Of Directors Meeting, held in public, on 25 November 2021** The minutes of the meeting held on the 25 November 2021 were **AGREED** as an accurate reflection of the discussion.	**DECISION**	

4.	**Action Log & Matters Arising** The following actions were reviewed; 27.05.21 **02** - **NHS Benchmarking Network** - Covered as short seminar – **CLOSE** 24.08.21 **05 - Safer Staffing Report** - AB's report will go to the next People Committee. Establishment reviews are ready for sign off. Formal sign off will be done annually at the Board in the future. Report will be presented to Board in March. Remain Open 24.08.21 **06 - Armed Forces Covenant** - **CLOSE** 25.11.21 **01 - IQPR Disaggregated Data** - Remain Open 25.11.21 **02 – IQPR Staffing and Financial Impacts** - Included in the Agenda - **CLOSE** 25.11.21 **03 - Estates & Facilities Annual Board Update** - **CLOSE** 25.11.21 **04 - CQC Inspection Reports** - **CLOSE**	**DECISION** **DECISION** **DECISION** **DECISION** **DECISION**	
CHAIR'S UPDATE			
5.	**Chair Update** PB provided a verbal update to the Board, outlining the engagement with the Court of Governors, which was ongoing. There was also work ongoing with the buddy organisations due to the recent CQC reports. PB commented that he hoped that visits to sites would recommence shortly following recent announcements and subject to agreement with AB and SK, and in accordance with IPC guidelines. The Board **NOTED** the update.		
EXECUTIVE UPDATE			
6.	**CEO's Report** JL presented his report, which was taken as read. He outlined the major focus on the quality improvement programme and thanked those partner organisations from the East Midlands Alliance who were providing support through the process. Planning was taking place within the work streams, looking at all levels within the Charity. Quality improvement was being approached as a Charity-wide initiative, with some areas being given additional support. Covid had continued to be a focus over the last period between Boards, but there had been less clinical impact than expected, however, the impact on staffing had been profound, further impacted by the recent cyber-attack on Kronos, which had required a manual work around to support the workforce. JL extended thanks to all of those who had supported the additional work until the incident concluded. Work was now ongoing with the legacy issues this has left the Charity with. MHOST would now be implemented on 31st January. JL highlighted that engagement was ongoing with those members of staff who remain unvaccinated and a further discussion on this would take part during the confidential part of the Board meeting. The Your Voice staff survey had been completed with a response rate of 57%, with the overall engagement score at 51%. The positives centred around line management and career progression. Those areas which required attention were beginning to be addressed. JL then thanked AO who had recently stepped down as CFO, noting that Kevin Mulhearn would be taking over as interim CFO.		

PB reiterated JL's thanks to AO and noted that the People Committee would be considering the detail of the staff survey at its next meeting. PB would also be circulating more details to Board members from the Your Voice staff survey.

PB noted that a member of staff had contacted him raising a concern regarding mandatory vaccination and how the Charity was approaching the subject.

JL replied that significant amount of work had already been undertaken, and noted that the numbers were low, however, the approach being taken was in line with NHS provider organisations within the East Midlands Alliance.

SN wished AO well in her future, and asked JL if the numbers of non-vaccinated staff could be split into patient facing and non-patient facing. JL replied that the information would be shared within the confidential part of the meeting. He added that mask wearing, and social distancing measures remained within the Charity for the foreseeable future.

SN also wanted to know what the overall effect on staffing would be with the introduction of MHOST and asked if a direct comparison would be done post implementation to ascertain the effect that the project had had. AB replied that formal evaluation was planned.

SN asked about the timeline regarding the integrated strategy development. JL replied that a report would be presented to the Board in March.

AO noted the financial impact of MHOST and anticipated that costs would not reduce dramatically to give a buffer, however, as of April, MHOST would be used to determine establishment figures.

SRW wanted to thank all staff for their hard work in recent weeks, particularly over the Christmas period.

PB added that recruitment was underway for a new CEO, with the process concluding in March.

RB commented that there had been a huge effort made by senior managers during the recent Kronos outage and wanted to compliment the Executive on the handling of the incident, adding that early flagging of concerns at that level would be helpful. PB wished to note how well senior management had dealt with the Kronos incident.

The Board **NOTED** the update

MATTERS ARISING / DISCUSSION TOPICS

7. Education Update

PMc, HT and CS joined the meeting and presented an education update.

PMc gave a presentation on the medical education department, outlining the existing and future initiatives being undertaken.

SN thanked PMc for the presentation and asked how many medical students were at the Charity and where they were from. He also asked if there was a limit and what was the financial return of having the students. PMc replied that there were 280 from Buckingham and 100 from Cambridge Universities, giving a total return in the region of £500k. The number of placements has reduced recently, however, the quality has increased, with no increase in safety incidents. There was still some capacity however, coupled with the fact that NHFT were now also taking students. SN asked if this was for both in and outpatient activity. PMc confirmed that this was the case.

HT then gave a presentation on Learning & Development, which was also taken as read. HT noted 180 individuals from within the Charity who had qualified in a variety of areas in the previous year, including the Charity's first MBA students and the first Associate Nurses. In addition, those students who

	were studying English and Maths had also attained qualifications. The future Directors programme was also progressing, with 3 more joining the cohort this year. HT and her team were looking forward to a review of learning and development in the coming year. OS thanked HT for her presentation and asked what the vehicle was for ensuring staff diversity and inclusion into the development programmes, and how was the patient voice included within the programmes. HT noted that diversity and inclusion was forefront in talent development. Those staff who required additional support were given it to ensure that they performed to their best ability. HT also outlined the patients who helped with the production of learning material and leant their experiences accordingly. RB noted that the amount of training delivered in previous years within the Charity was much higher than seen in other organisations. HT confirmed that this was the case and that it was testament to the students. She also acknowledged that the baseline training data compared well against other organisations, which was because of being creative in delivery especially during the pandemic. RB thanked HT. SN acknowledged the achievements to date and asked about career development coupled with MBAs and if those people left or stayed within the Charity. HT confirmed that she kept a close eye on this group from a retention viewpoint, as well as checking if the qualifications were fit for purpose. SN explained that he wanted to gain a sense of who was staying and who was moving on. HT acknowledged that not everyone would be able to stay within the Charity, but that the skills offered would be beneficial to the healthcare sector in general. PB asked how the Board and the People Committee could gain assurance that investment in learning and development was translating into improved outcomes and quality. HT outlined 'practice education', which was being introduced and how it would be rolled out across wards, and in turn, correlate to an increase in quality. PB felt that continued focus on this question would be necessary. CS presented the slides relating to St Andrew's College and patient education, noting that it had been a challenging environment over the last couple of years. There had been an OFSTED inspection in June 2021, with an overall rating of Good, with Outstanding for behaviour and attitudes. CS also highlighted a range of initiatives being undertaken by the education department, as well as support for careers within secondary schools. The Lightbulb rollout was increasing from local to regional and hopefully national in due course. JC wanted to thank both CS and HT regarding their hard work and support in the recent weeks. PB thanked all for their presentations, in particular for how they illustrated the differing aspects of the Charity. The Board **NOTED** the presentations		
8.	**Trauma Presentation** DM presented her slides on Trauma, highlighting the research behind the work being done. PB acknowledged the learning around burnout and the impact of trauma on staff, and asked DM how the learning had translated into practice. DM outlined a survey that had been done in December 2020, which covered moral injury as well as other aspects of wellbeing, noting that there had not been an overall decline seen in staff wellbeing, however, there had been peaks and troughs observed. DM also noted two conferences held on staff well-being, which give the opportunity to look at evidence based work. PB asked what impact this would have on the quality improvement programme. DM replied that moving		

	staff between wards would have an impact on wellbeing, and that a secure base was highly important to them. AB was supportive of the work, and wanted to highlight the term trauma, and the emotive aspects attached to it. DM agreed. SN was impressed by the formal publications and conference presentations, and asked how DM's time was divided between education, clinical and research. DM noted that 2 days per week were spent on research. SN asked how income generation was progressing, and what courses were being offered. DM outlined the potential courses on offer, and how they would be income generators. DM also highlighted the online conference which had become very successful over the period of the pandemic. PB acknowledged the work done by the centre and noted the opportunities that this work could offer, adding that there was more that could be done by way of policy influencing. PB wished the Board to keep a line of sight on this work. The Board **NOTED** the presentation.		
9.	**Pensions Scheme Act 2021 Update** AO presented the paper which was taken as read, and noted the changes to the Act which would apply to St Andrews, along with the aspects that the Board should to be aware of. SRW noted that the pension scheme was 100% funded and that the reliance on the Charity covenant would be minimal, with the buy-out deficit being lower since the last valuation in 2019. PB noted how helpful this was from a trustee perspective. PB wanted to make sure that this would be built in to the decision making process in the future. AO agreed and would consider and report back to Board. The Board **NOTED** the update	**AO**	**24.03.22**
QUALITY			
10.	**CQC Report and Action – Progress Update** AB presented the update which was taken as read and reiterated to the Board that the Quality Improvement Plan (QIP) was the immediate response to the improvement notices from the CQC, and was progressing well, with timescales being met on all actions. This was overseen by a weekly meeting, chaired by JL where the individual team reports were considered. Women's Services were also being supported by Dr Vishelle Kamath, along with a series of specific targeted training sessions being undertaken and supported by the CEC both on a day and night shift basis. AB highlighted some aspects that were outside of the Charity's control, the Kronos outage being one of them, along with the national shortage of registered nurses. The work undertaken on monitoring and allocation of staff was now beginning to show results. There had been a meeting with the CQC the previous week, which centred on what they were looking for and how the regulations would be applied. The nine Buddy Work streams were progressing well, with Julie Shepherd, NHFT Director of Nursing (Quality Improvement Director) meeting with everyone fortnightly, and then reporting directly to the Buddy Forum. SK added further information to the challenges experienced with Covid and Kronos. At the peak, of the recent wave, there were 900 staff absent, as opposed to approximately 300 as of the date of this meeting. There had been no clinical impact to the patients and there was a significant demonstrable improvement in quality despite the challenges. SN asked how far along the timeline for the re-inspection was the Charity. AB replied that the QIP was designed to respond to the CQCs findings in the		

	necessary timescales, however, addressing cultural challenges would remain a focus for the Charity after any inspection. SN asked if it was possible for the CQC to re-inspect prior to the 6 month timeline. AB replied that they could. He further added that an inspection would be unannounced. JL noted that the update sessions with the CQC had lessened in frequency to monthly meetings, suggesting a recognition of the work being undertaken. The training being delivered by Learning and Development, gave a level a comfort that the right trajectory was being followed for improving quality and care. SN asked how the staff replied to questions from the regulator. AB replied that this was an area of focus and that the training on offer would help with this. Previous CQC interactions with staff during inspections had clearly impacted the outcome. SN commented that in other inspections, trauma and research being mentioned had helped, and felt that the long-term cultural change and staff turnover should be reported to QSC and People Committee in order to show improvement. SN complimented the staff on how they were working on quality aspects. RB commented on building confidence with the regulator and asked how achievable the actions would be. RB also noted that in previous reports there had been 4 wards which were the focus and asked if this number had reduced at all. She also asked for an update on the partial assurance given in an audit of Long-Term Segregation (LTS) recently considered at ARC. AB replied that the 4 wards were still being supported, however, the Charity needed to be looked at as a whole. SK responded to the LTS question, by outlining the reasons for LTS, and the challenges experienced in moving patients out of it. PB concluded that QSC would consider this item in more detail at its meeting the following week. He noted AB comments that past compliance had been taken by the CQC as a guide to future compliance, and that legacy issues including cultural challenges, meant that the work of improving quality and the experience of patients and staff would remain a focus for the Charity after the Buddying support came to an end. AB noted that continuous improvement was an integral part of the process along with how the board monitored and offered challenge. The Board **NOTED** the update		
ASSURANCE			
11.	**Committee Updates** <u>Audit and Risk Committee</u> RB presented the update which was taken as read and noted that the Committee had been impressed by the systems and work undertaken within the Risk Management function. There had also been two internal audits conducted and reported in the period, which gave partial assurance. The Committee considered various options about how Internal Audit would be resourced in the future, with a hybrid option incorporating co-sourcing being decided upon. The timeline for the review of the Charity's annual report and accounts was also considered by the Committee. The Board **NOTED** the update <u>Quality Safety Committee</u> SN presented the update which was taken as read. The committee had continued to monitor the development of IT systems within Community Partnerships, as well as reviewing the 9 Buddy Workstreams for improvement and benchmarking. Deep Dives were received from the Birmingham and Essex sites with follow up presentations scheduled. Serious Incidents were looked at with benchmarking data also requested. The IQPR was discussed further, and it was agreed that aa revised dashboard would be presented to the Committee.		

	PB noted the clinical models work and asked when it would be ready for review by the Board prior to taking to the Court of Governors. SK outlined what was currently in place and how they would be addressed in order to present more robust models. The Board **NOTED** the update		
12.	**Governance Oversight Group Update and Decisions for the Board** AO presented the update to the Board which was taken as read, and noted that Sally MacIntyre, Programme Director, had tendered her resignation. AO explained that she would be taking over the project until her leave date at the end of March. RB wanted to note that this project required a single focus, and wanted to know how far the project would get before AO would leave. AO noted that by 31st March a clear action plan would be in place, with timelines for completion. The Board extended best wishes to Sally for the future. The Board **NOTED** the update		
GOVERNANCE			
13.	**Court, Board of Directors and Committee Calendar and Board of Directors Annual Work Plan – resubmission** PB and DL presented the revised calendar to the Board. SRW noted that Investment Committee dates were now confirmed, along with a slight amendment to one ARC meeting and one Research Committee meeting. The Board **NOTED** and AGREED the revised calendar	**DECISION**	
14.	**Integrated Quality & Performance Report** JC and AW presented the report which was taken as read, and explained that as a result of the Kronos outage, resource had been diverted from this initiative for the short term. AW noted that at divisional level, there was only one area of concern which had now been dealt with. At ward level, and across the 11 measures, there was a low level of concern seen. AW also noted the PREMS data presented for the first time, along with people and training being focus areas. JL wanted to reference the safety framework and noted that within the context of the buddying network, the work was seen as of a very high quality, in addition, the PREMS data being seen for the first time was a highlight. PB asked what the little or no data comment meant in the context of the 92% mentioned. JC replied that this related to areas that had no statistically relevant data which was classed as a positive. SN had concerns regarding statistically significant comments and suggested qualification of using these terms would be helpful, and further asked if benchmarking was being used in relation to PREMS. AW replied that none of the statistics were clinical and would be happy to look at the data from that perspective in the future, and that benchmarking would be done accordingly. SK gave assurance to SN regarding statistics, stating that individual trends were looked at. SN suggested looking at a comparable trust with regard to benchmarking the PREMS data. <u>Finance</u> AO reported that the financial performance was in line with expectations from the re-forecast and reiterated the risks with regard to occupancy levels along with the staffing models being introduced.		

	PB asked AO for an update from Finance Committee. AO updated that KPIs had been discussed along with the new budgets. SN added that bed occupancy rate projections had been reassured due to the opening of new wards. The Board **NOTED** the report		
15.	**Divisional Presentation** SK introduced the Neuropsychiatry service which was set up in the 1970s and had received Headway accreditation. MN introduced himself, Vincent Harding (VH) and Keith Jenkins (KJ), along with the parents of a previous patient. MN presented the slides to the Board which outlined what the service offered. During the presentation VH outlined John's Campaign and how this was used within the division to help the patients. KJ outlined the support which was on offer for the relatives of people living with acquired brain injury. The parents answered a range of questions regarding the background and care received by their daughter. PB asked how prepared the clinical team felt they were for a visit by the regulator. MN replied that work had begun to highlight those areas which required focus in order to achieve outstanding. Further comments were made on how the division had performed so well during recent developments within the Charity. PB thanked everyone for their presentations. The Board **NOTED** the presentation		
ANY OTHER BUSINESS			
16.	**Questions from the Public for the Board** No questions were received for the Board.		
17.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
18.	**Date of Next Meeting :** Board of Directors, Meeting in Public – 24th March 2022		

Approved – 27 January 2022

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

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

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
24.08.21 **05**	**Safe Staffing Report – Committee oversight** It was agreed that the new Safe Staffing report would be presented to both the Quality & Safety Committee and the People Committee for reporting, progress and assurance purposes ahead of submission to the Board.	AB	25.11.21	~~Open~~ Closed	**25.11.21:** Staffing report presented to latest People Committee and adapted report to be considered at QSC **27.01.22**: Report will be presented to Board in March **24.03.22** Item on Agenda – recommend Close Action
25.11.21 **01**	**Integrated Quality & Performance Report – Disaggregated data** As part of providing the Board assurance, the People Committee are to look at a disaggregated data for People KPIs in the future.	MK	10.02.22	Open	
27.01.22 **01**	**Pensions Scheme Act 2021** PB noted how helpful this was from a trustee perspective. PB wanted to make sure that this would be built in to the decision making process in the future. AO agreed, and would consider and report back to Board.	AO	24.03.22	~~Open~~ Closed	**24.03.22:** This has now been built into the authority matrix.

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of meeting	Thursday, 24 March 2022
Agenda item	**06**
Author	Jess Lievesley, Chief Executive (Interim)
Responsible Executive	Jess Lievesley, Chief Executive (Interim)
Discussed at previous Board meeting	Updates have been discussed at the Charity Executive Committee meetings
Patient and carer involvement	A number of these items would have been discussed with patients, carers
Staff involvement	Where staff have been involved in topics included within the paper this will be highlighted specifically in the relevant section
Report purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S ☒ E ☒ C ☒ R ☒ W ☒**
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☒ Innovation and Research ☒
Committee meetings where this item has been considered	

Report summary and key points to note

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

Appendices - None

CEO Report

This is the CEO report to the Board of Directors to provide information on a range of topics germane to the effective running of the Charity and provides an update of areas of focus for the Charity Executive Committee over the last reporting period that are not dealt with under other agenda items for the Board.

1. Quality

Quality Improvement Plan

From a quantitative perspective, I am pleased to be able to report that all of the key metrics indicate that improvements have been made in the delivery of care within our Women's services with restrictive practices and incidents at all levels having reduced. Pleasingly we are also seeing improvements in our qualitative feedback from service users as we begin to progress the 'My Voice' program (see below) which, along with improved friends and family results, do give confidence that the progress we are committed to deliver is resulting in improved outcomes and experience for those in our care. Mandatory training across all of the wards is now above 90% and changes in the 'feel' of the wards has been reported by external stakeholders and Buddy Trusts.

We do have a number of identified risks related to person's who have been identified as being delayed in their transfer of care to more suitable environments and we are working with commissioners and system partners to try to resolve this as promptly as possible, to support the continued recovery journey's for these individuals.

We are focusing a great deal of leadership time and attention to support our teams identify and address underlying cultural challenges- particularly where this relates to risk averse practice or prevailing views or behaviours that are not in keeping with our care values.

Update on Buddy arrangements

A number of site visits have now taken place with much of the focus in the Women's Wards. This has allowed the supporting Trusts to gain an understanding of our services and support with some of the Quality work that is required. Each Workstream has regular catch up meetings scheduled to ensure that progress is being made. All actions identified within the Workstreams have also been mapped onto the Charity-wide QIP to minimise duplication of work.

There have been a good deal of positive and supportive feedback from these visits, with improvements within Women's MSU in terms of practice and care being recognised.

We remain grateful to the East Midlands Alliance of NHS Trusts and the direct support from leadership provided by Northamptonshire Healthcare NHS Foundation Trust for the work and input they are providing to the Charity with our Quality Improvement Programs.

PREMS – Patient reported experience measures
Since its launch in January, all wards are now being actively supported to improve the uptake of My Voice, which will provide us with a great deal of information to correspond with the wider qualitative data we are now capturing as part of the patient safety framework. QSC will be monitoring our progress in this area as we expand its implementation and update Board accordingly.

Community Partnerships CQC report
The Board are asked to formally acknowledge the Community Partnerships CQC rating of "Good", with some outstanding practice identified in areas that the CQC recognised as being in limited supply nationally.

2. People

Culture
We have received strong interest from staff and we have appointed c100 'Lead the Change' Champions to work with us and help identify issues and to co-produce solutions and implementation plans. The first meeting with the Change Champions is scheduled for 30 March.

We have met with Mersey Care reference their Just Culture Change Programme as well as NFHT and LPT from the East Midlands Alliance to learn about their Cultural Change Programmes. We are sourcing external support for diagnostics, cultural surveys and programme support.

Sickness and absence management
Absence levels at 10% are unstainable at this level within the Charity and whilst the current position has been compounded by COVID, there is a need for a significant amount of focus to help drive improvements Charity wide. As well as being a key aspect of our cultural diagnostic, the improvement in our approach to sickness absence and related performance is a Workstream in itself and is being led by our Director of Delivery and Workforce Experience. In addition workforce wellbeing as a strand of our strategy has remained a priority area against which we will be detailing our approach and milestones within the March Board reports.

Recruitment and retention
Recruitment continues to be challenging and pay is proving to be our biggest issue. We have 204 new members of staff so far in 2022, including 12 nurses and 121 HCA's. We currently have 29 more nurses and 109 more HCAs in the pipeline.

Retention in February was 14% with the biggest reason for leaving being pay. Staff pay has been reviewed at CEC and Pay Group with pay proposals for Real Living wage, Pay Progression, Pay Review being included in the budget Process.

Appointment of Freedom to Speak Up Lead
Laura Dorrington has been appointed as Freedom to Speak up Lead reporting to CEO. Laura currently works for us as a Quality Business Partner and prior to that, she worked as a Recruiter in our Recruitment Team.

