CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Friday 31st March 2023 at 9.30 am

The Centre for Development and Complex Trauma, Main Building, Northampton, NN1 5DG
& Microsoft Teams

		Purpose	LEAD	Page No.		Timing
1.	Welcome and Apologies	Information	Paul Burstow		*1*	*09.30*
Administration						
2.	Declarations of Interest	Information	Paul Burstow		*2*	*09.31*
3.	Minutes from the Board of Directors Meeting in Public on 24 January 2023	Decision	Paul Burstow	✓	*3-12*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*13-16*	*09.35*
Chair's Update						
5.	Chair Update	Information	Paul Burstow		*17*	*09.40*
Executive Update						
6.	CEO Report	Information	Dr Vivienne McVey	✓	*18-22*	*09.45*
Committee Assurance Reports						
7.	**Committee Updates**				*23-40*	*10.00*
	• Audit & Risk Committee (23/01)	Assurance	Rupert Perry	✓		
	• People Committee (09/02)	Assurance	Dawn Brodrick	✓		
	• Quality & Safety Committee (14/02)	Assurance	Steve Shrubb	✓		
Quality						
8.	Safer Staffing Report	Assurance	Andy Brogan	✓	*41-53*	*10.20*
9.	Quality Workstreams update	Assurance	Andy Brogan	✓	*54-56*	*10.35*
Operations						
10.	Integrated Quality & Performance Report, incorporating: • Quality Scorecard • People Scorecard • Finance Overview • IT Security Overview	Assurance	Anna Williams, Kevin Mulhearn, Martin Kersey & John Clarke	✓	*57-67*	*10.45*
Governance						
11.	Board Code of Conduct	Decision	Duncan Long	✓	*68-97*	*11.10*

12.	Revised Charity Governance Structure	Decision	Duncan Long	✓	*98-101*	*11.15*
Break 11.20 am to 11.25 am						
Service and Patient Story						
13.	Oliver McGowan training on Learning Disability & Autism Board session	Information	Martin Kersey (Liam Freestone & Jo York)	✓	*102*	*11.25*
Any Other Business						
14.	Questions from the Public	Information	Paul Burstow		*103*	*11.55*
15.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*104*	
16.	What would our patients and staff think about our discussions today?	Information	Paul Burstow		*105*	
17.	Date of Next Meeting – Thursday 18th May 2023	Information	Paul Burstow		*106*	
Meeting Closes at 12.00 noon						

Annexes - Items for information only	**Lead**		
Annex A – Governance Oversight Group update	Dr Vivienne McVey	✓	*108*
Annex B – Board Skills Matrix	Duncan Long	✓	*109-113*

Welcome & Apologies

(Paul Burstow– Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 24 January 2023

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Old Patient Library, Main Building
and Microsoft Teams
St Andrew's Healthcare, Northampton

Tuesday 23rd January 2023 at 09.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Dawn Brodrick (DB)	Non-Executive Director
Karen Turner (KT)	Non-Executive Director
Rupert Perry (RP)	Non-Executive Director
Vivienne McVey (VMc)	Chief Executive Officer
Kevin Mulhearn (KM)	Chief Finance Officer
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director
Andy Brogan (AB)	Chief Nurse
Dawn Chamberlain (DC)	Chief Operating Officer
In Attendance:	
John Clarke (JC)	Chief Information Officer
Duncan Long (DL)	Company Secretary
Anna Williams (AW)	Director of Performance
Eddie Short (ES)	Director of Strategy & Business Development
Alex Trigg (AT)	Director of Estates & Facilities
Julie Shepherd (JS)	Improvement Director
Stuart Wallace (SW) Item 10	Head of Legal
Richard Stedman (RS) Item 11	Head of Operations (ALD)
Fiona Hannah (FH) Item 11	Manager, Winslow & Broom Cottage
Melanie Duncan (MD) Minutes	Board Secretary
Apologies Received:	
Steve Shrubb (SS)	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 open to attendance by the public. Apologies received from Steve Shrubb were noted.		
ADMINISTRATION			
2.	**Declarations Of Interest & Quoracy** Members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose. Julie Shepherd declared her position with NHFT. The meeting was declared quorate.		