3. System working

Both I and the wider Executive Team continue to engage with local system partners, not only within the context of the East Midlands Alliance and Buddying arrangements referenced within our March Board papers. Executive colleagues, including our recently appointed Board Advisor, have engaged with partners from West London NHS Foundation Trust (Broadmoor), Merseycare NHS Foundation Trust as well as with a wider network of NHS strategic and operational leaders, learning from them in areas such as culture, quality improvements and performance benchmarking.

Through the NHS Confederation I have also been invited to roundtable meetings with the CQC and Sir Gordon Messenger who is conducting the review of leadership within the health and social care sector commissioned by the Secretary of State.

4. Pink Rooster arrangement

In keeping with our strategic intent to progress our charitable agency and relevance locally, within our main site we have recently agreed terms for a three year Lease of 186 Billing Road for occupation by the Northampton based dementia Charity, Pink Rooster, this letting allows Pink Rooster to develop their charitable dementia and therapy service and in turn supports our links into local community services. It is anticipated that Pink Rooster will occupy in approximately three months post the completion of legal formalities.

5. Covid 19

Covid 19 situation

The Covid 19 situation is improving in the Charity in line with what is being observed across the country. The daily Covid 19 meetings have been stepped down to three times per week to ensure proportionate levels of oversight of the management of the effects of the pandemic within the Charity. The number of staff having to isolate due to Covid 19 is reducing as well. There continue to be outbreaks of Covid in different areas (defined as 2 individuals, either staff or patients testing positive) although it is of note that no patient or staff member has become seriously unwell with Covid since the last update to the Board. This is similar to the pattern observed in other providers and clinical teams continue to manage outbreaks supported by colleagues in NHSE/I and UKHSA according to policy and procedure. The Charity recognises the challenge of minimising hospital transmission in these circumstances where most if not all public restrictions have ended and there is no longer a legal requirement to isolate after testing positive for Covid 19. The need to adhere to strict IPC procedures is being communicated to all staff. It is to be noted that placing an area into outbreak necessarily restricts the wards in terms of accessing leave and other off ward therapeutic activities and it is understood that UKHSA is likely to introduce revised guidelines for the management of Covid 19 outbreaks in healthcare settings in the near future. There is no shortage of Personal Protective Equipment (PPE) or Lateral Flow Testing devices (LFTs) which we continue to access without any problems.

Vaccination

The requirement for healthcare staff to be fully vaccinated against Covid became law on 6 January 2022 but the enforcement of this requirement was subject to a further period of consultation and following this, the requirement to be vaccinated has effectively been removed. However, the Charity continues to offer vaccinations while promoting the

importance of vaccination against Covid in the interests of safety and wellbeing of staff and patients.

6. Ukrainian conflict

As a Charity we have been deeply saddened to see the events unfold in Ukraine. We have done all we can to support our colleagues during this difficult time, specifically reaching out to our Ukrainian staff and providing additional leave and support. We have also displayed our support by lighting up our most publically viable building (FitzRoy House) in the colours of the Ukrainian Flag, something that has drawn out a great deal of pride and unity amongst our colleagues on our social media platforms.

We have conducted a rapid review of all contracts, investments and energy provision and can confirm to the Board that we have no direct relationships with Russian contracts or subsidiaries and we will be using our position as a major contractor and local anchor institution to ensure we are promoting a stand against the events that we have witnessed in Ukraine in recent weeks.

7. Communications and engagement

Lead the Change

Our Lead the Change programme launched in February and invited staff to become 'Change Leaders.' An impressive number of staff members are now involved – almost 100 people volunteered to Lead the Change.

We are inviting them all to a one-day workshop on 30 March where they will be given the skills and framework to 'Discover, Design and Deliver' a programme of change in the areas that they agree are the most important to staff and patients.

We are anticipating bringing the group together on a monthly basis to report their findings and agree next steps.

Quality improvement/Buddy Workstreams

The Lead the Change programme will overlap with many of the projects underway as part of our Quality Workstreams. We have decided to use the Lead the Change brand to communicate all the changes, as a way of simplifying the message.

We are now producing a regular newsletter for staff highlighting key progress and important new developments. A version will also be shared with external stakeholders. The staff newsletter is available here: Lead the Change newsletter (stah.org)

MHOST, our new staffing model

We've recently shared some success stories from our wards, highlighting the benefits they have found since moving to the new, flexible MHOST staffing model. Instead of focusing purely on staff numbers, MHOST looks at patient acuity, and offers wards more flexibility to do things differently to best support their patient group.

Fenwick, a Neuro ward, has changed its shift patterns to have more people on duty when needed, and fewer when patients are asleep. MHOST has meant that Fenwick have been able to start increasing patients' leave, and nurses are more available to carry out therapeutic activity on the ward. Since December they have also experienced a huge decrease in incidents, despite having an additional three patients.

Hawkins ward has made similar changes, ensuring they have more staff available between 5-7pm when incidents are historically more likely to occur.

On Bracken ward, MHOST has given the team the flexibility to appoint a meal servery assistant, who is allowing nursing staff to free up their time. The new team member, Flo, is being made to feel very welcome by the team and patents.

Long Service events
We are always delighted to congratulate and celebrate members of staff who dedicate much of their career to our Charity. We recently held a series of socially-distanced Long Service events to recognise long-standing staff members' commitment. In Northampton we presented 75 awards, ranging from 10 years to 40 years' service with the Charity. In Essex we presented one award, and 18 in Birmingham. All individuals received a gift voucher, framed certificate, and box of cupcakes made by Workbridge.

Particular note must go to Ged Rogers, Clinical Education Manger who has been with us for over 35 years, and Lesley Deacon, a HCA in our CAMHS Service, who has celebrated her Ruby anniversary with us. When asked at the event why she has stayed at St Andrew's for over 40 years, Lesley explained: "It's a great place to work with really dedicated, warm and friendly people. Also, I get a lot of out this job. I feel if I can help just one person leave the hospital and go on to live a happy and fulfilling life, then I've done my job and that makes me feel good. I have always wanted to make a difference and I think I do here."

CQC media coverage
The positive CQC report relating to our Consultancy service achieved some local coverage, including mentions in the BBC Radio Northampton news bulletins.

The Northampton Chronicle and Echo also covered this, with a mention of the Women's Service report too: St Andrew's Healthcare mental health community service rated 'good' in first watchdog inspection | Northampton Chronicle and Echo – but the rest of the article was fine.

Other media coverage

February kicked off with a St Andrew's column in the Chronicle and Echo written by Pride Network member Zoe Smith. Zoe wanted to mark the 50th anniversary of the very first Pride March in the UK and to round off the month, another network member Casey Fox also had her column about heteronormativity in the workplace published in the same newspaper. These pieces ensured our Pride Network got maximum coverage during LGBT+ History Month.
We also celebrated Children's Mental Health Awareness Week, which was the perfect opportunity to promote the College's LightBulb programme. To mark the campaign, two sixth form students from Northampton School for Girls shared their mental health experiences and how the St Andrew's programme had previously helped them.

Their story was picked up on the Chronicle and Echo website and in the print edition, Business in the News, UK News Latest, South East Online, the Healthcare Newsdesk and Wellbeing News.

Just days after that story was covered, St Andrew's released another press release announcing that local Northampton company Billing Finance had generously donated £5,000 to the LightBulb programme. This means that Cheryl Smith and her team can continue delivering it into schools.

The Chronicle and Echo covered the story both online and in the newspaper, as did Credit Strategy magazine and Rosette Publishing.

Headteacher Cheryl also gave an interview to online publication Tutorful about how to improve learning through digital technology. The story got picked up in quite a few other publications, including the Chiswick Herald, the Hounslow Herald, the FE News, the Independent School Parent, Educate Magazine, Essex TV and FE News.

An interview with Lead Occupational Therapist Sarah Hayes received a double page spread in the prestigious NR Times. She spoke about her experience of working with older people who have dementia and the privilege she feels in being able to support them.

Integrative Psychotherapist Liz Ritchie, who is also our resident media contributor, has been extremely busy throughout February commenting on a whole range of mental health related subjects. For the eager eyed newspaper reader you will have seen her name pop up in many different publications.

On February 1, trade magazine The Big Hospitality and the MCA published an article on how the pandemic has significantly impacted the mental health of those working in the hospitality sector. Liz gave her opinion on how business leaders must take care of their own mental health as well as taking care of their staff, too.

Later in the month, Liz also commented on a piece about manifestation which made it into London Loves Business, Business Leader and HR News.

Rounding off the month traditionally associated with love, was an article in The Nursing Times which quite neatly refers back to a member of staff who was showing a bit of appreciation for his colleagues on Mental Health Nurse Day.

Various nurses across the Charity were asked to talk about their role and why they do what they do to mark the awareness day, which annually take place on February 21.

Check out what they all said on the St Andrew's Twitter feed or read what Senior Staff Nurse John Barry Waldron had to say which made it into the nursing magazine.

Paper for Board of Directors	
Topic	East Midlands Board Paper in Common
Date of meeting	Thursday, 24 March 2022
Agenda item	**07**
Author	Jess Lievesley, Chief Executive (Interim)
Responsible Executive	Jess Lievesley, Chief Executive (Interim)
Discussed at previous Board meeting	Updates have been discussed at previous Board meetings
Patient and carer involvement	At this stage this paper has not been discussed with patients and carers but many of the work programmes and topics it describes do involve both patients and carers
Staff involvement	Many St. Andrew's colleagues are involved in the work programmes described within this paper
Report purpose	Review and comment ☐ Information ☒ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☐ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☐ Innovation and Research ☒
Committee meetings where this item has been considered	Charity Executive Committee & Board of Directors

Report summary and key points to note

This Common Board Paper has been produced by the East Midlands Mental Health and Learning Disability Alliance which as the Board will recall comprises of the five NHS Mental Health & Learning Disabilities Trusts across the East Midlands and the Charity.

The report will be presented to all partner organisation Boards' in due course, providing an update of the work to date and reflecting the role the group of Chief Executive and Chairs are playing to promote positive outcomes for service users through the wider network of NHS and system leaders.

The Board are asked to note this report, specifically the 3 key points as highlighted in the paper, namely that Provider Boards are asked to:

a) note the updates in the common Board paper including the range of joint work on quality and the success in attracting additional external funding to the East Midlands through the Alliance.

b) **approve** the updated Collaborative Agreement which has been amended following feedback from all six Boards and is supported by the CEO group.

c) review the appended common Board paper on the Perinatal Provider Collaborative.

Appendices – N/A

East Midlands Alliance for Mental Health and Learning Disabilities

Common Board paper

February 2022

Introduction

This common Board paper provides an update to Boards on the work of the East Midlands Alliance for the period October 2021 to February 2022.

CEO meetings

The CEO group has continued to meet on a fortnightly basis sharing current issues and challenges. Giles Tindsley, the NHS England regional Head of Mental Health, will join the CEO meeting on 11 February.

Health Education England funding to support the retention of Clinical Support Workers

The Alliance agreed to receive £752,000 of funding from Health Education England to support the retention of Clinical Support Workers. The Alliance Board agreed to a proposal from the Chief Operating Officer group to focus on four strands of work:

1. Develop a common programme to wrap round training, induction and support to increase retention and establish the Clinical Support Worker role as the first step on a supported career pathway. Engage a partner to develop and deliver a structured induction programme, wrap round support, on-going training, development packages and a support network. The idea is to develop a leading edge programme to be delivered across the Alliance.
2. Develop a competency framework linked to values based recruitment. This initiative is also aimed at improving retention, reducing turnover and increasing effectiveness. The aim is to develop a competency framework that identifies new Clinical Support Workers that will see the role as the starting point on a healthcare career.
3. Some of the funding will be used to support a values based recruitment process for CSWs developed at an East Midlands Alliance level and rolled out across providers.
4. Targeting more men into the Clinical Support Worker roles in mental health settings. Men are significantly under-represented in these roles in some providers in the East Midlands.

The first element of this programme is the lunch of two cohorts of 20 Clinical Support Workers within an externally funded development programme run by Talent for Care and supported by Health Education England.

Northamptonshire Healthcare has agreed to receive and hold this funding for the Alliance.

NHS England funding for the expansion of supervision capacity for psychological therapies

The Alliance agreed to receive £153,000 of funding from NHS England to support innovation in supervision. The Alliance Board agreed to support a proposal from the Chief Operating Officer group to focus the funding on a hub to provide specialist support across the Alliance with a focus on increasing capacity through the part-time return of recently retired clinical staff. St Andrew's Healthcare has developed a proposal to host the Hub. Lincolnshire Partnership agreed to receive and hold the funding for the Alliance.

CAMHS workforce challenges

There have been a series of meetings between Alliance partners to share approaches and agree joint actions to improve the position on CAMHS workforce across the East Midlands. A large action plan has been developed and progressed. The highest priorities in that plan are:

1. Request age profile data from HRDs relating to CAMHS inpatient units to scale the problem.
2. Holding a CAMHS clinical summit led by the Medical Directors on 4 February.
3. Joint review of the Derbyshire CAMHS risk mitigation plans relating to their loss of CAMHS capacity.
4. Developing a proposal to block purchase the commissioning of Higher Education training places for key CAMHS roles.
5. Receive and review a proposal from Lincolnshire Partnership to establish an OSCE Hub for the East Midlands.
6. Meet with HEE to discuss options to bid for their available funding to support CAMHS work.
7. Receive and review a proposal from Derbyshire on rotational roles across the Alliance

An update and review of the joint CAMHS action plan took place at the 25 January Alliance Board.

The Alliance CEO group held a joint session with Alliance Medical Directors to review and address concerns over the use of recruitment premia to move CAMHS consultants between Alliance member providers.

The meeting heard about the risks and challenges in Derbyshire caused by the loss of three of their four CAMHS consultants to Nottinghamshire. It also discussed the broader impact of using recruitment and retention premiums on pay inflation, gazumping between Alliance members and the risks that an unplanned movement in staffing can cause.

The group discussed opportunities to develop shared posts, sharing expertise and region wide rotas. There was also discussion about longer term service redesign to reduce the need for beds. The meeting heard about an example of a new joint CAMHS post which is split between two providers and focuses on both community and inpatient services.

The group discussed the reliance on agency doctors, the opportunity to grow your own doctors and international recruitment. The group also discussed the nature of the CAMHS work and work environments alongside potential actions to make environments safer.

The meeting shared concerns that moving community staff to cover inpatient settings will ultimately drive up demand for inpatient support. The group discussed capping locum rates and agreed to stop the use of RRP.

The following actions were agreed:

- There was agreement to take a common Alliance wide approach.
- The Medical Directors would write to CAMHS consultants acknowledging the challenges and setting out the intent to work together in this space.
- The Alliance CEOs were agreeing not to use RRP.
- The Medical Directors will develop a short, medium and long term plan.
- There would be an immediate focus on mitigating the issues in Derbyshire.
- A summit will co-produce a medium and long term plan.
- The HR Directors will be drawn in.
- Wider engagement with the CQC, Royal Colleges and HEE would form part of the plan.
- Itai will coordinate.
- The Alliance will develop an MOU in relation to CAMHS.
- This group will come back together to review progress.

The summit with CAMHS consultants from across the East Midlands to agree what will change and how the available investment resource to transform CAMHS services might be used took place on 4 February and the CEOs will invite the Medical Directors to meet with them again to review the agreed plan and next steps.

A review of the risk mitigation in Derbyshire took place on 7 February with senior representation from across the Alliance. The meeting heard that Derbyshire have mitigated their immediate clinical staff risks but set out a set of supportive next steps for Alliance partners to support the Trust. The CAMHS Collaborative agreed to further develop a single plan of action on CAMHS workforce.

Eating Disorders workshop

The CEO group agreed to hold a joint eating disorder workshop to hear from the leads of CAMHS and Adult Eating Disorder services on the challenges that they face, to share innovation and consider joint actions. A workshop on 10 December was well attended and opened by Angela Hillery.

The issues and challenges included:

a) Significant increases in referrals, acuity and caseloads
b) Waiting lists for review and treatment
c) Keeping people safe while they wait for treatment – focus of the teams
d) Access to beds outside of the East Midlands collaborative area
e) Workforce supply
f) The transition from CAMHS to Adult services
g) Clarifying ownership of physical health monitoring with Primary Care and commissioners
h) Potential for new targets – RTT
i) Modelling likely demand and capacity as the service expands in Derbyshire to create a comprehensive service

The innovation shared included:

a) New roles – e.g. Advanced Nurse Practitioners
b) Work with Gastro colleagues in acute trusts

c) Peer Mentors, diabetes offer and Gastro clinics (Derbyshire)
d) Close work with Community Mental Health and the PD Hub (Northants)
e) FREED services
f) Group work to meet some of the increased demand
g) Guided self-help guidance
h) Buying in support from Beat to help with service waits
i) Support, training and advice to Primary Care to address anxiety relating to being responsible for people with eating disorders
j) Use of OPEL levels for ED services
k) Closer joint work between Leicestershire and Northamptonshire
l) Intensive Home Treatment model
m) Direct consultation models working with GPs and VCSE (Lincolnshire)

The workshop also considered very significant differences in the services provided in each ICS, the AED Collaborative inpatient bed review and funding offers from NHS England to develop a medical monitoring models for children in crisis and to undertake training to be better able to manage disordered eating referrals.

National visit to the East Midlands Academic Health Science Network

The national NHS England Transformation team are undertaking a series of visits to each Academic Health Science Network. The East Midlands Network invited the Alliance to take a prominent role in their review in November, focusing on mental health and the successful partnership between the AHSN and Alliance. David Williams and Graeme Jones presented alongside Eddie Alder from the AHSN on the development of the Patient Safety network and broader support from the AHSN to the Alliance.

East Midlands Mental Health Patient Safety programme

The development of the joint Alliance and AHSN Mental Health Patient Safety programme was the main topic for the Alliance Board development sessions in October. The plans for the three main strands of the programme have been developed and learning and best practice is being shared across the region and from beyond.

The overall aim of the programme is to improve the safety and outcomes of mental health care by reducing unwarranted variation and providing a high quality healthcare experience for all people across the system by March 2024. The three strands of the programme are:

1. Reducing Self harm and Suicide
2. Reducing Restrictive Practices
3. Improve Sexual Safety in inpatient services

Participation from the six providers has been good and the AHSN are arranging a learning day with regional awards on 14 June 2022 at St Andrew's in Northampton.

An Understanding Safety Culture webinar was held on 31 January to discuss how to introduce a safety culture, to understand an example and how to use Quality Improvement and Human Factor Ergonomics to Improve Safety.

Alliance buddy support to St Andrew's

The Alliance is providing buddy support to St Andrew's as part of their improvement programme. Northamptonshire Healthcare are leading the support programme. The CEOs of St Andrew's and Northamptonshire Health care have met with the national Director for Mental Health, Claire Murdoch, to brief her. An update on the progress of the support programme is presented to each Alliance Board. All Alliance partners have nominated lead Directors and taken the lead role with one of the workstreams.

Provider Collaboratives

Each Alliance Board receives written updates from each Provider Collaborative including successes, progress, risks and issues for escalation. In recent months the Board has noted the strong progress made by the Veteran's collaborative, the workforce challenges in CAMHS and Adult Eating Disorders and the quality and financial challenges being addressed by the Impact Forensic collaborative.

The Alliance Board agreed a letter of support from the CEOs to NHS England supporting the establishment of a Perinatal Provider Collaborative under the leadership of Derbyshire Healthcare. The CEOs also expressed their preference for two collaboratives in the Midlands, to focus on mother and baby units in the first instance and the importance of ICSs and local providers developing and delivering community models that best meet the needs of their local populations.

Alliance Strategy Director forum

The Alliance Strategy Director forum has continued to meet with a focus on the planning, strategic developments, innovation and the links with the NHS England Provider Collaborative programme and the new East Midlands Integrated Commissioning Board. In recent months the Strategy Directors commissioned a CAMHS innovation horizon scan from the AHSN and met with the regional Head of Mental Health to agree the focus and scope for the planning process for 2022/23.

East Midlands Integrated Commissioning Board

Sarah Connery and Ifti Majid have represented the Alliance on the Integrated Commissioning Board. The Integrated Commissioning Board has discussed Perinatal services and had discussed whether future collaboration should have a Midlands wide or a West Midlands/East Midlands footprint.

There had also been some discussions on who will hold contracts in the future and the link to ICSs and local LHLDA alliances. The CEOs asked that the Strategy Director group consider this at their next meeting and produce a proposal for CEO review.

Proposed revised governance arrangements for the Alliance

The Board development sessions in October included a presentation by Kevin Lockyer, Chair at Lincolnshire Partnership and Graeme Jones on the revised and streamlined Collaborative Agreement for the Alliance. The revised version has been to all six Boards for consideration and comment. All six Boards were supportive of the revised document. The main comments were on the need to

ensure that the final version includes specific reference to autism and the need to define the exit notice period. A final version is appended to this Board paper for approval.

Recommendations

Provider Board are asked to:

a) note the updates in the common Board paper including the range of joint work on quality and the success in attracting additional external funding to the East Midlands through the Alliance.

b) approve the updated Collaborative Agreement which has been amended following feedback from all six Boards and is supported by the CEO group.

c) review the appended common Board paper on the Perinatal Provider Collaborative.

Appendices

1. Perinatal Provider Collaborative common Board paper
2. East Midlands Alliance Collaborative Agreement

Common Private Board Paper

East Midlands Perinatal Mental Health (PMH) Services Provider Collaborative Update

Purpose of Report

The purpose of the report is to update all Boards/Governing Bodies of organisations participating in the perinatal mental health provider collaborative. The paper updates on the current position and reflects discussions held at dedicated sessions of the Midlands Perinatal Mental Health Clinical Network in November and December 2021 and January 2022.

Introduction

Further to the Common Private Board paper circulated to all participating trust Boards in March 2021 updating on the work of the East Midlands Mental Health and Learning Disabilities Provider Alliance (the Alliance) during 2020/21, NHSE/I announced in Autumn 2021 that Phase 2 of the Provider Collaborative work, which includes Perinatal Mental Health Services, should be taken forwards. This is a further opportunity to work towards the Alliance's strategic ambition to improve the health and wellbeing of the local population by working in collaboration.

As outlined in the March 2021 paper, it is proposed that Derbyshire Healthcare FT (DHCFT) will be the Lead Provider for the Perinatal Mental Health Services Provider Collaborative and that the Alliance will be the overarching governance mechanism for this collaborative in addition to current provider collaboratives.

The partners in the Provider Collaborative are:

- Derbyshire Healthcare NHS Foundation Trust (Lead Provider)
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust

This partnership, including community perinatal services providers, provides an opportunity to bring together decision making on inpatient services from providers across the whole pathway, and work closely with community teams to connect services and improve quality.

Key principles of the provider collaborative are that it is clinically driven and that input from Experts by Experience are integral to both the planning, development and oversight of delivery of the model.

Developments to date

- DHCFT has been in ongoing dialogue with NHSE/I and a letter of support (23 November 2021) has been written from the Alliance to NHSE/I to reiterate their support for DHCFT to take this role, that the provider collaborative take an East Midlands footprint and the remit be specialist inpatient services.

- DHCFT has undertaken Trust Board level discussion to review Lead Provider risks and confirm commitment to taking on the role. This includes a proposal to use the

Northamptonshire Healthcare Commissioning Hub for commissioning support (as for the provider collaboratives for Adult Eating Disorders Services and CAMHS).

- A national Task and Finish Group on Perinatal Provider Collaboratives presented their findings in November 2021 recommending that provider collaboratives should take a whole pathway approach to perinatal mental health.

- The Midlands Perinatal Mental Health Clinical Network has had three sessions to discuss the development of the provider collaborative – including presentation from the national lead, Becky Gill. This well-established forum has broad clinical and operational involvement from all proposed providers in the collaborative.

- A project group has been established by NHSE/I to oversee the development of the PMH provider collaborative and carry out the Gateway assessment process.

- A proposed timeline for 'go live' has been outlined as July-October 2022. In order to ensure that clinical input and engagement with Experts by Experience is meaningfully driving the clinical model and business case, NHSE/I have been asked to review this timeline and confirm an October 2022 date.

Midlands Perinatal Mental Health Clinical Network

The clinical network met on 11 January and confirmed their support for the following:

- That the provider collaborative should have an East Midlands footprint (ie including two Mother and Baby Units, at Derby and Nottingham)

- The clinical network supported the view that the East Midlands Provider Collaborative should include the responsibility for in-patient services at Mother and Baby Units only, but work closely with community teams in order to connect services and therefore enhance the quality of service user experience.

The network also discussed **clinical ambitions** to drive the collaborative to enhance the experience and outcomes for patients and families. Several initial principles were identified.

That the East Midlands perinatal mental health provider collaborative:

- will not disrupt natural patient flows
- will seek to maximise continuity of care between MBUs and community services (including admissions and discharge processes)
- will ensure equity of service provision across both MBUs
- will work to ensure equity of access (link with epidemiology and demographics to ensure that services are available to those with greatest need)
- will work to reduce unwarranted variations of care
- will develop embedded Expert by Experience engagement in ongoing operation and development of the collaborative

Next Steps

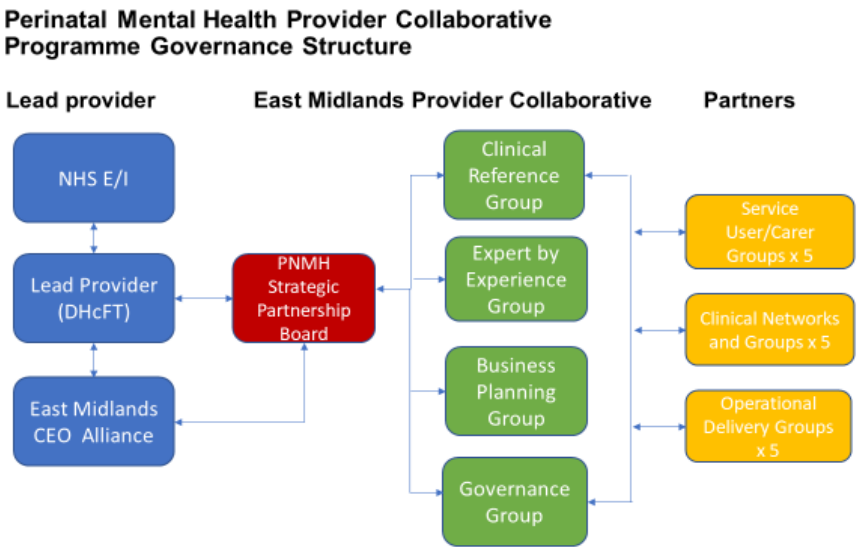
- Initial perinatal mental health provider collaborative planning meeting on 19 January involving Executive Leads from provider trusts and representatives from ICSs to discuss taking forward the governance (see Annex A) and leadership of the collaborative, and to establish meaningful ongoing partnership with commissioner colleagues
- Appointment of Clinical Lead
- Liaison with Clinical Network to establish Clinical Reference Group and Expert by Experience Group to input to the collaborative clinical model and business case and take an ongoing role in the collaborative once operational.

Recommendations

Boards/Governing Bodies are asked to note the update and support appropriate engagement and representation to the proposed provider collaborative governance arrangements.

Annex A

The proposed wider Provider Collaborative governance to support development, planning and engagement to develop an effective business case is as below:



East Midlands Alliance for Mental Health and Learning Disabilities

Collaborative agreement

Version 10

7 February 2022

For approval

1. Background

1.1 The East Midlands Alliance for Mental Health and Learning Disabilities was formed in summer 2019 bringing together the six largest providers of mental health, learning disability and autism services in the East Midlands. The establishment of the Alliance was based on a Memorandum of Understanding agreed by the providers boards.

1.2 The Alliance has made strong progress in areas of joint work including the establishment of four Provider Collaboratives to take on the organisation and commissioning of specialised veterans, forensic, child and adolescent mental health and adult eating disorder services from NHS England.

1.3 As the work programme has expanded and the formal responsibility for specialised services moves across from NHS England to the Alliance, the provider Boards have agreed to establish an Alliance Executive Board based on a new Collaborative Agreement.

2. The Alliance partners

- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- St Andrew's Healthcare

3. Aims and objectives of the East Midlands Alliance

3.1 The Alliance was established in 2019 based on a Memorandum of Understanding approved by the six provider members. The aims in setting up the Alliance were to:

- establish a more formal collective arrangement to strengthen joint working and support delivery of the NHS Long Term Plan,
- to share learning across the East Midlands,
- undertake the strategic oversight of the Provider Collaboratives
- to develop a stronger collective East Midlands voice for mental health, learning disability and autism.

3.2 The establishment of the regional alliance is consistent with the national mental health leadership view that each NHS Trust will be part of a local system provider alliance and a wider regional provider alliance.

3.3 The agreed initial objectives in setting up the Alliance included:

- Working together to improve the quality and effectiveness of mental health, learning disability and autism services in the East Midlands
- Working more collectively to deliver the NHS Long Term Plan across the East Midlands region
- Establishing a more effective voice for mental health, learning disability and autism via an Alliance
- Sharing best practice and effective solutions to common issues
- Thinking and acting more strategically across the East Midlands
- Being consistent with the national policy direction
- Establishing a vehicle through which to take strategic decisions relating to the East Midlands Provider Collaboratives

4. Governance

4.1 The Alliance Board does not seek to establish a new organisation or legal entity. The Alliance Board is established by the Providers, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Providers.

4.2 The Alliance Board will function through engagement and discussion between its members so that each of the Providers makes a decision in respect of each matter considered by the Alliance Board. The decisions of the Alliance Board will, therefore, be the decisions of the individual Providers, the mechanism for which shall be authority delegated by the individual Providers to their representatives (normally their CEO) on the Alliance Board. The Providers will ensure that the Alliance Board members understand the status of the Alliance Board and the limits of the authority delegated to them.

4.3 The Alliance is made up of willing partners and as such, any of the six member organisations can withdraw from the Alliance. This should be done in writing from the CEO and Chair of the organisation to the other Alliance members giving three months' notice. Withdrawal from the East Midlands Provider Collaboratives will be managed in line with the withdrawal procedures, including notice periods and surviving terms, set out in the respective Partnership Agreements.

5. Executive Board

5.1 The Alliance will be overseen by an Executive Board which will be made up of the Chief Executives of the six provider partners. The Board will meet every two months.

5.2 The Alliance Board will oversee the development and implementation of an annual work programme, respond to opportunities and shared challenges through collaborative work, allocate specific tasks to the professional groups and act as the Part B Board for the East Midlands Provider Collaboratives.

5.3 The Alliance Board will receive updates from each of the East Midlands Provider Collaboratives including key risks, issues and strategic decisions. The Alliance Board will act in line with the respective Provider Collaborative agreements which have been approved by the Boards of the Alliance members.

5.4 The Board will be chaired by one of the provider Chairs for a one year term before rotating to another provider Chair.

5.5 Conflicts of interest will be declared at the start of each Alliance Board meeting. Conflicts of interest relating to the pathway specific East Midlands Provider Collaboratives will be managed in line with the relevant approved Partnership Agreement.

5.6 The Alliance Board will agree an annual work programme informed by the Boards of the member organisations.

5.7 The Alliance will hold regular joint Board development sessions to share progress and review issues of common interest to member Boards.

5.8 A common Board paper will be circulated following each Alliance Board to keep provider Boards updated and to set out any decisions for the member Boards.

5.9 The Alliance Board will undertake an annual review of the effectiveness of the governance arrangements and the impact of the Alliance. This review will be carried out with the Chairs of the member organisations.

Signed by

for and on behalf of .....

Derbyshire Healthcare NHS Foundation Trust

Signed by

for and on behalf of .....

Leicestershire Partnership NHS Trust

Signed by

for and on behalf of .....

Lincolnshire Partnership NHS Foundation Trust

Signed by

for and on behalf of .....

Northamptonshire Healthcare NHS Foundation Trust

Signed by

for and on behalf of

.....

Nottinghamshire Healthcare NHS Foundation Trust

Signed by

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for and on behalf of

St Andrew's Healthcare

Paper for Board of Directors	
Topic	NHS Improvement Annual Solvency Commitment
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**08**
Author	Alexandra Owen, Chief Finance Officer
Responsible Executive	Alexandra Owen, Chief Finance Officer
Discussed at Previous Board Meeting	Reviewed annually
Patient and Carer Involvement	Not appropriate due to the commercial nature of the document
Staff Involvement	Not appropriate due to the commercial nature of the document
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☐ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Considered at Committee Meetings	

Report Summary and Key Points to Note

As a 'Commissioner Requested Service' we come under the scrutiny of NHS Improvement. They track our financial performance to ensure that we are financially sound and able to continue to provide services. They do this on a quarterly basis but once a year require confirmation from us as a Board of Directors.

They require us to make the following statement:

"The Board of St Andrew's Healthcare formally confirm that St Andrew's Healthcare reasonably expects to have the required resources to keep our Commissioner Requested Services running over the course of the next 12 months.

In making this statement we have considered:

- *The level of current and likely future demand for Commissioner Requested Services.*

- *The availability of appropriately skilled workforces.*
- *The availability of facilities.*
- *The availability of working capital and other financial resources.*

I remain confident that we can make this statement and seek the Board's agreement to do so.

Appendices:

- Continuity of Services 7 Self-Certification
- Self-Certification against the G4 Licence Conditions
- Self-Certification against the G6 Licence Conditions

Continuity of Services 7 Self-Certification

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

In making this statement the Executive Team have considered:

- The level of current and likely future demand for Commissioner Requested Services.
- The availability of appropriately skilled workforces.
- The availability of facilities.
- The availability of working capital and other financial resources.

Signed on behalf of St Andrew's Healthcare:

Name: Alexandra Owen

Position: Chief Finance Officer

Signature: ……

Date: 24 March 2022

24 March 2022

To: Sarah Dorje, Deputy Director of Independent Providers, NHS Improvement

Sent via sarah.dorje@nhs.net

Dear Sarah

Re: Self-Certification Against the G4 Licence Condition (Fit and Proper Persons as Governors and Directors) for St Andrew's Healthcare

Following a review of licence condition G4, the Directors of the Licensee confirm:

- that the Licensee has not, in the financial year most recently ended appointed any person as a Director who is unfit within the meaning of licence condition G4(5);
- that the Licensee's contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person; and
- that, in the financial year most recently ended the Licensee enforced that provision promptly upon discovering any Director to be an unfit person (if applicable).

'Director' is defined in licence condition D1 (Interpretation and Definitions) and includes any person who performs the functions of, or functions equivalent or similar to those of, a director or a company constituted under the Companies Act 2006.

Signed:

Name: Alexandra Owen

Position: Chief Finance Officer

On behalf of the licensed entity's Board of Directors.

24 March 2022

To: Dr Mark Hendy, Provider Transformation Programme Director, NHS Improvement

Sent via the Licensing Portal

Dear Mark

Re: **Self-Certification Against the G6 Licence Condition (Systems for Compliance with Licence Conditions and Related Obligations) for St Andrew's Healthcare**

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with condition G6.

Signed:

Name: Alexandra Owen

Position: Chief Finance Officer

On behalf of the licensed entity's Board of Directors.

Paper for Board of Directors

Topic	Quality Improvement System Support and Buddy Workstreams Update
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**09**
Author	Andy Brogan, Chief Nurse /Julie Shepherd, Improvement Director
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	Updates previously provided and discussed at the Board meeting on 27 January 2022.
Patient and Carer Involvement	A number of these items have been discussed with patients and carers, as part of the Quality Improvement Workstreams on the wards.
Staff Involvement	A number of these items have been discussed with staff as part of the response to improving quality and responding to the CQC inspections through focus groups and via the improvement workstreams.
Report Purpose	Review and comment ☒ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☐ Innovation and Research ☐
Considered at Committee Meetings	Updates have been discussed at the Charity Executive Committee meetings and weekly Quality Improvement meetings.

Report Summary and Key Points to Note

The presentation focuses on the quality improvement offer via the Mental Health Alliance. This improvement offer is led by an External Quality Improvement Director and consists of targeted support, through buddy workstreams focusing on the areas of greatest opportunity for improvement. Each workstream is supported by external organisations with expertise in the improvement areas

The presentation will update the Board on progress and the interdependencies with the internal quality improvement programmes, including the targeted support to the Women's service, the Quality Improvement Plan, and the introduction of a refreshed approach to staffing our wards consistently.

Appendices - None

Paper for Board of Directors	
Topic	CQC Report and Action – Progress Update
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**10**
Author	Jenny Kirkland, Director of Nursing, Quality & Physical Healthcare
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	The Women's and Men's CQC reports were discussed at the Board meeting on 27 January 2022.
Patient and Carer Involvement	A number of these items have been discussed with patients and carers, as part of the Quality Improvement projects on the wards in response to the CQC inspections.
Staff Involvement	A number of these items have been discussed with staff as part of the response to the CQC inspections through focus groups and via the improvement workstreams.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☒ Innovation and Research ☒
Considered at Committee Meetings	Updates have been discussed at the Charity Executive Committee meetings and weekly Quality Improvement meetings.

Report Summary and Key Points to Note

The attached is the report to the Board regarding the actions being taken following the CQC inspection of Women's and Men's services at Northampton.

The Quality Improvement Plan (QIP) has been developed with staff and is monitored on a weekly basis, with input from all divisions and support functions.

Four CQC related QIP actions have been closed through the assurance process with evidence shared with IMPACT.

Three CQC related QIP actions due to have been completed by February are going through final assurance processes, with one action to remain open, as this relates to sufficient staffing on the ASD/LD wards. Additional plans and trajectories are being worked through with the relevant teams to ensure that this remains a priority.

93 further CQC related QIP actions are currently in progress.

The East Midlands Health Alliance Quality Support Programme led by NHFT continues to support the Charity with the wider improvements identified, and these have been informed and linked to the actions identified in the QIP.

Appendices - None

CQC Report and Actions – Progress Update

ALERT:

The CQC inspected the Community Partnerships service in December 2021. The report was positive, with an overall rating of Good, with specific note given to the leadership of the service. The Safe domain was recorded as Requires Improvement due to the Basic Life Support training compliance sitting at below 75% on the day of the inspection. This was rectified before the report was written but is an automatic outcome from the CQC.

The actions following the inspections of Men's and Women's services in summer 2021 are being monitored by the weekly Quality Improvement Plan (QIP) meeting. There are 97 related actions currently open as a specific result of the inspections. A robust assurance process has been implemented, with the requirement to embed the actions, a need to provide evidence, and that assurance processes have been implemented. Four actions due to have been completed in January 2022 have been completed and closed, three of the four CQC actions due to be completed in February 2022 have been completed and are going through the assurance process to be closed. One action due to be closed in February 2022 relates to adequate staffing, specifically within the ASD/ LD division, and this will remain open.

Delays continue to be experienced with collating and presenting meaningful data, especially in regards to compliance, which is being met by extensive manual work-around. The delays in automating these processes, due to capacity issues within the information team, will have a direct impact on the ability to roll the improvements implemented within the Women's wards across the whole Charity, as time is spent on assessing compliance rather than the quality of service delivered. We continue to provide the requested information to our external partners, including CQC and commissioners within the required timeframes.

ADVISE:

The weekly QIP meetings are well attended and include representation from all divisions and support functions. The divisions not directly impacted by recent CQC inspections have been requested to review the learnings and identify relevance and actions for their areas of service and will be required to present this to the QIP meeting on a rolling basis.

The following table gives a breakdown of the number of actions aligned to the relevant CQC regulations by division and current progress state. Closed relates to an action that has been completed, and the assurance process has been completed and assurance gained. Completed awaiting closure relates to actions that the responsible person believes has been completed and is going through the internal assurance process where evidence is reviewed and, if relevant, additional assurance gathered and presented to the responsible executive and Executive Director for Quality for closure. In progress actions are currently being implemented.

	LSSR			LD ASD			MED SEC			Charitywide		
	Closed	Completed awaiting closure	In Progress	Closed	Completed awaiting closure	In Progress	Closed	Completed awaiting closure	In Progress	Closed	Completed awaiting closure	In Progress
Regulation 10 Dignity and Respect			3				1		2			2
Regulation 12 Safe care and treatment	1		27		2	14	1		10	1		
Regulation 13 Safeguarding service users from abuse and improper treatment			1		1				1			
Regulation 16 Receiving and Acting on complaints						1						
Regulation 17 Good Governance			6			3			2			3
Regulation 18 Staffing			2			2			3			2
Regulation 9 Person Centred Care			2			5						
Total	**1**		**41**		**3**	**25**	**2**		**18**	**1**		**7**

Specific focus remains within the Women's service due to the anticipated re-inspection within six months of report publication. This project has additional support and is led by Dr Vishelle Kamath.

To provide a level of assurance to the CQC a weekly meeting is attended by Dr Vishelle Kamath and the Director of Nursing for Quality Jenny Kirkland.

The East Midlands Health Alliance Quality Improvement Programme, led by our 'buddy trust' Northampton Healthcare Foundation Trust, continues to support the broader improvement work for the Charity that has been identified. The nine Workstreams are led by a member of the alliance, with a named individual from SAH supporting. The Workstreams have all individually developed plans for improvement – plans on a page, which are tried and tested Quality Improvement processes. These are monitored via a weekly internal review meeting and twice monthly with the Quality Improvement Director. Additional support has been provided to the Workforce Safeguards Workstream form NHSE/I and further support is being discussed with the Head of Mental Health Improvement NHSE/I in respect of leadership training and development, and potential access to Mental Health Model Hospital data. These Workstreams have been cross referenced to the relevant QIP actions to ensure central oversight and support with prioritisation.

ASSURE:

The quarterly divisional Integrated Quality and Performance reviews have commenced, which enable a collective review of a range of leading and lagging indicators, combined with clinical judgement and oversight of actions on the Charity wide QIP attributable to the relevant division and the Divisional QIP. This is triangulated with staffing data and financial performance.

Four CQC related actions from the QIP have been completed and closed in the period following the assurance process being completed. These related to dignity and respect, and safe care and treatment, and included improvements in restrictive practices, evacuation equipment and training and provision of information in a format that supports ward staff and patients to understand their own ward safety data.

Three CQC related actions from the QIP have been completed and are currently going through the assurance process to finalise and close the action. These actions relate to safe care and treatment, safeguarding service users from abuse and improper treatment, and staffing; and included improvements in monitoring and oversight of therapeutic interventions, enhanced support improvements, including the review and update of policy and procedure, the piloting of new technology to support the contemporaneous documentation of enhanced observations, reviews and updates of risk assessments, training programmes and the induction programme. Significant work with regards to closed culture has been undertaken across the Charity, with specific focus on the LD/ASD wards. This has included a new training package, a new co-produced language standard that has been developed with patients and staff, and a closed culture audit that is currently going through second line review.

The Quality and Safety Committee is provided with full oversight of the Charity QIP and assurance is provided through this structure.

Paper for Board of Directors

Topic	Safer Staffing Report
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**11**
Author	Chloe Annan, Safer Staffing Matron
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	Not previously discussed by the Board.
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	Regular staff engagement sessions are being held, both at Charity and ward level. Weekly Q&A sessions on MHOST and Safer Staffing have been held and have had good attendance and feedback. SSM continues to attend ward staff meetings and spend time on the wards.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Considered at Committee Meetings	

Report Summary and Key Points to Note

This report provides the Board with an overview of safer staffing across the Charity, in line with the requirements of the National Quality Board and the Developing Workforce Safeguards.