3.	**Minutes Of The Board Of Directors Meeting, held in public, on 29 September 2022** The minutes of the meeting held on the 24 November 2022 were **AGREED** as an accurate reflection of the discussion and decisions taken.	**DECISION**	
4.	**Action Log & Matters Arising** It was agreed to **CLOSE** the following actions: • 26/05 **01** – Risk Appetite (addition of a new action linked to strategic risks – as below) • 26/05 **08** – Integrated Performance Report • 26/07 **02** – Mental Health Bill • 26/07 **03** – ARC - Committee Risk oversight • 26/07 **04** – Governance oversight group – ARC visibility (addition of a new action linked to ARC programme of activity) • 29/09 **01** – Board minutes • 29/09 **02** – Board action log • 22/11 **03** – Service and patient story - Essex All other actions on the log remained open, either in line with the agreed target dates or to return at a future Board. New Actions: Existing Strategic Risks (as recorded on current BAF) are to be reviewed and aligned to new Strategy ambitions and directions and Board level risk appetite to be agreed for all strategic risks recorded within the BAF. New programme of ARC assurance activity to be established in line with revisions to Terms of Reference and in line with matters reserved and authority matrix.	**DECISION** **VMc & DL** **RP & DL**	 **21.07.23** **21.07.23**
CHAIR'S UPDATE			
5.	**Chair Update** PB gave a verbal update and noted the continuing and intensive work and dialogue regarding the Independent Business Review and the development of the Charity's new operating model. PB also noted the sad news that a service user that spoke at the recent LDA summit, had passed away. PB wished to extend sincere condolences to the family and staff who had cared for him. The Board **NOTED** the update.		
EXECUTIVE UPDATE			
6.	**CEO's Report** VMc presented her report which was taken as read and highlighted that recent focus has been on the priorities agreed by the Board at the November meeting, whilst dealing with the day-to-day challenges seen within the Charity. Staffing has improved in recent weeks, with very few alerts being raised on staffing levels, which whilst yet to be reflected in the report data, there is a feeling that staffing is beginning to stabilise within the Charity. There have been no Red Alerts for staffing within the last six weeks. The strategy was progressing with a high level of co-production across the organisation, along with carer and patient input, underpinned with staff workshops planned for February and March. There had been a fantastic response to the request to join the workshops and additional sessions are being scheduled in Essex and Birmingham, along with involving our Governors in the sessions.		

	VMc noted that the operating model was also progressing and that more on that would be discussed in part two as well as highlighting progress on the Charity's EPRR arrangements. DC added that partial compliance had been achieved in on the NHSE EPRR return, which was more than comparable to partner organisations. The basics are firmly in place and further background work on EPRR had commenced with manuals and procedures being rolled out in the coming weeks. A desktop exercise and live evacuation event was also planned for the coming months. KT asked how the staff from overseas were settling in. VMc replied that all staff had been placed, with an evaluation phase currently underway as there has only been one cohort so far. MK added that the staff were settling in well, with good pastoral care in place. The staff all lived together in order to support each other. KT asked AB if the training already received by the staff equipped them to work within the hospital. AB replied that the staff were registered general nurses, who would receiving further training in mental health nursing. The pause to evaluate had given the time to assess how the training was being adopted. KT thanked both MK and AB. SN asked where the development of community services and partnerships sat in the new strategy and organisational structure and whether any plans were available. VMc replied that the area was being evaluated by business development in order to assess the options, more specifically at present in relation to Berkeley Close, however, there were priorities regarding the operating model that were also being addressed. VMc reiterated that the Executive were focussing on the agreed priorities and the changes to the operating model and would shift focus to business development in the near future. ES further outlined the work being done by the team regarding an outline model for the Berkeley Close scheme which was in development. SN asked when this would be ready for discussion. VMc replied that this was due back at Exec in February and then Board, possibly in March, but that the work on the operational model was also involved and so timelines may be affected. The Board **NOTED** the update.		
COMMITTEE ASSURANCE REPORTS			
7.	**Quality & Safety Committee** RB presented the report which was taken as read and highlighted the new approach to quality being taken by the Committee, where there was higher concentration on fewer matters. This approach would be trialled over the next 2 to 3 meetings where the committee would focus on three or four big areas, whilst keeping a view on emerging risk areas in order to react as needed. PB noted that it was good to have clarity on how the committee was maintaining its lines of sight over quality and the governance processes in place. PB also noted that the Quality Strategy would be presented to Board for approval at the March meeting. The Board **NOTED** the report **Audit & Risk Committee** EL gave a verbal update of the recent meeting, outlining the recent discussions and assurances given at the meeting the day before: • Approval of the external audit plan, strategy, and fee • Draft Reserves Policy would return to ARC following further discussions and work with Grant Thornton		