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

The Board is asked to:

- Review the position of our safer staffing in line with the requirement to publish staffing data.
- Review and acknowledge the increased workforce risks and support the mitigating actions identified throughout.

- Note the work undertaken to date and ongoing work to develop an evidenced approach to decision making, and to ensure compliance with the Developing Workforce Safeguards recommendations.

Appendices - None

Safer Staffing Report

Executive Summary

The purpose of this report is to provide assurance on the current position across all sites and wards, in accordance with the National Quality Board (NQB) guidance and the Developing Workforce Safeguards. This report focuses on reporting Safety and Quality data over the last three months and staffing data for all wards against the Charity's agreed Safer Staffing levels for the period of February 2022, following our move from the Hurst model to MHOST at the end of January.

The last three months have provided some significant challenges to staffing due to the COVID 19 pandemic and the Kronos outage. The report describes how the Charity responded to mitigate some of these shortages, where these occurred. The report outlines changes made to staffing baseline establishments following our move from Hurst to MHOST and provides the board with assurance on how safer staffing is being managed across the Charity.

Background

As part of the NHS England 'Hard Truths' minimum standards NHS trusts are required to present a monthly update report to the Public Trust Board containing a summary of planned and actual staffing on each ward; and this is a gold standard St Andrew's will now follow.

Organisations are expected to monitor their compliance with the NQB recommended 'triangulated approach' to staffing decisions. which combines the use of evidence-based tools, professional judgement and outcomes, to ensure the right staff with the right skills are in the right place at the right time considering patients' needs, acuity, dependency and risks.

Safe Staffing Daily Oversight and Monitoring

The Clinical Ops Hub continues to be a vital source of managing safer staffing on a day to day a basis. With an allocated Senior Manager on Site (SMoS) for each shift, they work closely with the allocated divisional bleep holders to record, action and monitor safer staffing across the site. Safer staffing discussions are now based around the 'feel of the ward', clinical acuity of the patients and skill mix of staff, rather than numbers alone.

A daily site meeting call takes place, led by the SMoS, with representatives from all divisions. This forum provides the opportunity for all issues related to safer staffing to be raised, escalated and discussed.

For wards where staffing concerns are escalated, the SMoS maintains oversight of the site as a whole and reviews the ability to redeploy between divisions. Where staffing concerns cannot be mitigated, actions cards may be implemented, guiding wards on the actions to take.

Staffing Fill Rates for February 2022

Below are the staffing fill rates for the month of February 2022, showing our variance on each ward for qualified and Unqualified staff against our planned number position. There are several wards that were above their planned position, and this is largely due to our temporary flex uplift process. Wards may be approved temporary flex uplifts if they have significant changes to patient acuity, occupancy or levels of enhanced support, which are not manageable within their planned number.

For the Northampton site, qualified fill rate in the day will be minimally impacted by the running of the Clinical Operations Hub – for which CNLs that hold the bleep (mostly in the afternoon and weekends) – are coded out of numbers to be able to fulfil this role efficiently. This has not been built into wards qualified base establishment, as ward level impact is minimal due to being shared out between the wards. The presence of the CNL on site and their ability to be visible across all of the wards within the division, helps mitigate some of the risk relating to qualified fill rate and skill mix.

February 2022 Actual vs Planned %

Division / Ward	Day		Night		
	Fill Rate % (Reg)	Fill Rate % (HCA)	Fill Rate % (Reg)	Fill Rate % (HCA)	Occupancy % (Vs Budget)
ASD & LD	**93.3%**	**102.0%**	**100.4%**	**109.5%**	**92.2%**
ASD Acorn	59.8%	110.1%	108.9%	96.7%	102.4%
ASD Berry	104.5%	123.4%	113.9%	132.9%	109.7%
ASD Brook	111.1%	91.3%	104.6%	107.9%	108.3%
ASD Fern	77.5%	74.8%	98.6%	100.6%	125.0%
ASD Garden Cottage	100.4%	100.9%	100.0%	61.1%	100.0%
ASD Marsh	90.7%	111.0%	102.9%	109.2%	57.5%
ASD Meadow	60.5%	108.1%	105.0%	83.8%	97.5%
ASD Sycamore	163.2%	97.8%	102.1%	99.3%	0.0%
LDD Church	106.6%	109.8%	125.8%	127.2%	90.0%
LDD Hawkins	76.0%	81.8%	78.9%	140.0%	68.6%
LDD Oak	100.0%	115.6%	83.6%	117.7%	90.0%
LDD Sunley	114.5%	90.3%	107.1%	95.7%	93.3%
MMH Wantage Cottage	0.0%	119.8%	0.0%	104.1%	50.0%
Birmingham	**106.0%**	**118.4%**	**96.4%**	**142.2%**	**99.4%**
MMH Edgbaston	126.3%	87.6%	67.9%	163.8%	100.0%
MMH Hawkesley	75.6%	109.5%	117.9%	136.6%	100.3%
MMH Lifford	107.9%	138.5%	118.2%	94.8%	100.0%
MMH Moor Green	110.2%	129.9%	106.8%	172.6%	93.3%
MMH Northfield (Old Lifford)	86.8%	137.2%	100.0%	118.0%	106.7%
MMH Speedwell	101.6%	101.0%	118.2%	92.4%	99.3%
WMH Hazelwell	115.2%	135.0%	141.4%	169.2%	87.7%
WMH Hurst	139.5%	127.9%	63.0%	192.3%	107.5%
CAMHS	**92.8%**	**110.7%**	**66.2%**	**149.7%**	**115.5%**
CAM Billing Lodge	0.0%	0.0%	0.0%	0.0%	0.0%
CAM Seacole Mixed Rehab	74.5%	85.8%	62.3%	107.1%	98.0%
CAM Sitwell Boys MSU	74.1%	877.5%	83.9%	517.9%	400.0%
CAM Stowe Mixed Admissions	129.8%	82.3%	61.3%	161.2%	92.9%
Essex	**86.3%**	**135.8%**	**84.5%**	**126.6%**	**73.6%**
MMH Audley	71.3%	257.5%	70.9%	157.9%	97.5%
MMH Danbury	93.4%	120.3%	103.9%	123.8%	57.4%
MMH Hadleigh	85.0%	88.8%	104.3%	85.7%	61.5%
WMH Colne	91.0%	144.4%	80.9%	178.9%	83.3%
WMH Frinton	77.4%	219.3%	79.5%	135.0%	81.3%
WMH Maldon	135.0%	72.3%	89.6%	70.2%	69.0%

Low Secure & Specialist Rehab	**89.7%**	**114.2%**	**75.6%**	**142.9%**	**93.3%**
FMH - 37 Berkeley Close	3.6%	90.0%	0.4%	97.9%	100.0%
MMH Berkeley Lodge	0.0%	0.0%	0.0%	0.0%	100.0%
MMH Heygate	69.6%	112.6%	63.0%	156.9%	71.0%
MMH Spencer North	112.7%	81.9%	107.5%	92.1%	110.0%
MMH Spencer South	96.4%	91.2%	106.8%	87.3%	105.0%
WMH Ashby	79.3%	210.7%	66.3%	198.7%	138.8%
WMH Bayley	71.0%	102.9%	51.1%	139.2%	63.1%
WMH Naseby	136.3%	66.9%	62.3%	167.1%	81.8%
WMH Watkins House	106.6%	128.9%	103.9%	132.7%	82.7%
Medium Secure	**110.0%**	**91.5%**	**91.2%**	**93.6%**	**92.7%**
MMH 23a The Avenue	0.0%	113.6%	0.0%	99.5%	100.0%
MMH Cranford	77.0%	105.2%	111.5%	94.8%	110.2%
MMH Fairbairn	130.0%	93.8%	99.6%	92.1%	113.3%
MMH Prichard	155.7%	91.6%	78.4%	132.4%	96.7%
MMH Robinson	124.8%	87.2%	99.3%	84.7%	100.0%
NPS Rose	103.6%	83.3%	106.4%	79.1%	93.8%
WMH Bracken	95.7%	89.4%	83.2%	87.7%	70.0%
WMH Maple	98.6%	80.4%	101.1%	100.2%	70.0%
WMH Willow	112.0%	95.7%	76.8%	95.1%	60.0%
Neuro	**98.6%**	**94.7%**	**100.5%**	**118.4%**	**97.6%**
NPS 38 Berkeley Close	0.0%	113.3%	10.7%	118.8%	100.0%
NPS Allitsen	102.0%	110.3%	101.1%	127.1%	95.8%
NPS Aspen	94.6%	104.7%	109.3%	142.6%	87.9%
NPS Berkeley Av 19	0.0%	42.0%	0.0%	71.4%	100.0%
NPS Cherry	86.6%	105.5%	123.9%	137.6%	100.0%
NPS Elgar	106.5%	120.2%	104.6%	136.9%	108.8%
NPS Elm	87.4%	90.8%	96.2%	114.2%	109.1%
NPS Fenwick	113.6%	85.7%	102.5%	100.7%	100.0%
NPS Redwood	78.8%	109.1%	95.4%	103.9%	100.0%
NPS Tallis	106.1%	88.9%	98.2%	155.4%	80.2%
NPS Tavener	93.9%	77.5%	84.7%	94.3%	93.3%
NPS Walton HD	122.0%	79.9%	101.4%	97.0%	99.7%
Grand Total	**97.1%**	**104.5%**	**90.2%**	**118.1%**	**93.6%**

Divisional Risk Summary

ASD/LD

The division is currently managing a number of qualified vacancies, which is temporarily affecting their ability to fill to their planned qualified number across all wards. It is planned for Acorn to have three qualified in the day and Hawkins 2.5, however this additional qualified is often redeployed to ensure sufficient cover and skill mix across all ASD/LD wards whilst recruitment is ongoing. Oak and Hawkins are planned to have two qualified at night, however the second qualified is moved on occasions to

support the division at night. Active recruitment is ongoing, and the introduction of flexible contracts is already seeing the staff pipeline improve.

Fern – are currently flexing down from their base planned number, due to a reduction in patient acuity and enhanced support levels compared to their usual average. This has been clinically agreed as safe and manageable to do so and reflects why their day fill rate is below 80%.

The division has flagged temporary current skill mix challenges on Church. Church is managing a temporary establishment gap within their therapy team, which has reduced patient activity and leave. This will be mitigated by an agreed temporary eight-week expression of interest for an activity co-ordinator role.

Oak & Sycamore – The division has begun discussions around the feasibility of combining Oak and Sycamore operationally, in terms of scheduling and sharing of staff. This is being reviewed by their new manager, who has been moved to support both wards through their current challenges. It is hoped that by these wards working closer together, it will reduce staff burnout and encourage new ways of working as the skills of the staff are shared.

The division has recently recruited a new Ward Operations Lead as additional operational support.

Birmingham
Hawksley is planned to have three qualified in the day; with Hurst and Edgbaston to have two on a night shift. The site is currently managing two qualified vacancies, which is temporarily affecting their ability to schedule to their planned number on every shift. There have been occasions where the second/third qualified on these wards have been redeployed to backfill sickness/absence and ensure sufficient cover across the site.

CAMHS
The division currently has a qualified gap of four, which is temporarily affecting their ability to schedule to their planned number every shift. The division has made significant progress in recruiting new qualified nurses to their wards; however, this has resulted in a high proportion of qualified nurses that are currently still within their preceptorship. This is anticipated to improve over the next three months as their qualified move out of their preceptorship.

Billing Lodge – is supported and managed operationally as part of Sitwell. All staff are scheduled to Sitwell and then redeployments and moves are made from there. Billing Lodge receives qualified support from Sitwell.

Essex
The site currently has 13.2 qualified vacancies which is temporarily affecting their ability to fulfil their planned qualified number every shift. It is planned for Frinton and Audley to have three qualified per shift, however their fill rates are currently below 80% due to the establishment gap and requirement to support the site and ensure sufficient qualified cover across all wards. This is currently clinically manageable with no specific concerns raised in relation to this reduced qualified ratio. Where there are qualified gaps, the site has been able to backfill these with HCA' to help minimise the impact on the wards and maintain safer staffing levels.

Low Secure
Heygate, Ashby, Bayley and Naseby all have qualified fill rates at night less than 80%. This is due to these wards being planned to have two qualified at night, however they are frequently redeployed within the division (or across the site) to help ensure sufficient qualified provision across all wards. This is being mitigated by the wards ability to backfill these qualified vacancies with HCAs and maintain safer staffing levels where possible.

Naseby – is currently flexing down from their agreed planned number due to changes in clinical acuity and reductions in enhanced support. This has contributed to their fill rates for HCAs in the day being less than 80%. This has been agreed by the division and is deemed clinically manageable.

Ashby has HCA fill rates both day and night of nearly 200% as they are currently flexing up from their planned number due to their recent move to a much larger environment and change in acuity levels since their base establishment was set. A full base establishment review for Ashby in light of this, is being conducted this month.

Medium Secure
The division currently has a qualified establishment gap of 16.8, which is temporarily affecting their ability to meet their planned qualified number on every shift. Cranford is planned to have three qualified in the day due to clinical acuity, however this third qualified is often redeployed to support qualified provision across the division, resulting in their qualified fill rate being less than 80%. This has been somewhat mitigated by Cranford's ability to backfill this with HCAs. Prichard and Willow both plan to have two qualified at night, however they are often unfilled or redeployed to support qualified provision across the division and site.

Bracken & Rose are displaying HCA fill rates of around 80%, due to both wards flexing down from their planned number for the month of February. This was clinically agreed due to a reduction in their levels of enhanced support and clinical acuity. This was deemed clinically manageable by the division.

The division has flagged some current skill mix challenges on Bracken. They have had several safe calls at night in relation to staff sleeping on duty, which has resulted in some regular night staff being redeployed onto days pending investigation. This is affecting Bracken's regular ratio at night and is resulting in an increased usage of WorkChoice and agency. This is however being looked at on a shift-by-shift basis, so skill is shared across the division.

Neuro
38 Berkeley Close and 19 The Avenue share qualified support of one both day and night and this is clinically manageable.

The Lowther Wards (Elm, Cherry, Aspen & Redwood) have experienced some high levels of absence amongst their regular qualified staff, which has affected their ability to hit their planned number every shift. Redwood has had a sudden spike in the number of staffing related Datix incidents they have reported, and this correlates with increased absence levels and recent instability in their senior leadership. The Lowther wards are however moving to a new operational and leadership structure from 1 April, with a new Service Manager in place overseeing the four wards as one unit, with the aim of sharing skill mix and expertise across the building. A full staffing and establishment review will be completed in light of this.

Right Staff
In accordance with NQB guidance, Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to all patients at all times. There are three key components to achieving this; evidence-based workforce planning; professional judgement and being able to compare staffing with peers.

As of 31 January, we fully implemented our MHOST staffing tool; for which new ward establishments were set and agreed, following triangulation with professional discussion and quality and patient safety indicators for each ward. Within these new base establishments is an agreed uplift headroom allowance, which moved from 22% to 25%. This will help ensure sufficient provision for planned annual leave, sickness, training and other types of leave.

Reporting on CHPPD

A further NQB recommendation is that organisations are able to compare local staffing with peers, taking into account of any underlying differences. NHS trusts currently report this in the form of Care Hours Per Patient Day (CHPPD). From May 2016, CHPPD has been the principal measure of nursing and healthcare support worker deployment; providing a single, consistent metric. From 1 April, we will also report our staffing in this way, allowing us to effectively benchmark against other organisations.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

Planned CHPPD Comparison – NHS Trust vs St Andrew's

NHFT	RN	HCSW	Overall	St Andrews	RN	HCA	Overall
Adult admission	5.9	7	12.9	Adult Admission	3.23	4.66	7.88
Adult admission	4.9	6.9	11.8	Adult Admission	5.38	7.17	12.54
Adult acute	3.7	2.9	6.6	Adult Acute	2.89	5.38	8.27
Adult acute	3.5	2.7	6.2	Adult Acute	4.19	11.93	16.12
				PICU	10.75	15.05	25.8
				PICU	8.96	8.96	17.92
PICU	6.6	8.4	15.1	PICU	13.44	13.44	26.88
Older adult organic	4.5	5.8	10.3	Older Adult Admissions	5.37	14.33	19.7
Older adult functional	2.9	3	5.9	Older Adult EOL	3.65	9.24	12.9
				Low secure	4.6	15.35	19.96
				Low Secure	4.61	16.59	21.19
Low secure	3	6	9	Low secure	3.23	7.53	10.75
				Rehab	4.78	7.17	11.94
Rehab	3	1.9	4.9	Rehab	3.04	6.71	9.76
CAMHS	4.2	6.4	10.6	CAMHS	6.14	16.13	22.27
CAMHS	4.7	6.4	11	CAMHS	6.45	6.45	12.9

Right Skills

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multidisciplinary team approach.

Mandatory Training Figures

Division	Dec-2021	Jan-2022	Feb-2022
ASD & LD	92%	92%	91%
Birmingham	94%	93%	92%
CAMHS	92%	91%	90%
Essex	95%	95%	94%
Low Secure & Specialist Rehab	92%	93%	92%
Medium Secure	92%	92%	91%
Neuro	93%	92%	91%

Risk Area

The Safeguarding Level 3 mandatory compliance rate is at 82% for the Charity and this has remained static for the last few months. Spaces are available and people are booking, however we are currently trying to manage a high level of no shows across our training courses. This has been raised with our NMs and Heads of Division to review in further detail locally and action; and will also form part of the Charity's Absence Management project. The Safeguarding team are also working closely with individual wards to provide more local training where required.

Area of Strength

Over the last couple of months significant work has been undertaken to improve compliance with ILS training for our qualified nurses, and this KPI and has now significantly improved to 97%.

Recruitment Update

As we moved to our new MHOST staffing model at the end of January, wards are now recruiting to their newly agreed base establishment, for both qualified and unqualified staff. Overall, as a Charity, our base requirement for unqualified staff has increased, due to being able to recruit for average levels of enhanced support. This does not see us require a large addition of staff; however, our proportion of permanent staff has increased, against WorkChoice/agency usage.

As a Charity, our total current recruitment target is 328.1 (this covers the inpatient wards only). This sees us need to recruit an additional 67.3 Registered Nurses, for which we are at 58% of reaching this target including staff in the pipeline. For HCAs we need to recruit an additional 260.8, for which we are at 56% of this target including pipeline staff.

RNs (CNL, SSN & SN)	Establishment			Recruitment target	Pipeline				Recruitment gap
	MHOST requirement	WTE	Known leavers		Interview stage	Offered	Start date confirmed	Pipeline as a % of target	
ASD/LD	98.5	91.3	0.0	7.2	2.0	7.0	6.0	208%	-6
CAMHS	27.5	23.3	0.0	4.2	0.0	1.0	0.0	24%	3
LSSR	77.5	62.0	0.0	15.6	0.0	0.0	1.0	6%	15
MEDSEC	84.5	67.7	0.0	16.8	1.0	3.0	3.0	42%	11
NEURO	88.5	79.9	0.0	8.6	2.0	4.0	4.0	116%	1
NORTHAMPTON	**376.5**	**324.2**	**0.0**	**52.3**	**5.0**	**15.0**	**14.0**	**65%**	**23**
BHAM	71.3	69.5	0.0	1.8	0.0	0.0	0.0	0%	2
ESSEX	57.5	44.3	0.0	13.2	3.0	2.0	0.0	38%	11
STAH	**505.3**	**438.0**	**0.0**	**67.3**	**8.0**	**17.0**	**14.0**	**58%**	**36**
Initiatives (3mth)							9	71%	27

HCAs (inc NA, SN pending pin)	Establishment			Recruitment target	Pipeline				Recruitment gap
	MHOST requirement	WTE	Known leavers		Interview stage	Offered	Start date confirmed	Pipeline as a % of target	
ASD/LD	350.0	257.8	0.0	92.2	10.0	21.0	4.0	38%	67
CAMHS	75.0	66.7	1.0	7.3	7.0	10.0	2.0	261%	-5
LSSR	140.0	122.9	0.0	17.1	10.0	7.0	0.0	100%	10
MEDSEC	269.0	188.3	0.0	80.7	5.0	3.0	3.0	14%	75
NEURO	247.3	199.4	2.0	45.8	10.0	24.0	3.0	81%	19
NORTHAMPTON	**1081.3**	**835.2**	**3.0**	**243.1**	**42.0**	**65.0**	**12.0**	**49%**	**166**
BHAM	137.0	122.2	0.0	14.8	**8.0**	**5.0**	**5.0**	121%	5
ESSEX	86.3	82.4	1.0	2.8	**4.0**	**3.0**	**1.0**	284%	-1
STAH	**1304.5**	**1039.7**	**7.0**	**260.8**	**54.0**	**73.0**	**18.0**	**56%**	**170**
Initiatives (3mth)							0	56%	170

Right Place & Right Time

Action Card Usage Since Implementation in January

We introduced a new staffing escalation process at the beginning of the year, which is made up of three key steps. This is to help guide staff on who and where to escalate to, should they have staffing concerns. It is only after these three steps have been exhausted, may wards have to look at implementing action cards should the risk not be mitigated. It is a last resort and is only for wards to implement should the ward be deemed unsafe and at risk, for both staff and patient safety. Prior to the action card being implemented, it must be escalated to the divisional bleep holder and SMoS for approval. We have had a few cases where wards have made local decisions to reduce ES due to staffing, without escalating this as a concern to the Ops Hub and this continues to be challenged.

Week (only weeks listed where cards have been issued)	Number of Actions Cards Used	Wards Affected
17/01 – 23/01	1	Sitwell
24/01/ - 30/01	1	Bracken

Sitwell 18/01/22 – Implemented after midnight, due to only having two registered nurses within CAMHS to cover the three wards: leaving Sitwell with no qualified nurse. The three-step staffing escalation process was followed, and the night site co-ordinator was already ward based. The divisional qualified contingency plan was reviewed and implemented, and it was agreed based on acuity that Sitwell was the most appropriate ward to run without a qualified. Nursing support was provided by the surrounding wards. There was no reported incident as a direct result of implementing this action card.

Bracken 30/01/22 – Implemented during the night staff due to a shortage of staff. The escalation process was followed and there was no further scope for side ward support. A patient on 3:1 was reduced to 2:1 for a short period of time due to other high-risk concerns on the ward and agreed with the night site co-coordinator and SMoS as being the safest way to manage the ward.

For both of these action cards, Datix reports were correctly submitted as per our new process. On review, there were no further clinical incidents reported on the wards for the above dates, as a direct result of staff shortages.

Safety & Quality Indicators

The indicators considered within this report reflect the approach taken in staffing reviews and reflect the current NHS England recommendations.

- **Incidents:**

	Dec 21	Jan 22	Feb 22
St Andrews All (Rate per 1000 OPDs)	140.49	133.21	121.02
ASD/LD	144.04	131.32	132.75
Birmingham	25.56	23.44	15.44
CAMHS	1081.41	875	650.7
Essex	46.51	86.24	79.91
LSSR	191.13	197.74	170.35
MSU	72.37	72.77	59.85
Neuro	146.88	127.93	147.99

As a Charity total, there has been a consistent decrease in the number of total incidents from December 2021 through to February 2022. On a detailed review, this is also the case for the total number of incidents related to staffing, for all levels of severity.

- **Staffing Related Incidents:**

	Dec 21	**Jan 22**	**Feb 22**
Total Count	119	124	63
Level 1 – No Harm	89	86	48
Level 2- Low	17	28	11
Level 3 – Moderate	13	10	4

(Note: this is currently a very manual process, in which the Datix team review incident detail and pull out and record where the report has mentioned staffing as a contributing factor to the incident.)

The highest reporting wards for staffing incidents over the last three months were Bracken, Sycamore and Redwood. For February, staffing incidents remained highest on Sycamore (9) and Redwood (9).

Of the four Moderate incidents in February – three were within ASD/LD (Oak, Sycamore and Church) and one for Neuro (Allitsen).

Church, Sycamore and Allitsen; all of these incidents related to needing to reduce planned levels of ES for a patient for a short period, however no clinical harm or further incident was reported as a direct result of this.

Oak: this incident relates to a reported poor skill mix, with an unexpected requirement for a patient to go to NGH on 4:1 escort. This patient required handcuffs, for which no trained staff had been planned for. This was escalated and the risk removed by redeploying appropriately trained staff from across the site. No clinical harm was reported as a result of this.

Support has been implemented on both Church and Oak within the last couple of months in the form of experienced Nurse Managers who have already begun to make both operational and clinical changes. Oak, Church and Sycamore are also being supported by a new Ward Operations role, introduced by the division to specifically support the wards with some of their scheduling challenges, including absence management and training.

- **Complaints:**
  For February 2022 there were a total of six reported complaints at ward level; however, none of these were relating to staffing levels.

  There was one PAL received for Acorn (within ASD/LD). A patient raised a concern that were unable to use ground leave due to staff shortages. This was followed up and the patient reported they had since been able to utilise this; however, felt staff could facilitate more visits but are always being told the ward is short staffed.

- **Freedom to Speak Up Concerns**
  For February 2022 there were no issues or concerns raised to our Freedom to Speak up Guardians specifically in relation to staffing.

Moving Forward & Charity Developments

- **Allocate – E-Rostering Update**

  A single go-live approach has been agreed across all sites for the new Allocate eRostering application. The project is currently gathering the data that is needed from SAP and building the system ready for testing and training our WorkChoice Leads (WCLs). WCLs will be the leads for the divisions in getting all the first builds of rosters for wards. This will include a basic data gathering exercise for each Nurse Manager to complete. The timetable for go-live is currently:

  - **April –** All the backend of the system and how staff data flows through will be completed. all the data gathering for each ward to get the first rosters built.
  - **May –** Our WCLs will build each ward's roster and be trained how to train managers on basic rostering to get the first roster built to the new Rostering policy.
  - **May –** With Essex going first as a group, we will use this to ensure that all processes work in a dry run. The rosters for each ward will be built by the WCLs and then each manager will be trained to maintain the roster. This will include how to book WorkChoice and Agency staff through the rostering.
  - **June –** The first Allocate rosters will be in place and being used instead of Kronos with the first live payroll completed at the end of June. We will begin to gather the more personal local data from managers during June and then train them how to use Auto-rostering. The SafeCare module which measures acuity against the roster will also be done during June
  - **July –** the first payroll will have run and the work will continue to enhance the experience of auto-rostering. All auto-rosters and the MHOST acuity element will be added to the system by the end of July.

- **Establishment Reviews**

  The next set of establishment reviews are being completed in line with our new MHOST timeline, which sees base establishments reviewed every January and June. There has been a delay in the MHOST data collection at ward level due to number of wards going into isolation during this 20-day data collection period. Ward reviews are now being prioritised by several factors, including current flex uplifts; any change in environment; and a comparison of July 2021 data collection with January 2022 collection.

- **MHOST Acuity Training**

  As part of the Workforce Safeguards workstream, our NHS expert will be providing MHOST acuity training to our ward leaders this month, including CNLs and NMs across the Northampton site. As part of the Developing Workforce Safeguards guidance, it is a requirement that there are staff trained in the application of this tool and its descriptors, to ensure accurate data collection when rating our patients; and to provide assurance to the board that this tool is being used effectively and in line with its license.

- **Changing the Language**

  In section 3 of the NQB guidance, it identifies three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions. An approach to deciding staffing levels based on patients' needs, acuity and risks, which is monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing. CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

  As we have moved to MHOST, we are also consciously trying to change the language we use, including changing our terminology from 'safe' to 'planned'. We have long associated the safety of a ward with a specific number, and as soon as wards are below this number – it has often been assumed that the ward is 'unsafe'. We all know that some days the ward's planned number will not be enough to safely manage the ward; and on the flip side there will also be days where the ward's planned number is more than is required.

We will continue work to refocus the discussions our bleep holders are having directly with the wards, focusing on the clinical acuity of the ward and skill mix of the staff on duty, rather than jumping straight to 'how many staff do you have today'. By changing this focus, we hope to ensure our wards are safely staffed. To further support the work already taking place, we will review our Nurse in Charge training and look at expanding our Clinical Bleep Holder training.

Risks for the Board to Consider

- Increased establishment gap across the Charity for both qualified and unqualified staff, as we move to increase our proportion of regular staff and reduce our reliance on WorkChoice and agency.
- Current increased reliance on WorkChoice and agency due to these vacancies, as well as temporary increased acuity and demand, which is seeing wards needing to work above their planned number. This is a risk due to impact on continuity of patient care, patient experience and a potential impact on staff wellbeing due to the pressures of working alongside and supporting unfamiliar staff.
- Challenges in recruiting servery staff due to an overcrowded market is seeing us unable to provide the allocated servery support agreed to all wards across the Charity. For wards without current servery support, they are receiving an 0.3 uplift in their nursing number. However due to the vacancies that already exist within the nursing establishment, it is further increasing our reliance on WorkChoice and agency and in some cases increasing our unfilled shift rate.
- There are still some instances of refusals to redeploy. We know that by moving staff between divisions it may negatively impact morale and wellbeing as they feel they are being moved out of their skill area and comfort zone. However, we also know that due to some divisions having a larger establishment gap than others, there is still a requirement to do this to support and ensure adequate skill and provision across the site.

Proposal

- The Safer Staffing Matron (SSM) will continue to support the established Developing Workforce Safeguards work to provide assurance of safe staffing across the Charity.
- SSM will continue to work closely with the Heads of Division to complete establishment reviews and help support and implement changes where required.

Paper for Board of Directors	
Topic	Workbridge – Turnaround & Transformation Plan
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**12**
Author	Holly Taylor, Director of L&D Laura Agnew, Deputy Director of Estates and Facilities
Responsible Executive	Martin Kersey, Executive HR Director Alex Trigg, Director of Estates and Facilities
Discussed at Previous Board Meeting	Not previously discussed at Board
Patient and Carer Involvement	Patient questionnaires, interviews and focus groups led by REDS. Liaison with clinicians and carers whose family members use Workbridge services.
Staff Involvement	3 month review including team huddles, ideas forums, 1-2-1 with staff. Followed by 60-day formal staff consultation process to review recommendations.
Report Purpose	Review and comment ☒ Information ☐ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☒ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Charity Executive Committee

Report Summary and Key Points to Note

- A thorough review of Workbridge services has been completed.
- A turnaround and transformation plan has been designed to help Workbridge realise its potential and alleviate current business risks in the services it provides.
- Our plan efficiently resources our retail outlets to enable them to provide consistent and highly valued public services for our Northampton community.
- This plan is underway and has a number of stages: The first stage was so make our services safe and a number of H&S issues have been urgently addressed. The second stage is to consolidate

the team, improving quality through increasing the calibre of its people so we can embed person centred learning and retail excellence. We are currently formally consulting with our staff over these changes. This stage will end on April 1st from which we can then rebuild core services and innovate to ensure Workbridge meets current and future learner needs.

- This plan has person centred learning at its core, extending our reach from 100 – 1000 learners.
- Our ambition is to move from a 0.5million cost/loss to break even within 3-5 years.

Appendices

Workbridge Review & Recommendations (narrated presentation and PowerPoint slides).

https://www.youtube.com/watch?v=GydqOuLsZy8

Committee Updates

Pension Trustrees

Quality & Safety Committee

People Committee

Committee Update Report to the Board of Directors

Name of Committee:

Meeting of Directors of St Andrew's Pension Trustees Limited

Date of Meeting:

3 February 2022

Chair of Meeting:

Martin Kersey

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- Re-Appointment of Fiduciary Oversight Manager and Pension Scheme Administrator
- Selection of Employer Covenant Advisor
- 2022 Trustee training plan
- Review of Fiduciary Manager Implementation process
- Setting of terms of reference for Investment Committee and Objectives for Fiduciary Manager and Fiduciary Oversight Manager
- Update on the Charity's Financial Position and Strategy
- Review of Valuation action plan and Actuarial Factors (used for member options)
- GMP reconciliation/rectification update and administration performance
- Governance review and updated suite of governance documents
- Annual plan and budget

Decisions made by the Committee:

- Agreed to re-appoint Isio as the Fiduciary Oversight Manager for a period of 3 years
- Agreed to re-appoint Barnett Waddingham as Administrator for a period of 5 years
- Agreed to appoint PWC as Employer Covenant Advisor for the 2022 Actuarial Valuation process
- Agreement of Investment Committee Terms of Reference (s.t. format review for consistency with Charity Governance documents)
- Agreement of Objectives for Blackrock and Isio
- Update of the Actuarial Factors
- Adoption of Conflicts of Interest Policy, Integrated Risk Management Policy
- Approval of Dormant Trustee accounts

Implications for the Charity Risk Register or Board Assurance Framework:

- No Change for Pension Risk on the Risk Register

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Committee Escalation Report to the Board of Directors

Name of Committee:

Quality and Safety Committee (QSC)

Date of Meeting:

08 February 2022

Chair of Meeting:

Professor David Sallah

Significant Risks/Issues for Escalation:

- The Committee received an update on the Capacity utilisation programme. It has been completed and it was confirmed that the next step is to assess the impact on staff and patients
- The Committee were provided with an update on Physical Healthcare, including the new dashboard that improves focus on actions and areas for improvement. The Committee was informed that there is excellent work being done in this area. The provision of associated GP services remain a challenge on the Northampton site.
- The Committee received further updates on the Quality Improvement programme, Buddy Workstreams and CQC related activity
- QSC continues to ask about and discuss culture change and how we achieve this alongside the many practical tasks and inputs we are seeing to improve the service.

Key issues/matters discussed:

- **Capacity Utilisation update**

  The committee received a final status update on the Capacity Utilisation Programme as it drew to an end. A system of continual assessment would be undertaken to measure the outcomes and the next step was to assess the impact on patients and staff.

- **Health & Safety – Training Plan**

  The Charity-wide H&S Training Plan was presented along with confirmation that embedding of practice and compliance would be monitored and determined through a programme of internal audits.

- **Model Hospital Benchmarking**

  The committee received an overview of Model Hospital Benchmarking and how it aligns with other benchmarking practices introduced within the Charity. The Charity was being included within this form of benchmarking as a trial for private providers and it would enable the Charity to draw comparisons with NHS Mental Health Trusts in order to target areas for improvement.

- **Physical Healthcare update**

  The committee were provided with an update on Physical Healthcare, including being presented with the Physical Healthcare Dashboard that has been introduced and improves focus on actions and areas for improvement. The committee discussed the

provision of GP services within the Charity and it was agreed as an action for further discussions to take place with the ICS over the provision of secondary GP services.

- **Quality Workstreams**

  The committee received an update on progress with the 9 Buddy led Quality Workstreams. The complexity of co-ordination was discussed, along with indicative risk assessments of each of the Workstreams.

- **QSC Effectiveness Review**

  The committee discussed the recently completed self-assessment based effectiveness review. It was noted that there had been a relatively low response rate and this impacted the ability to derive any clear themes. One clear theme related to improving the quality of papers submitted. The results of the review would be incorporated into the Charity-wide Governance Project.

- **MHOST update**

  The update provided further information on the MHOST implementation as well as assurance relating to the safer staffing model. The first round of MHOST has been implemented and it was agreed that an impact assessment on the roll-out would be completed and reported to the committee at a future meeting.

- **Quality Account – report structure review**

  The committee reviewed the initial structure of the 2021-2022 Quality Account and confirmed the timeline for completion, review and approval. The Committee also agreed that three highlighted areas would continue to be included within the account as they were important subjects relating to quality and governance. These areas were Diversity and Inclusion; Board and Directors, and Court of Governors.

- **CAMHS Division deep dive**

  The deep dive was presented by the division and noted. The division's presentation focussed on the key areas for assurance as requested by the Committee, including principal function; CQC ratings; areas of good practice; areas of concern and action plans in place. Discussions covered the relatively new leadership team, work on occupancy, recruitment, culture relating to change and staffing.

- **Birmingham Division deep dive follow-up**

  The deep dive follow-up was presented by the division and noted. Discussions focussed on four key areas raised at the last meeting, including celebrating success, co-production, vaccinations and GP provision. There was good progress in all areas and an opportunity for the main Northampton site to learn from some of Birmingham's successes.

- **ASD/LD Training – Skills Development Framework**

  An overview of the training skills framework was presented and discussed that highlighted the on-going work being done to address the training needs within this division that were raised during a previous divisional deep dive.

- **Executive Medical Director report**

  The committee noted the EMD report that included updates on Clinical Governance; Quality Improvement; the effect of the Kronos incident and the technology being used to support clinicians.

- **Chief Nurse report**

The committee noted the Chief Nurse report, which included further updates on Handovers, Nursing Strategy, Safer Staffing and the centralised AHP function.

- **Quality Improvement Plan and Women's Service CQC progress**
  The quality Improvement plan and progress update on the CQC related actions for the Women's service were presented together and noted, along with discussions around the robust process in place for closing actions, that includes demonstrable evidence for all closures. The Committee requested further information on how the data and information within the QIP could be triangulated with other metrics and reports such as the Integrated Quality and Performance Report.

- **Serious Incidents**

  The serious incidents in the last period were reviewed, noting the improved position of the commissioners in this area and that the processes now in place were being well received. The new weekly meetings were helping with the sharing of lessons learned and no themes were evident from the data for this period.

- **Integrated Performance Report**

  The Integrated Performance Report template was presented and noted, including the quality scorecard, which highlights the results of quarterly quality visits, which are designed in principle to highlight potential red flag areas. More work is being done on recording and monitoring clinical supervision and an action was agreed in this area to provide the necessary assurance around quality of care.

- **Covid-19 update**

  The committee noted the latest Covid update that highlighted the latest Covid statistics, including the reduction in positive patients and wards/areas in outbreak. An update on vaccinations highlighted that the potential for mandatory vaccination had seen a rise in staff vaccinations and that a watching brief was being maintained on the legislative process.

- **East Midlands Mental Health Patient Safety Network update**

  The committee received a verbal update on progress, noting that the conference was planned for June, and would hopefully be held in person, with St Andrew's being offered as a location. Data was now returning from communities of practice on key areas within the network.

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

  The Quality and Safety Group report was received and noted, including the improvements in safeguarding which had been seen recently, with the recent rating received from NHSE/I for IPC.

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

  The Mental Health Law Steering Group report was received and noted.

Decisions made by the Committee:

- **Quality Account – report structure review**

  The Committee agreed that three highlighted areas would continue to be included within the account as they were important subjects relating to quality and governance. These areas were Diversity and Inclusion; Board and Directors, and Court of Governors.

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:

- None

Committee Escalation Report to the Board of Directors

Name of Committee:

People Committee

Date of Meeting:

10 February 2022

Chair of Meeting:

Paul Burstow

Significant Risks/Issues for Escalation:

- Sickness absence remains high at 10% in January – a project group is in place to ensure targeted resource to reduce absence levels.
- The Achieving Positive Cultural Change deep dive received partial assurance with the CEC being asked to commission external support to develop and deliver a Culture and Organisational Development Strategy.

Key issues/matters discussed:

Staffing

- An update on the delivery of the Staffing Action Plan was provided focusing on the MHOST tool roll out from 31 Jan complimented with a Safer Staffing Policy & Procedure, MHOST Operating Manual and engagement events.
- International recruitment has commenced with advertisement and candidate sourcing in progress via the company MSI.

Your Voice results

- An in depth overview was provided of the your voice scores for the charity (51% overall engagement) including initial data of how this compares to the NHS.

Lead the Change – Culture programme

- The Committee considered a deep dive report into the charity's actions to achieve positive cultural change. Based on the report and the discussion the Committee was only able to take partial assurance.
- The Committee resolved to ask the CEC to examine the options for undertaking an external review and securing support for the charity's culture change programmes through the development and implementation of an overarching Culture and Organisational Development Strategy and Action Plan and KPIs for the Charity.
- As part of the charity's quality improvement programme the Committee heard that we are following the NHSE/I Culture and Leadership Tool with 4 stages: *Discovery (identifying the issues), Design (developing our change work streams), Delivery (implementing the changes) and ongoing Evaluation (measuring success).*
- Since the Committee 94 Change Leaders have been appointed with an initial workshop scheduled for 30 March.

Health and Safety

- Following the HSE Improvement Notice (formally closed in October), the charity can expect much closer scrutiny of how we implement our H&S arrangements.
- Of the 10 HSE actions 6 are completed and 4 are in progress and these will be closed ahead of the required deadline (H&S Auditor training, HSE Safety Climate Survey, Managers H&S development and H&S induction process).
- All lagging indicators illustrate a continued improvement YTD from 2020/21.
- The leading Indicators are more complex with reactive monitoring an ongoing challenge. In December the kronos outage impacted access to documentation and the timeliness of AIs.
- Staff injuries during restraint are down 11% YTD, however this is below target and staff injuries increased in December compared to the previous month by 68%.
- In December there were 3 RIDDOR reports submitted to HSE (2 due to restraint injuries and 1 due to an accident).
- RIDDOR reports have reduced 36% YTD compared to 20/21 with a challenging target of 20% EoY.
- Fire safety audits are taking place in Northampton and Essex over February and March.

People KPIs

- People KPIs including turnover, absence, agency spend and mandatory training were reviewed as well as the flow of information (i.e. where the People KPIs are reviewed from ward to board).
- Sickness absence was highlighted as an area of focus for management. It was noted that there was a significant variation in the percentage rates of absence and sickness days between divisions. The Committee has asked for an update and for division level breakdowns at future meetings.
- Key highlights are: turnover remains stable and compares well to external benchmarks at 13.9%. Mandatory training is within target at 93% with BLS and ILS positively increasing to 91% and 94% respectively.

Mandatory Vaccination Update

- An update was provided on the current vaccination numbers noting the government's intention is to revoke this as a condition of deployment.

Effectiveness review

- The review found the Committee was effective in meeting its commitments against the current Terms of Reference.

Reporting groups

Updates were provided from the following:

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

Decisions made by the Committee:

- The Achieving Positive Cultural Change deep dive received partial assurance. CEC requested to commission a review and support to develop an overarching strategy for culture.
- The Reputation Management deep dive was deferred to the May Committee meeting.
- It was agreed an additional Committee meeting would be set up prior to May focusing on the Lead the Change culture programme.

Implications for the Charity Risk Register or Board Assurance Framework:

- The absence People KPI is below target with monthly sickness at 10% (January) impacting staffing particularly on the Northampton site, and with significant variation across Divisions.
- Health and Safety is identified as an area for ongoing monitoring with the time taken to complete accident investigations a challenge. Multiple actions are in place to ensure improvements.
- Mandatory training Safeguarding level 3 compliance is increasing but below target at 82%.

Issues/Items for referral to other Committees:

- For the Audit and Risk committee to consider the format of the material risk deep dive template to ensure a focus on outcomes and lessons learnt.
- For the Audit and Risk committee annual calendar to include the Whistleblowing assurance item after the Your Voice results are received (to be linked to the governance review).
- For the Quality and Safety Committee to consider the findings of the Your Voice staff survey for quality in Divisions with low engagement scores.

Appendices: None

Paper for Board of Directors	
Topic	Governance Project Update
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**14**
Author	Alexandra Owen
Responsible Executive	Alexandra Owen
Discussed at Previous Board Meeting	Discussed at multiple Board meetings.
Patient and Carer Involvement	Not appropriate to be discussed with Patients and Carers at this stage.
Staff Involvement	A number of these items have been discussed with colleagues as part of the Governance project review, including Co Sec, Legal, Finance, HR and other enabling functions and operational colleagues where appropriate.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Considered at Committee Meetings	Updates have been provided to Executive colleagues and to the Governance Oversight Group.

Report Summary and Key Points to Note

Attached is a summary of progress against the key themes of the Governance project.

Board colleagues are asked to review the summary for discussion during the meeting.

Appendices

Governance Project Update

Overview

The Governance and Risk project has been based on the feedback from the commissioned EY report, which commenced towards the end of 2021, led by Sally MacIntyre as Programme Director. To give the Board visibility on the progress of this project and a voice in steering its direction, the Governance Oversight Group was initiated at the end of 2021.

The key strands of the project identified are as follows:

- Board Effectiveness
- Committee Structures
- Risk & Assurance Framework
- Governor Effectiveness
- Smart Governance

Taking each of these in turn I have provided below a very high-level summary of the current position and where we will be at the end of March 2022 when the SRO ownership of the project changes to John Clarke. This list is not exhaustive and there is significant work continuing not included within the summaries below.

The Project initiation documents, detailed action plans and detailed weekly updates are being prepared and circulated to the Steering Group members to provide assurance on progress against all of the key objectives.

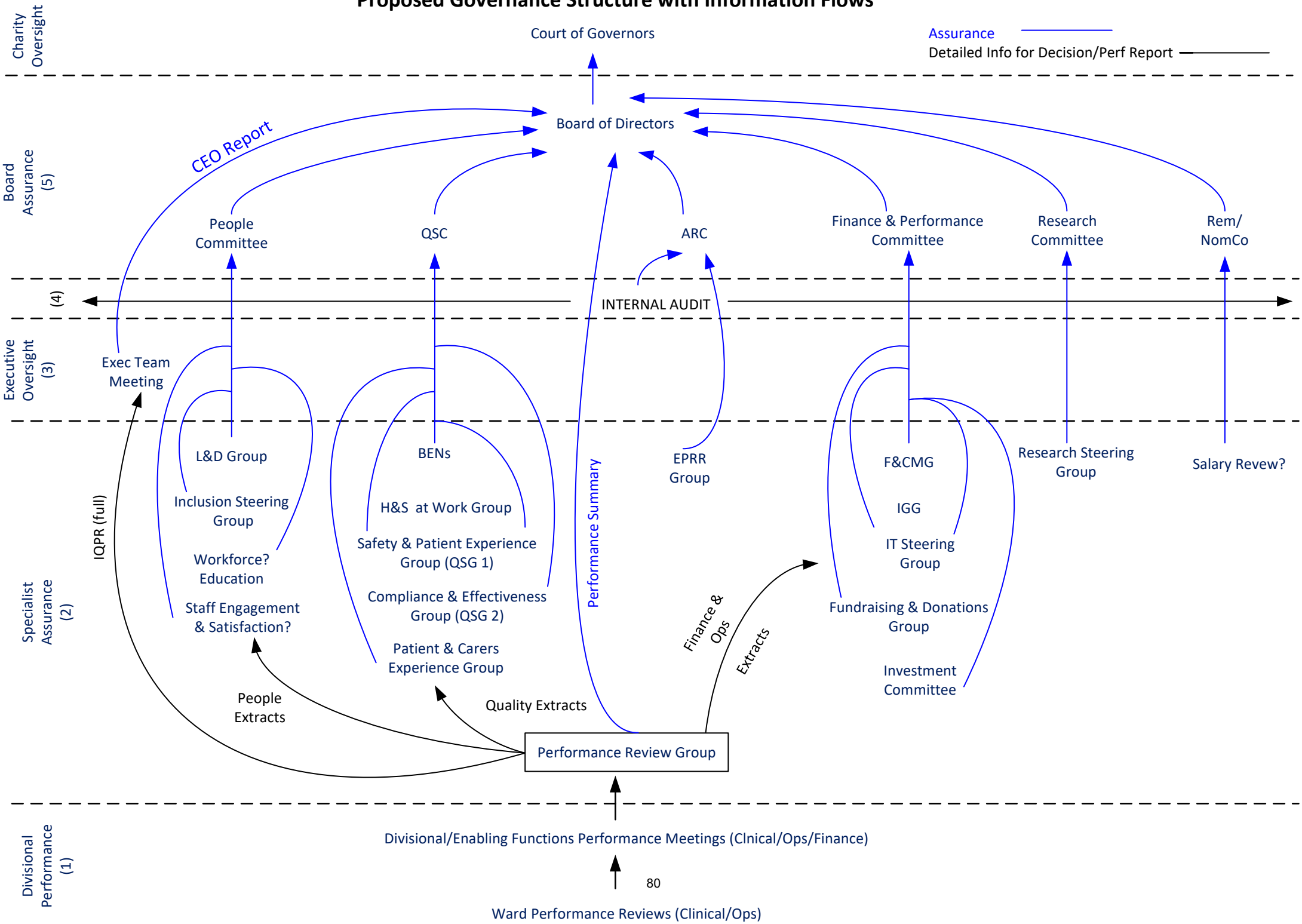
Board Effectiveness

Sub-Theme	Action Taken to Date	Action to be Completed by 31/03/22	Actions Beyond 31/03/2022
Board Dynamics	NHSP engaged and two sessions already undertaken.	-	Remaining three sessions to be completed and consider further support as needed to embed learning.
Board Ways of Working	Code of Conduct drafted and reviewed internally.	Share with remaining parties for agreement.	Rollout and embedding of Code of Conduct, consider expansion to CoG.
Matters Reserved	Initial review undertaken and refreshed, where historical items now included in Delegated Authority matrix these have been removed.	-	Matters Reserved to be reviewed by Legal and submitted to Steering Group before being reviewed and accepted by the Board.
Policy Approval	Review of 'material' policies to create a list for ongoing Board approval being undertaken.	Draft list to be completed.	List to be approved by Steering group and added to annual Board activity timetable.

Committee Structures

Sub-Theme	Action Taken to Date	Action to be Completed by 31/03/22	Actions Beyond 31/03/2022
Role & Objectives	Role and Objectives refined and clarified through ToR and Committee structure and attendees.	To be reviewed with each Committee Chair on 18/21 March 2022.	Feedback from review collated and reflected in revised ToR if agreed. Changes to be embedded and reviewed within 12 months.
Charity Executive Committee	Name changes to reflect status as an Executive oversight meeting. ToR revised to reflect these changes and the changing membership.	Executive Team ToR to be agreed.	Changes to be embedded and reviewed within six months.
Committee Specific recommendations.	EY recommendations for each Committee considered and reflected in revised ToR, membership and objectives.	To be reviewed with each Committee Chair on 18/21 March 2022.	Feedback from review collated and reflected in revised ToR if agreed. Changes to be embedded and reviewed within 12 months.
St Andrew's College	-	-	Position in governance structure still to be finalised.
ToRs	ToR for all committees reviewed to ensure duplication eliminated and to ensure that duties reflect the revised objectives of each Committee.	To be reviewed with each Committee Chair on 18/21 March 2022.	Feedback from review collated and reflected in revised ToR if agreed. Changes to be embedded and reviewed within 12 months.
Members/Attendees	Membership of each Committee reviewed and changed to provide consistency across all Committees. Attendees defined into voting members/speaking attendees/attendees.	To be reviewed with each Committee Chair on 18/21 March 2022	Feedback from review collated and reflected in revised ToR if agreed. Changes to be embedded and reviewed within 12 months.

Proposed Governance Structure with Information Flows



Risk and Assurance Framework

Detailed GAP analysis completed identifying progress made on EY recommendations, as a result of project Pegasus, and remaining actions required completed. Actions have been added to overall project plan with timescales, Project Lead for this area will be Mohammed Sajid Ali, Head of Risk and Internal Audit and he will update the main Governance project plan so that the Governance Steering Group can assess progress over time. Work on the Board Assurance framework will be led by Duncan Long, Company Secretary and again progress will be updated on the main governance project plan.

Governor Effectiveness

Sub-Theme	Action Taken to Date	Action to be Completed by 31/03/22	Actions Beyond 31/03/2022
CoG defined in Articles.	-	-	Agreed to be reviewed in later stages of Project
Chair Performance Assessment.	Lead Governor role defined and appointed, along with the Lead Governor Group, Senior Independent Director (SID) role description drafted.	Review of SID role description agreed.	All remaining recommendations to be completed with remaining Governor Effectiveness Actions.
CoG Meetings structure and Reporting.	Structure and reporting style to CoG meetings revised with Lead Governor input.	-	Evolution of meetings to continue supported by Lead Governor Group.
Governor Turnover.	-	-	Agreed to be reviewed in later stages of Project.
Independence of Governors.	-	-	Agreed to be reviewed in later stages of Project.
Engagement in appointment of Trustees.	-	-	Agreed to be reviewed in later stages of Project.
Governor visits to Wards.	Governor visits support and guidance document drafted and reviewed.	-	Document to be agreed and circulated.

Smart Governance

Sub-Theme	Action Taken to Date	Action to be Completed by 31/03/22	Actions Beyond 31/03/2022
Governance cycle aligned to business cycle.	Statutory filing deadlines mapped, and all Committee meeting timings adjusted to reflect requirements. Monthly information flows mapped to support 1, 2 and 3 assurance levels.	-	Timing of meetings to be included within Committee annual timetables – transition period over coming year with adoption of new timetable if agreed from 2023/24.
Board and Committee effectiveness review	EY Recommendations for effectiveness reviews to be considered by NomRem Co included within draft ToR, requirement for annual review included within all draft ToR	To be reviewed with each Committee Chair on 18/21 March 2022	Feedback from review collated and reflected in revised ToR if agreed. Changes to be embedded and reviewed within 12 months.
Delegated Authority for decision making.	Authority Matrix prepared and reviewed.	Delegated Authority to be demonstrated to Board 25/03/22.	Training, rollout and review process to be prepared to support implementation of policy.
Governance support	Discussed as part of Steering Group meetings, no changes recommended at present, but standardised documents will support uniformity across all Committees.	-	To be reviewed once Committee structure changes embedded.
Writing Guidance	Standardised report templates, agenda and minutes drafted for Board, Committee and Working Groups to support quality and uniformity of reporting.	-	Revised template to be agreed and adopted by all Committees/Groups.
Standardised management information/IQPR	IQPR information flows and timing reviewed and included within revised structure documents.	-	Automation of IQPR fundamental to the success of the IQPR changes, transition period over coming year whilst system changes are made to enable this.

Conclusion

Significant progress has been made over recent weeks in moving the Governance project forward. From April 2022 Melanie Duncan will lead the project with support from John Clarke as SRO to ensure the project is completed within the two-year timescale originally agreed.

Paper for Board of Directors	
Topic	Integrated Quality Performance Report
Date of Meeting	Thursday, 24 March 2022
Agenda Item	**15**
Author	Anna Williams, Director of Performance, Kevin Mulhearn, Chief Finance Officer, interim Lara Conway, Deputy Director of Workforce Planning John Clarke, Chief Information Officer
Responsible Executive	Jess Lievesley, Chief Executive Interim
Discussed at Previous Board Meeting	Routine paper with an iteratively improving approach. This specific version has not been previously discussed.
Patient and Carer Involvement	Patients and Carers have not been directly involved in this paper. The voice of those we work with will be included as part of My Voice. Insight gained from My Voice will be used to inform the measures included within the Integrated Quality and Performance Report.
Staff Involvement	Staff have not been involved in this paper. The voice of staff will be included via the outputs of Your Voice.
Report Purpose	Review and comment ☒ Information ☐ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	The quality and patient experience elements of the report have been considered and discussed in detail at QSC. The workforce elements at People Committee and the Finance elements at FinCom.
Report Summary and Key Points to Note	

Integrated Quality & Performance reporting improvements update

The approach improvements presented in this report include

- Expanding the IQPR matrix to put SPC variation and target side by side (in readiness for clinical targets to be added from the next reporting period)
- The ward level quality snapshot is now systemised, further disaggregating the in control metrics (common cause, statistically insignificant concern and improvement trends and little or no data)
- People scorecard has the addition of an enabling function view

Pending improvements – these are progressing but are not yet presentable

- Expanding the IQPR scorecard to include additional outcome measures, including My Voice (presented separately) and key leading indicators
- Further development of rolling averages and forecasting

February review

Quality – at a Charity level, five of the quality KPIs (included in quality scorecard) show are showing a special cause improvement (incidents of violence, restraints, long term segregation, enhanced support episode and staffing levels required for enhanced support). The remaining metrics show common cause variation. At ward level 92% of the quality scorecard KPIs are either in control, have little or no data or show a statistically insignificant trend. The quality scorecards for each division and ward were shared at the last QSC. Leading indicators continue to be a focus (quality assurance visits and clinical supervision) and are shared with QSC. My Voice (PREMs) response rates are low – additional promotion is underway. Benchmarking insight gathering is on-going, in order to derive targets.

People – training and agency spend are favourable to target. Annualised voluntary turnover is marginally adverse to target yet benchmarks favourably. Monthly voluntary turnover is within target – reflecting an improving position. Registered Nurse and HCA establishment ratios are presented for the first time following the move to MHOST. There is a resulting significant gap for HCAs – recruitment activities are on-going. Sickness % has shown a positive reduction in the month, yet remains adverse to target. In common with other healthcare providers, both locally and nationally, the Charity is working tirelessly to mitigate potential impacts to patient care arising from the combination of a challenging recruitment market and above target absences levels. Remedial actions are shared in the report.

Finance – February 2022 Year to Date net surplus is £2.7m better than the re-forecasted position. Occupancy was below the expectations set out in the reforecast. Cash balances held are better than forecasted due to the Net Surplus favourable position.

Appendices - None

St Andrew's Healthcare Integrated Quality Performance Report

reviewing February 2022

1) Quality Scorecard

Quality Scorecard at a Charity level there are no special cause concerns. The underdevelopment addition of benchmarked targets for 22/23 will support the identification of areas of comparative improvement requirement. The planned inclusion of leading indicators and additional quality metrics will complete the view.

Charity Position

Measure	Incident		Violence		Incident L1		Incident L2		Incident L3		SI		Restraint		Seclusion		LTS		LTS Days		ES Episodes		ES WTE	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
StAndrews																								

Divisions

Measure	Incident		Violence		Incident L1		Incident L2		Incident L3		SI		Restraint		Seclusion		LTS		LTS Days		ES Episodes		ES WTE	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
ASDLD																								
Bham																								
CAMHS																								
Essex																								
LSSR																								
MS																								
Neuro																								

Divisional level

ASDLD - LTS concern has been triggered by two inappropriately placed patients. Every effort is being made to secure an appropriate setting.

Essex - increased level 3 incidents are due to deterioration in the mental state of two patients during a period of prolonged Covid outbreak (now over). Increased seclusion levels follow aggressive behaviours of three patients – management and medication plans have been reviewed.

* The Charity level is an aggregate of the Divisions excluding Community Partnerships

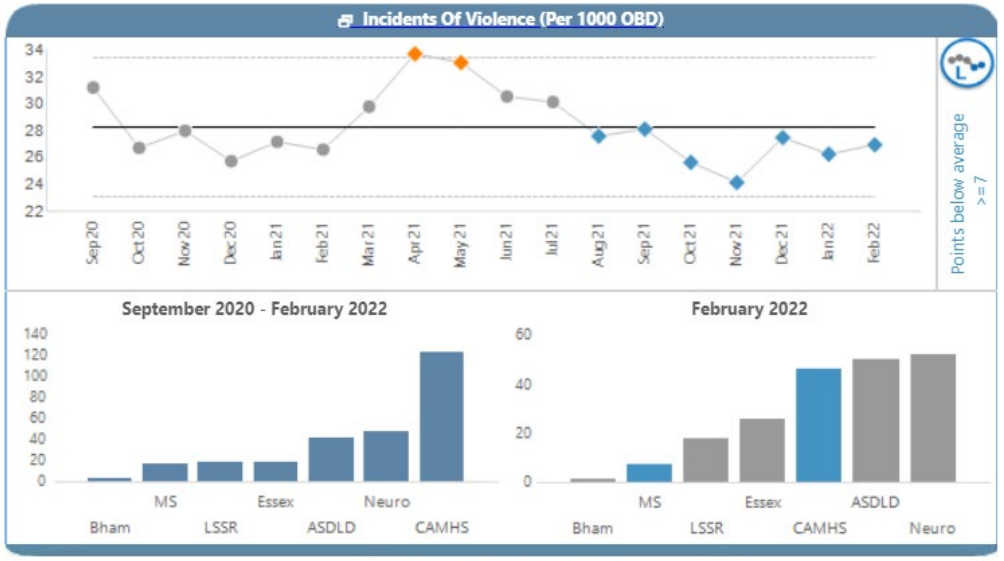
Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info

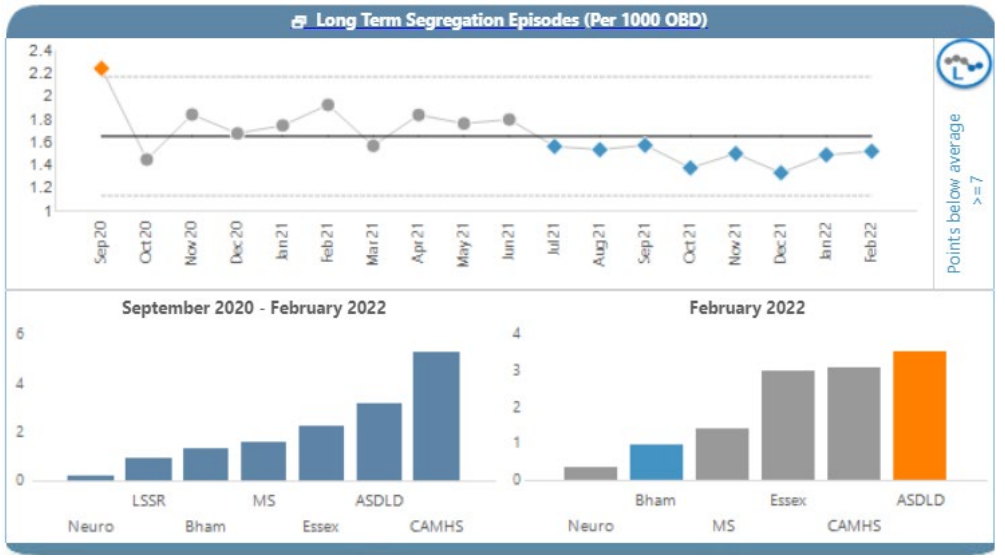
Concerns Improvements In Control

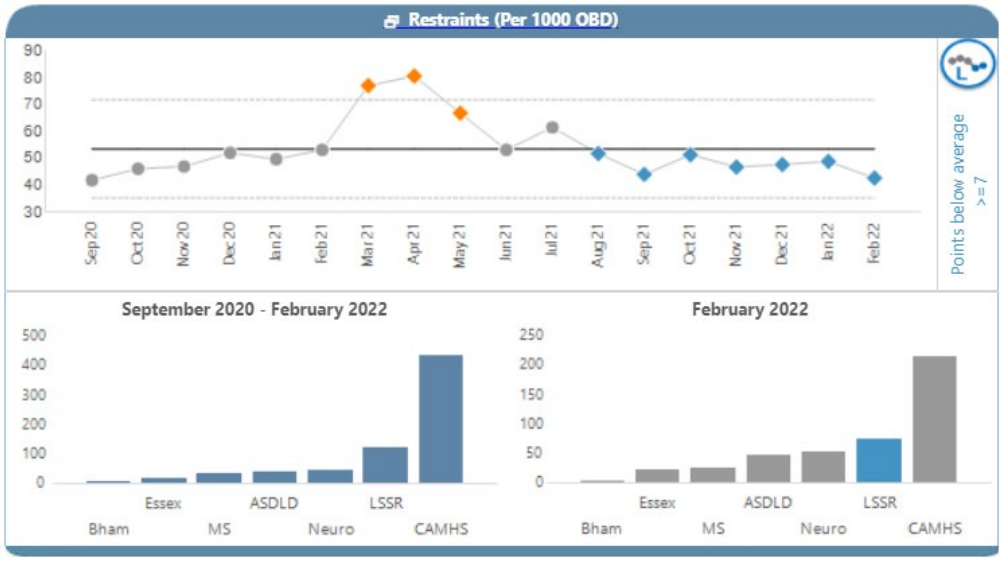
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

Exception reporting – Violence, Restraint & Long Term Segregation

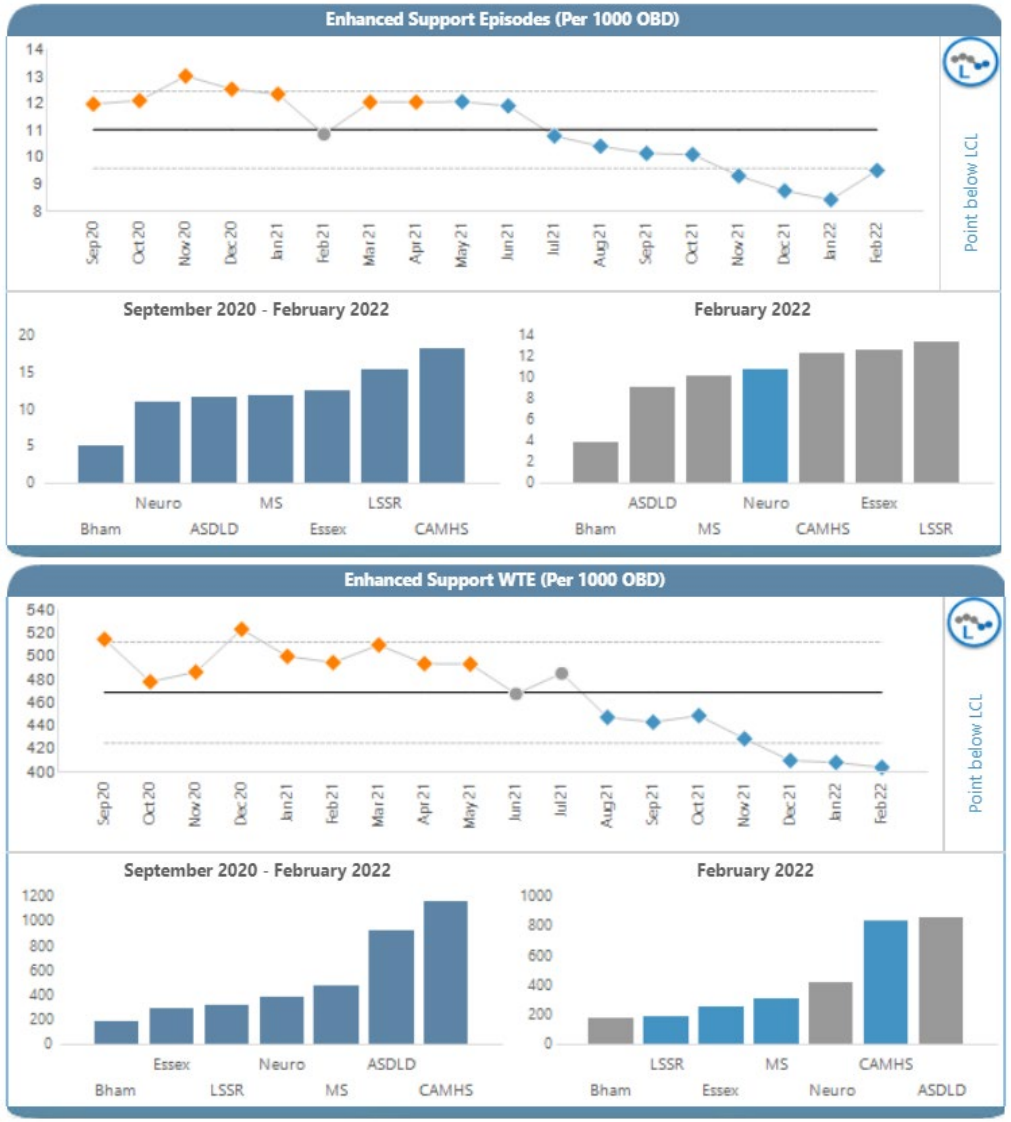






New special cause variation improvements - incidents of violence, restraint and LTS have been below the mean for seven or more consecutive months and therefore demonstrate special cause improvements presented for the first time. This reduction correlates with the REDUCE programme that has been in place since September 2019. Benchmarking will inform a target for this trajectory.

Exception reporting – Enhanced Support



Sustained improvement - fewer new episodes of enhanced support, correlating with a reduction in the level of resource required to facilitate enhanced support. Special cause improvements initially reported to the Board in January have been sustained. This reduction correlates with the REDUCE programme that has been in place since September 2019, alongside the sustain scrutiny on enhance support. Benchmarking will inform a target for this trajectory.

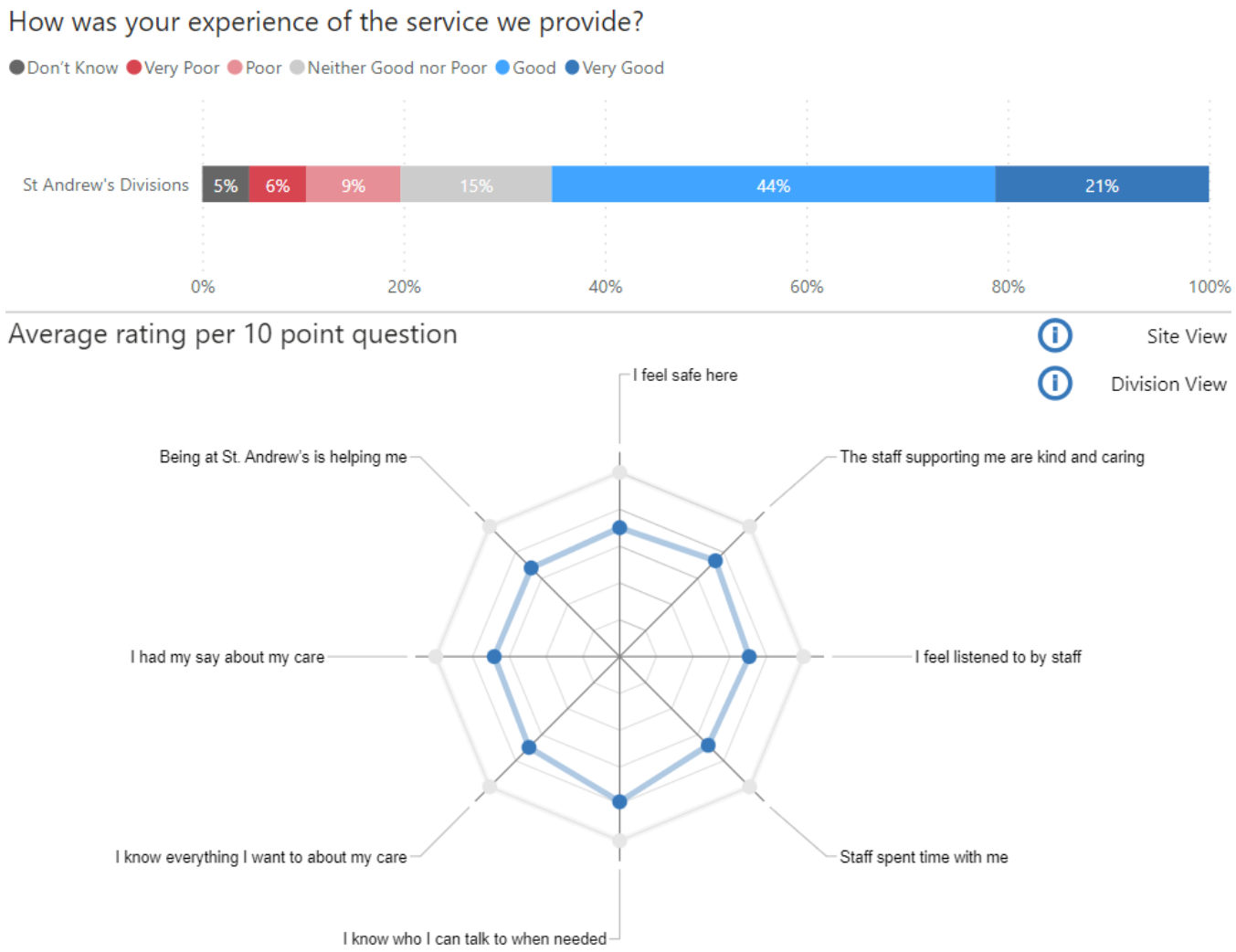
Ward level assurance

The quality scorecard presented in this report provides a Charity position alongside a disaggregated divisional view. The Quality & Safety Committee is provided with a further level of granularity in the form of the ward level quality scorecards, associated causal analysis and remedial actions. The below table represents a hybrid – providing an overview of the status, at ward level, of the 11 current quality KPIs. In summary 92% of the ward level quality KPIs are in control, have little or no data, or show a statistically insignificant trend, 5% show statistically significant improvements and less than 3% show statistically significant concerns (this is consistent with January 22).

Division	Wards	SPC Concern	SPC Improvement	SPC Common Cause	Trend Concern	Trend Improvement	Little or No Data
ASD & LD	14	4 %	5 %	21 %	14 %	17 %	39 %
Birmingham	8	2 %	3 %	13 %	13 %	9 %	60 %
CAMHS	4	2 %	10 %	31 %	6 %	8 %	42 %
Essex	7	2 %	2 %	19 %	15 %	12 %	49 %
Low Secure & Specialist Rehab	9	0 %	8 %	19 %	4 %	13 %	56 %
Medium Secure	11	0 %	5 %	26 %	7 %	11 %	52 %
Neuro	12	6 %	6 %	28 %	8 %	2 %	50 %
Totals	**65**	**3 %**	**5 %**	**22 %**	**10 %**	**11 %**	**49 %**

Whilst the above demonstrates lagging quality indicators are largely in control, the monitoring of leading indicators - including the results from Quality Assurance visits and clinical supervision rates - highlights the need for continued effort and are a focus of the Charity's Quality Improvement Plan. Detailed analysis of the clinical leading indicators and the QIP status are being shared with the Quality & Safety Committee.

My Voice



PREMs has been named My Voice. The collated responses show 63% of respondents rate their experience as good or very good (62% January 2022). Response rates are a concern, being well below the desired level. Increased promotional activity is underway. Actions and learnings from My Voice will be included in ward, division and Charity wide QIPs. With lesson learnt being addressed via the dedicated Embedding lessons learnt into practice work stream (one of the nine work streams in the Improvement Programme).

As at 11.03.22

2) People Scorecard

People Scorecard at a Charity level, training and agency spend are ahead of target. The remaining metrics show no common cause variation, however target achievement has proved challenging.

Measure	Vol Turnover		Vol Turnover Month		RN Ratio		HCA Ratio		Training		Agency Spend		Sickness %	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
StAndrews														

Divisions

Measure	Vol Turnover		Vol Turnover Month		RN Ratio		HCA Ratio		Training		Agency Spend		Sickness %	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
ASDLD														
Bham														
CAMHS														
Essex														
LSSR														
MS														
Neuro														

The top table shows the full charity position with the below highlighting the inpatient divisions. The smaller table shows the enabling functions. The following pages explain the variations.

Please note as CAMHS are a smaller division they may be disproportionately impacted by a small number of staff members - individual divisional reviews are in place to assess this.

Measure	Vol Turnover		Vol Turnover Month		Training		Sickness %	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target
Functions								

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

Concerns Improvements In Control

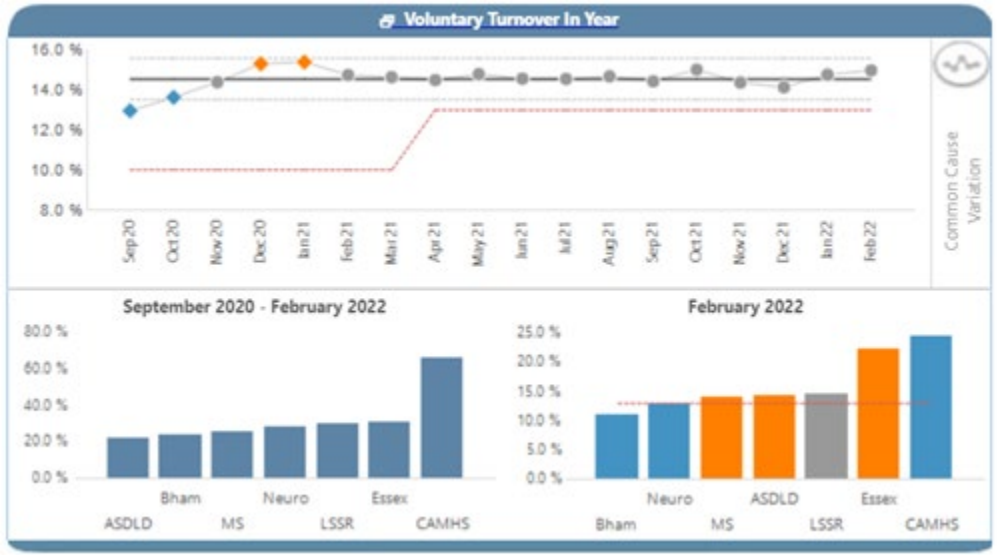
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

Exception reporting – Voluntary turnover in year & in month (adverse to target)

Charity wide

Inpatient divisions



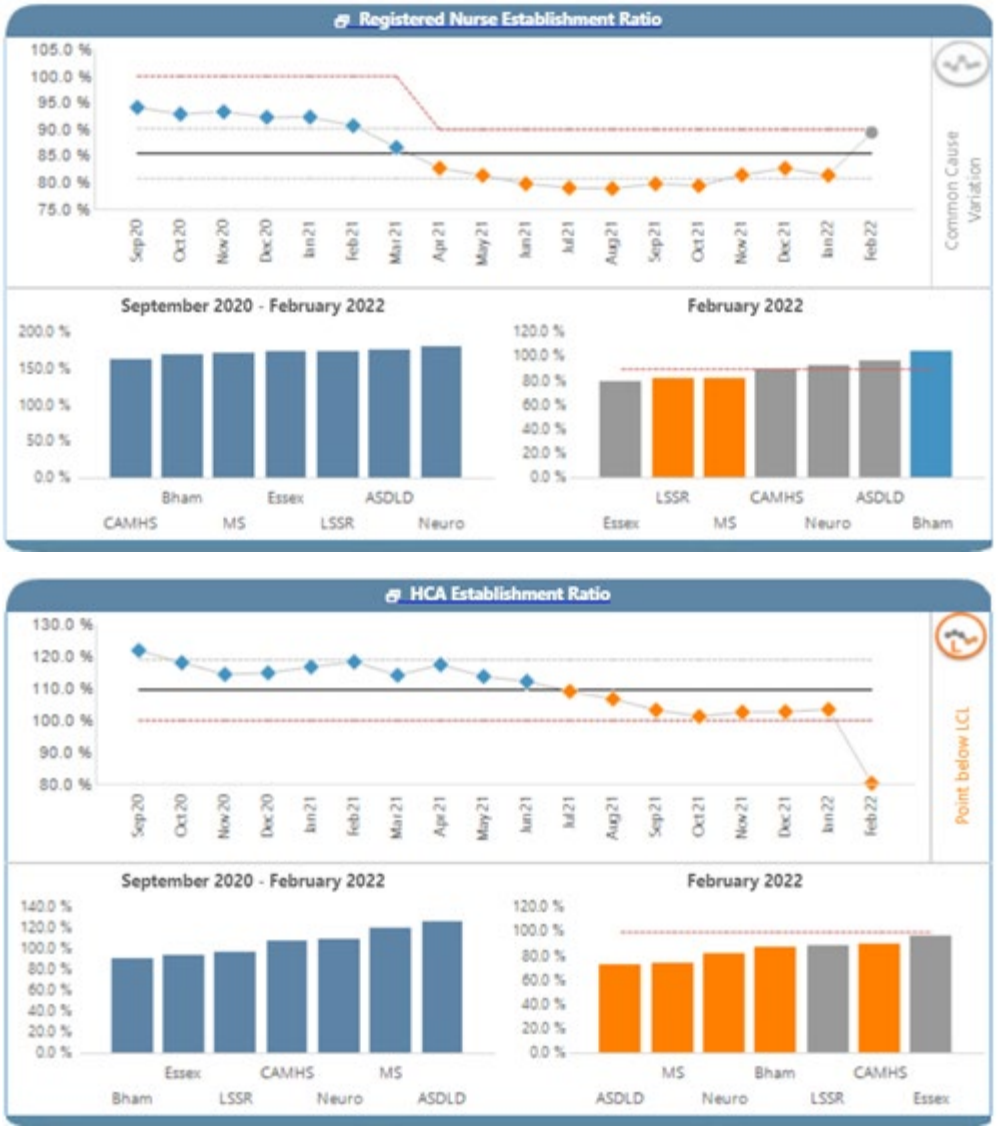
Charity wide voluntary turnover over the past 12 months is 14.4% (15.4% for inpatient divisions), marginally above the 13% target. Consistent with recent improvements, the February monthly figure for the inpatient divisions is below the tolerance at 1%. As previously shared the Charity compares favourably in the latest NHS benchmarking. Turnover being reported within the private sector is between 20-30%+ with Nurse turnover at Cygnet 30% (10% STAH) 54% for HCAs (13% STAH).

Causal analysis: People report leaving the Charity for a better package and/or work life balance, with pay reasons increasing considerably in recent months. Being investigated are; moves from permanent to WorkChoice and the enabling function monthly rates.

Remedial actions:

- Progression to the Real Living Wage proposed within pay review
- Pay progression for critical roles, including Nurses
- Project to increase flexible working options linking to Allocate
- Lead the change programme co-producing culture change
- Managerial capability continues to be reviewed and managed

Exception reporting – Establishment ratio (permanent staff)

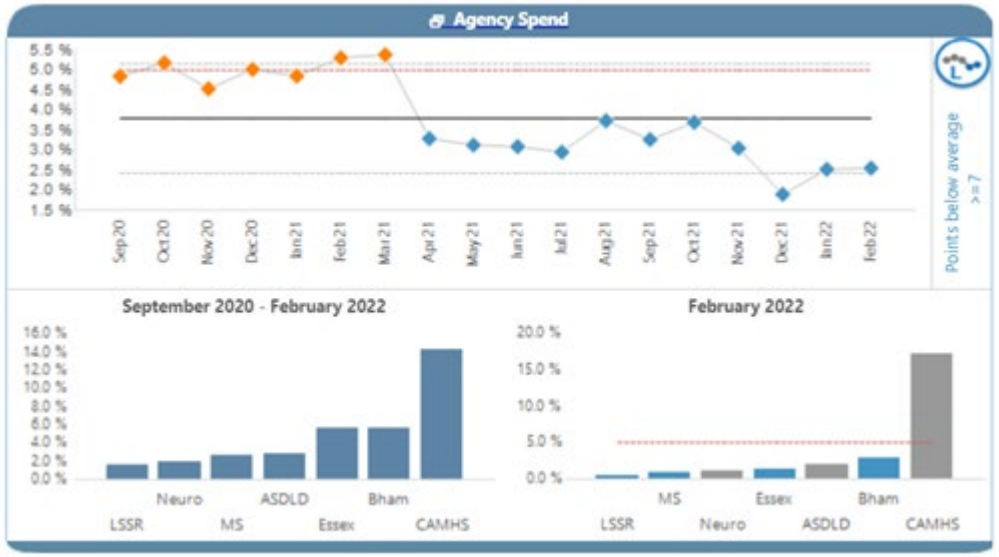


As described in the Safer Staffing paper the move to MHOST on the 31st January 2022 brings with it a new approach to establishment. As a result the Charity's registered nursing requirement has reduced overall bringing the establishment ratio for registered nurses to 87% (adjusted from 89.5% due to 12 non-ward based nurses). In contrast, the inclusion of an average volume of enhanced support staffing has increased the HCA requirement by 295. The resulting reduction in the establishment ratio is evident on the trend graph. The associated total recruitment gap is 328.

Remedial actions:

- Significant recruitment activity is underway
- HCA pipeline grown by 140% from February to March
- Assessment volumes raised
- Moving regular WorkChoice Nurses and HCAs to substantive contracts
- Advertising all posts as part time / flexible to increase potential candidate pools

Exception reporting –Agency Spend

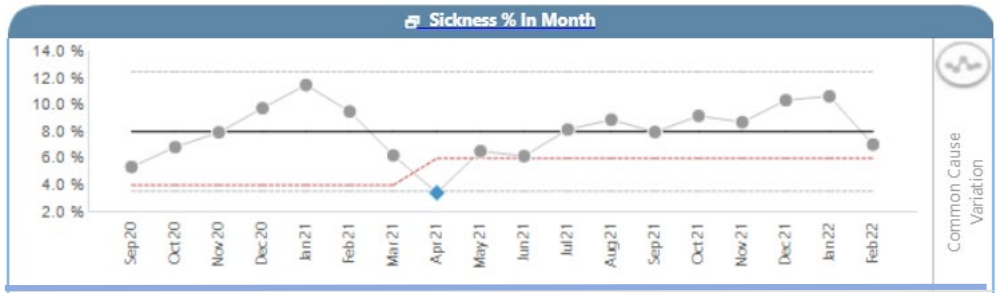


Charity wide agency spend is 2.5% and remains low with a cost in February of £132k. All divisions are below the tolerance except CAMHS at 17% (this reflects planned and consistent agency utilisation in order to mitigate a period of under establishment).

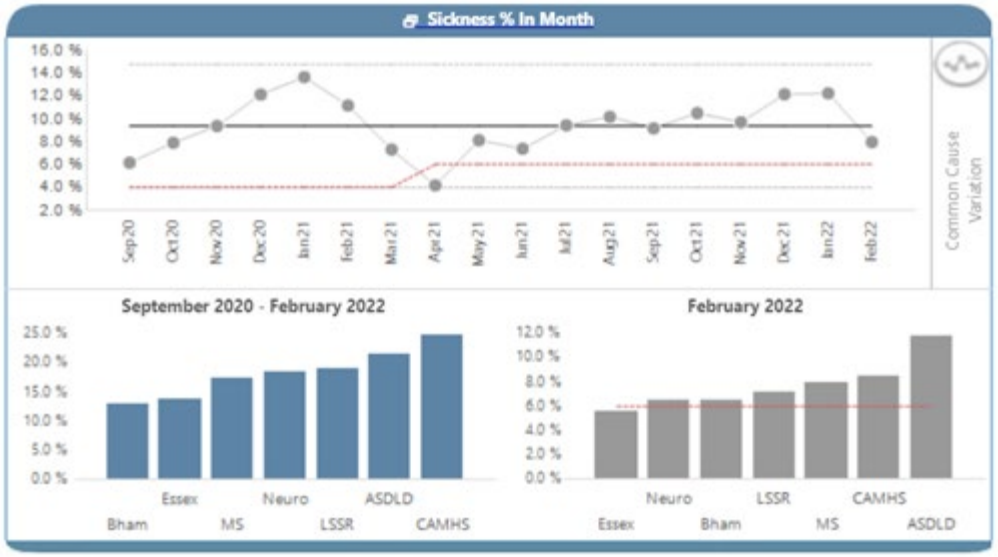
The current levels reflect a lack of availability of agency staff. The Charity continue to work closely with agencies to increase numbers for specific wards to support staffing.

Exception reporting – Sickness (adverse to target)

Charity wide



Inpatient divisions



February saw 7% sickness charity wide (8% for divisions & 5% for enabling functions) equating to 29,290 hours of working time, at a cost of £415k (£276k for wards). This figure is likely to be higher pending return to work submissions in the latter part of March. Whilst the latest month shows a positive reduction, sickness absence remains in excess of the charity wide target and continues to have a significant impact on ward staffing.

Short term absence levels remain higher than budgeted for and there are 78 long term absence cases (64 in January). Due to the unique nature of the charity, benchmarking to comparable organisations is challenging. Overall NHS sickness levels are largely static at 4.6% (based on 12 mental health Trusts). However, these figures include both acute and community services which typically have lower sickness rates.

Remedial actions

- A project group has been set up with a priority focus on reducing sickness absence
- The continued roll out of vaccination and flu programmes
- The employee relations team are providing central management for long term sickness cases
- A continued focus on wellbeing with a Head of Wellbeing appointed

Finance Overview

St Andrew's Healthcare – Board Finance Overview

February 2022

February 2022 Year to Date Net Deficit is £2.7m (£2.4m Operational) better than the re-forecasted position.

- £2.1m due to direct cost savings (relational to lower staffing levels) and £0.3m higher income.
- Non Operating Costs £0.3m below forecast – mainly due to lower OPEX Project expenditure during November to January 2022 as the Charity focused on the Kronos recovery and COVID wave.
- The forecasted financial performance (Board approved September 2021) has consistently been achieved every month to date and provides confidence in the financial recovery plan.

February 2022 Occupancy was below the expectations set out in the reforecast.

- The occupancy was consistently in line with expectations at the end of January 2022.
- The expected growth in February 2022 was delayed due to the deferred opening of the new Mackaness ward (now opening mid-March) and delayed admissions into wards which were in isolation (now planned throughout March).
- Consequently February 2022 occupancy growth was delayed into March 2022.

Cash balances held are better than forecasted due to the Net Surplus favourable position.

- Cash continues to be closely monitored and in March 2022 we expect to liquidate £5m of the Investment Portfolio and repay part of the loan balance.
- Improved operating position is reflected in stronger bank covenants for Qtr4 and cash held is better than forecasted at February 2022.

Year End Outlook – 31 March 2022

- Projection is that **full year losses will be below** the forecasted level of £14.5m. **Operationally will exceed forecast**.
- However, a risk has emerged with the **Investment Portfolio value reducing**, linked to recent FTSE movement. **Subject to March 2022** Stock Market movement it is estimated there could be an £1m-1.5m unforecasted deficit.

St Andrew's Healthcare – Board Finance Performance Report

February 2022

Financial Performance - £m	Month - Feb-22			Feb 22 YTD			Full Year		
	Actual	Forecast	Variance	Actual	Forecast	Variance	Forecast	Budget	Variance
Income	12.1	12.3	(0.2)	145.0	144.8	0.3	158.4	171.4	(12.9)
Direct & Indirect Costs	(9.8)	(10.2)	0.4	(114.2)	(116.3)	2.1	(126.6)	(128.7)	2.1
Net Contribution	**2.3**	**2.0**	**0.3**	**30.8**	**28.5**	**2.3**	**31.8**	**42.7**	**(10.8)**
Enabling Services	(2.4)	(2.4)	0.0	(27.6)	(27.7)	0.1	(30.1)	(30.3)	0.2
Depreciation	(1.0)	(1.1)	0.0	(12.5)	(12.5)	0.0	(13.6)	(13.7)	0.1
Operating Surplus/(Deficit)	**(1.2)**	**(1.5)**	**0.3**	**(9.3)**	**(11.8)**	**2.4**	**(11.9)**	**(1.3)**	**(10.6)**
Non Operating Costs	(0.1)	(0.1)	(0.1)	(1.0)	(0.9)	(0.1)	(1.0)	(1.5)	0.6
Exceptional Costs	(0.1)	(0.1)	(0.0)	(0.9)	(0.9)	(0.1)	(0.9)	(0.6)	(0.3)
Disposal of Fixed Assets & Impairment	0.0	0.0	0.0	(0.2)	(0.2)	0.0	(0.4)	0.0	(0.4)
Project Costs - OPEX	(0.1)	(0.2)	0.1	(1.3)	(1.8)	0.5	(2.0)	(4.0)	2.0
Investment Gains/Losses	0.0	0.0	0.0	1.5	1.6	(0.0)	1.6	0.0	1.6
Net Surplus/(Deficit)	**(1.5)**	**(1.9)**	**0.4**	**(11.2)**	**(13.9)**	**2.7**	**(14.5)**	**(7.4)**	**(7.1)**

Occupancy	Month - Feb-22			Feb 22 YTD			Full Year		
	Actual	Forecast	Variance	Actual	Forecast	Variance	Forecast	Budget	Variance
Available Beds	679.0	683.0	(4.0)	691.2	692.8	(1.6)	700.1	700.5	807.0
Avg Occupied Beds	572.3	588.2	(15.9)	575.4	577.4	(2.0)	579.1	621.8	657.7
Occupancy %	84%	86%	(2%)	83%	83%	(0%)	83%	84%	82%

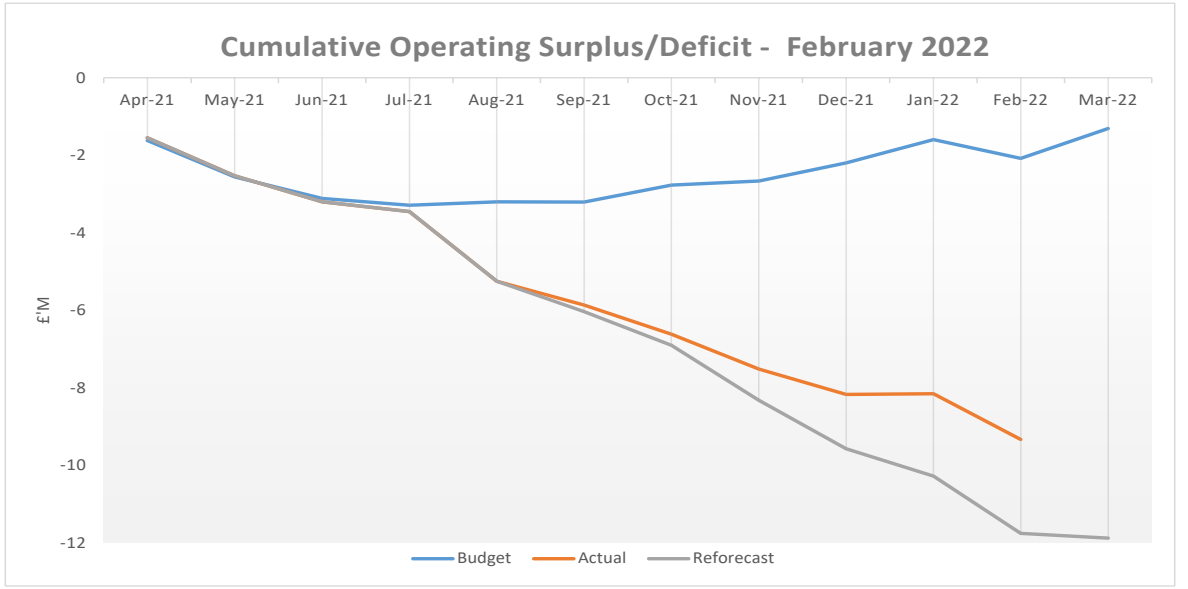
St Andrew's Bank Covenants 2021/22	Mar-21	Jun-21	Sep-21	Dec-21	Jan-22	Feb-22
Covenant 1. Interest Cover - Ratio of EBITDA to net finance charges in respect of any 12 month period. **Should not be less than 3.00 : 1.**	4.1 : 1	4.3 : 1	6.1 : 1	6.1 : 1	6.7 : 1	6.6 : 1
Covenant 2. Net Leverage - The ratio of total net debt (borrowings less cash and cash equivalents) at period end to EBITDA for the preceding 12 months. **Should not exceed 3.00 : 1.**	-0.4 : 1	1.6 : 1	0.9 : 1	0.4 : 1	0.2 : 1	0.4 : 1
Covenant 3. Loan to Value - Total Net Debt **should not exceed 70%** of the market value of the securities.	-0.59%	2.58%	1.77%	0.6%	0.5%	0.98%

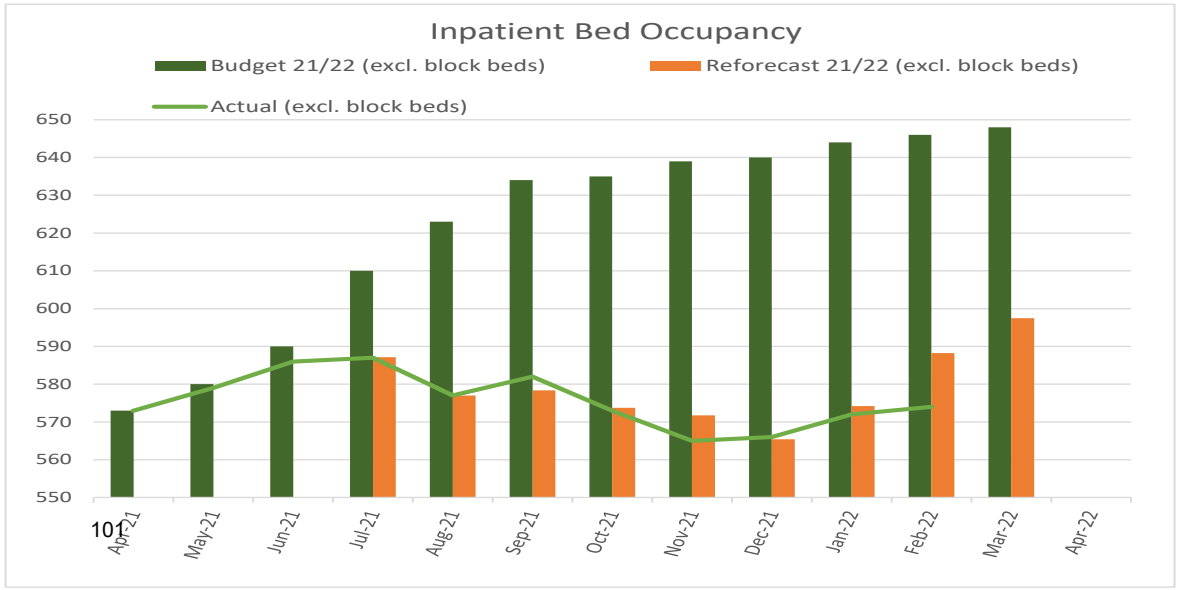
St Andrew's Consolidated Balance Sheet 2021/22	Mar-21 Audited	Jun-21 Actual	Sep-21 Actual	Dec-21 Actual	Jan-22 Actual	Feb-22 Actual
	£M	£M	£M	£M	£M	£M
Intangible and tangible fixed assets	209.0	205.9	203.3	198.2	197.3	196.6
Investments						
Stock Market Investments	15.7	15.8	15.9	17.6	17.6	17.6
Investment Properties	5.7	5.7	5.7	5.7	5.7	5.7
Current Assets						
Stock	0.6	0.5	0.4	0.5	0.5	0.4
Trade debtors	7.3	10.4	9.0	9.6	9.5	8.9
Other Debtors & Accrued Income	5.2	5.6	6.1	4.4	4.4	4.7
Prepayments	1.7	1.3	1.6	2.0	2.5	2.1
Cash	5.8	4.1	4.5	5.8	6.2	4.9
	20.6	**21.9**	**21.6**	**22.3**	**22.9**	**21.0**
Current Liabilities						
Trade Creditors	(7.6)	(4.9)	(3.8)	(2.8)	(3.5)	(3.5)
Taxation and Social Security	(3.1)	(3.4)	(3.6)	(2.8)	(3.0)	(2.6)
Other Creditors & Accruals	(8.5)	(8.6)	(9.0)	(8.6)	(8.6)	(8.4)
Staff Accruals	(4.0)	(3.3)	(3.6)	(4.4)	(3.4)	(3.6)
Deferred Income	(2.5)	(2.7)	(3.5)	(4.3)	(4.3)	(3.6)
	(25.7)	**(22.9)**	**(23.5)**	**(22.9)**	**(22.8)**	**(21.7)**
Net Current Assets/(Liabilities)	**(5.2)**	**(1.0)**	**(2.0)**	**(0.5)**	**0.1**	**(0.7)**
Total Assets Less Current Liabilities	**225.2**	**226.4**	**223.0**	**221.0**	**220.7**	**219.2**
Bank Loans (between 1 and 5 years)	(19.8)	(24.8)	(24.9)	(24.9)	(25.0)	(25.0)
Pension Scheme Liability	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)
Total Assets Employed	**204.7**	**200.9**	**197.4**	**195.4**	**195.1**	**193.5**
Reserves	**204.7**	**200.9**	**197.4**	**195.4**	**195.1**	**193.5**

St Andrew's Healthcare – Board Finance Performance Report

February 2022

Cashflow Summary - February 2022	£m
Net Surplus/(Deficit)	(11.17)
Add Back Non Cash Items	
Depreciation	12.53
Fixed Asset Impairment/(Profit on Disposal)	0.16
Investment Portfolio Valuation Movement	(1.94)
Net inflow/(outflow) from Operations	**(0.42)**
Total inflow/(outflow) - Working Capital	(5.21)
Total inflow/(outflow) - Capital Expenditure	(2.05)
Total inflow/(outflow) - Asset Disposal	1.75
Total inflow/(outflow) - Investment Portfolio	0.00
Total inflow/(outflow) - Loan Facility	5.00
Net Cash (Outflows) / Inflow	**(0.92)**
Cash at the beginning of the period	**5.82**
Total Cashflow Movement	(0.92)
Cash at the end of the period	**4.90**





IT Security overview

IT Security Metrics (Dec – Feb 2022)

Legend	No Change	Trending Down	Trending Up

February

	DEC	JAN	FEB	RAG Rating	Causal	Remediation
Vulnerabilities not fixed within SLA Highlights the amount of infrastructure vulnerabilities that haven't been fixed within the agreed timescales	2	0	0		**Causal Analysis**: Vulnerabilities are actively tracked to ensure compliance, any breaches in terms of SLA's are either presented for risk acceptance or dispensated to investigate a fix.	**Remedial Actions:** IT Security and Advanced will continue to monitor and track SLA breaches and raise any Non-Conformances if required.
Overdue Penetration Test Remediation The last Pen test for the Charity was in July 2021. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: No overdue actions again this month.	**Remedial Actions:** IT Security will continue to monitor the remediation and co-ordinate their resolution.
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 2 P3 3	P1 0 P2 0 P3 1	P1 0 P2 1 P3 4	103	**Causal Analysis**: All incidents in February related to phishing attacks, one of which was from a compromised NHS email account. The P2 incident relates to staff clicking on a malicious phishing link, but the credential capture page was blocked by the web filter.	**Remedial Actions:** IT Security are reviewing the current phishing awareness methods as a multi-pronged approach is required. 1:1 conversations with staff who click on links have been implemented to provide more targeted awareness as well.

IT Security Metrics (Dec – Feb 2022)

Legend	No Change	Trending Down	Trending Up

February

	DEC	JAN	FEB	RAG Rating	Causal	Remediation
Blocked Network Attacks These are blocked network attacks directed at our external network edge	55,452	46,699	59,214		**Causal Analysis**: We are constantly being port scanned and probed by external threat actors. Our firewall is configured to block this traffic. Russian IPs are automatically dropped and blocked at the firewall.	**Remedial Actions:** The increase is being monitored but does seem to coincide with the increased threats against heath care provides.
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	0	0	0		**Causal Analysis**: There has been positive engagement from action owners. Updates have been provided with some actions closed.	**Remedial Actions:** Regular catch ups are conducted with audit action owners. Next steps will be automation from 4action and ensuring action owners have visibility of 4action. (External Audit OBS)
Outstanding Operating System Patches % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 99% Client = 94%	Servers = 93% Client = 92%	Servers = 93% Client = 96%	104	**Causal Analysis**: An average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). Client devices are all built to a government secure industry standard, have anti-malware installed, are protected by the web filter even off the network and have firewalls enabled	**Remedial Actions:** The patching process for client devices is due to be reviewed with more staff working remotely or not being based in an office which causes some delays e.g. Community Partnerships.

IT Security Metrics (Dec – Feb 2022)

Legend	No Change	Trending Down	Trending Up

February

	DEC	JAN	FEB	RAG Rating	Causal	Remediation
Anti-Malware Installation Compliance % of machines on the network that have anti-malware protection installed and enabled	100%	100%	100%		**Causal Analysis**: None	**Remedial Actions:** None
Blocked Attacks on Staff Accounts Attempted logins from malicious actors to staff accounts. These aren't successful and are flagged by our SIEM tool	34	39	55		**Causal Analysis**: Attackers perform password attacks against accounts they find on LinkedIn or through other means. They will use 1000s of common passwords through automated tools. Finance is the most targeted department per ratio of 100 staff	**Remedial Actions:** IT Security monitor these on a daily basis and will investigate to ensure they are not successful. High risk departments have Multi-Factor Authentication enabled e.g. Finance, HR, IT, Estates.
Security Awareness % of applicable staff who have completed their e-learning module on cyber security & information governance	91%	91%	88%	105	**Causal Analysis:** L&D are seeing challenges in staff booking and being released to attend training with the current staffing challenges. Not at the required level of 95% for the Data Security & Protection Toolkit.	**Remedial Actions:** IT Sec & Info Gov have revised the training and are looking to have different training courses for different job roles to ensure staff are getting the right information at the right level. Currently with L&D to implement.

Navigating St Andrew's SPC charts

Target line

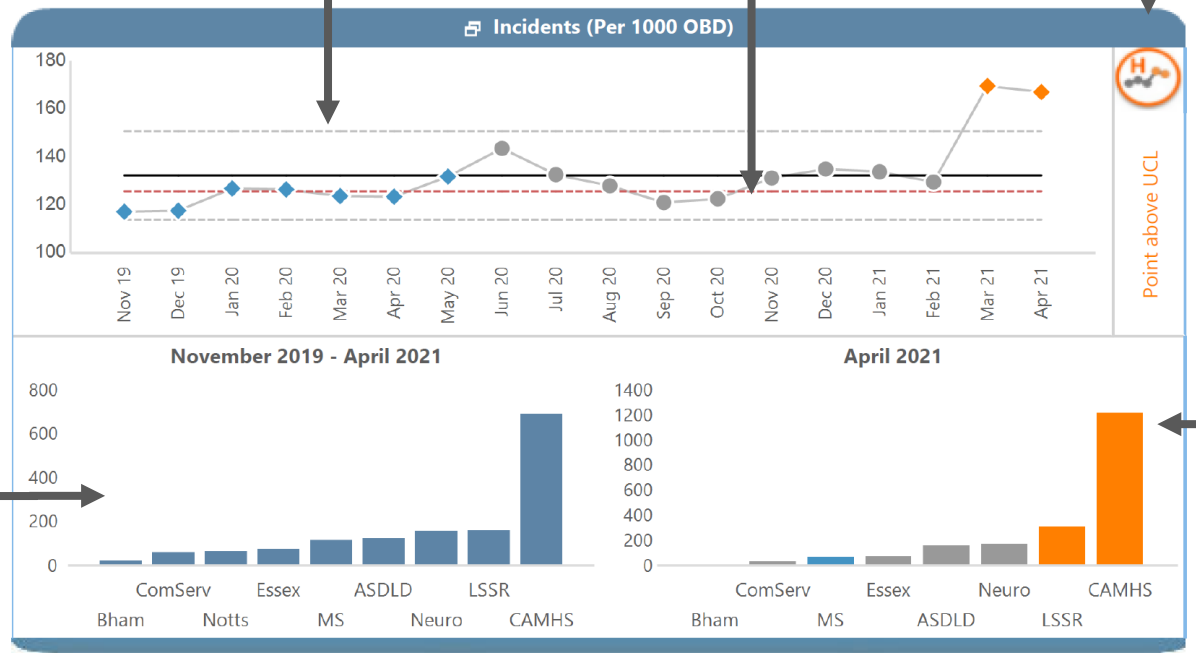
Proposed target for the KPI

SPC icon for the latest month

Orange icon = Special cause concern
Blue icon = Special cause improvement
Grey icon = Common cause variation
Trend line = Not enough data for statistical significance. Icon replaced by trend line.

Charity level SPC chart

Shows the trend for the last 18 months as a per 1000 occupied bed days rate



Division average for the last 18 months

Helps understand how the last 18 months compare to the latest month

Latest month by Division

Shows how Divisions are contributing to the overall charity level in the SPC chart above.

The bar colour illustrates if a Division itself has an SPC concern/improvement

Example Narrative

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

The latest month Division chart shows that CAMHS and LSSR are high contributors, with both triggering an SPC special cause concern in their own data. Although their high contribution is in line with the last 18 months trend, the latest month rate is much higher.

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

Divisional Presentation (including Patient Voice)

Medium Secure Division –
Women's Services

Dr Sanjith Kamath
Dr Alex Hamilton
and Patient

Lead the Change

(Martin Kersey & Tom Bingham - Verbal)

Questions from the Public for the Board

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public -

Friday 27 May 2022 9.00am

(Paul Burstow - Verbal)