	• Agreement to partial assurance for operational risks, and adequate assurance for material risks and the BAF process • Internal Audits – limited assurance was given to the recently published EPRR audit and partial assurance for the Health & Safety audit • ARC noted the increased number of overdue actions to 11, some rated as high priority. • ARC continue to have concerns regarding the fragility of the Internal Audit and Risk function in terms of resource. • ARC wished to acknowledge the continued excellent work done by Darren Handley, LCFS on Counter Fraud • ARC received the first draft committee Terms of Reference and a workshop is to be scheduled to review these further and finalise the ARC annual work plan • ARC approved the Annual Accounts Timeline. AL asked about the overdue audit actions and wanted to know how overdue they were. EL replied that some were nearly a year old, which could lead to criticism of the committee. VMc added that this situation highlighted that the governance and assurance process links required further strengthening. PB added that further discussion regarding the important work of the Committee would be required and how it links to the Charity's mission and is not allowed to operate within silos. The Board **NOTED** the update		
QUALITY			
8.	**Integrated Quality & Performance Report** AW presented the report which was taken as read and highlighted the patient discharge and staffing information included in the report, along with the improvements seen because of the feedback given to the Operations Committee. RP asked if the organisation was on target to replace agency staff with permanent staff. DC replied that the plan was to utilise bank staff, which would remove the reliance on agency staff and that recruitment was ongoing and constant, and that whilst staff turnover was ok, there would always be a degree of churn. DB asked if visibility of the plan targets referenced within the dashboard could be built into the report to help show where the Charity was aiming to get to. AL added that sight of the plan would be helpful and assist in managing the expected trajectories. AW and MK would include in the next report, following further discussion at People Committee. PB asked if the data on CAMHS included in the report mirrored the assurance levels offered by the QSC report. Executives replied by highlighting that CAMHS continued to experience issues. SK outlined that the combination of acuity of patients and therapeutic activity all played a part along with the on-boarding of new staff. The RiO electronic patient record was also being developed to enable better recording of activities. DC added that the biggest concern was leadership, and that it was being addressed. KT confirmed that CAMHS had not been removed from QSC scrutiny, it was highlighted as coming off the agenda in relation to specific areas of focus, and however the committee was still maintaining oversight of CAMHS. QSC were monitoring all divisions from a risk perspective and that any challenges that emerged in the future regarding CAMHS (or any division) would be brought back to the agenda should it be required. SN asked about mandatory training levels and how they were being addressed, including the training of new starters. DC replied that operations, working in partnership with HR were addressing the training levels with deadlines being put in place. SN asked for a report to be given to Board	**AW & MK**	**31.03.23**

	outlining what was being done with timelines and outcomes. PB asked the People Committee to consider the report and provide assurance to the Board. RB noted the reduction in sickness absence levels and welcomed the good news, and also asked when the effectiveness of the retention framework could be anticipated. VMc outlined that this subject would be covered over several papers in both parts of the Board meeting, including the new Nursing Establishment plan and the new operating model. MK outlined progress against the retention framework and confirmed that it would be presented at the next People Committee, demonstrating the actions being put in place over the next six months. PB requested that QSC consider what further steps could be taken to increase the My voice response rates included within the IQPR and provide assurance to the Board on actions being taken. The Board **NOTED** the report	**DC & DB** **SK & SS**	**21.07.23** **21.07.23**
9.	**Establishment Review Update** AB presented the paper which was taken as read and noted that this was the second full year of undertaking the process, with a comprehensive review having been conducted. AB noted that the report indicated that there was a requirement for a significant increase in registered staff on the wards, with staffing already flexing up to this level. There was evidence that the correct number of registered staff could result in a decrease in incidents. AB suggested that a Board decision be deferred until other reports covering financials and the operating model had also been considered. KM added that there was financial investment in safer staffing and the new operating model. PB agreed that the decision would be deferred to Part Two of the meeting, following consideration of other reports which related to the subject. RB was encouraged by the report, particularly the thoroughness of it, and asked what the reactions were from management. AB replied that there had been challenging one to one conversations, and that recruitment would be ongoing, which would be a challenge. There is a risk associated with the establishment numbers and this is being managed. AL was supportive of the plan and asked if the KPI triggers on the IQPR would change if the new staffing figures were accepted, and if there could be any regulatory challenge. AB replied that the reporting within the IQPR would reflect the changes, and that the narrative to explain the data would be important to reflect any direct impact. AL further commented that if the Board approved the new Establishment levels, that it would be doing so along with accepting the resultant shift in data, and that it was the right thing to do, despite the change in figures. DB asked if there was a correlation between acuity levels going up and experience of staff. AB replied that no direct correlation had been observed, but that it was being monitored given the loss of experienced staff currently seen. SN asked about recruitment of qualified staff, and asked how optimistic AB was in recruiting the numbers needed, and was there a fall-back plan? AB replied that the fall-back plan was to utilise bank and agency staff in order to achieve staff fill rates. AB further noted that solutions would not be found in recruitment alone, but that the retention plan would be integral in making the initiative work. SN also asked how the changes would be received by staff and likewise conveyed to the regulator. AB replied that evidence-based discussion was helping a great deal, as typically, staffing invoked an emotional response initially. AB also acknowledged that this initiative would require a large financial investment.		

	EL asked what percentage would be substantive staff compared to agency staff in the new model. AB replied that it would be the quality of agency staff that would be key in making the model work and not just the ration of agency to permanent, as well as booking agency staff for longer periods to increase consistency. DC added that making more use of bank and MDT staff along with a move toward a more therapeutic environment would be beneficial. EL wanted to check that permanent staff who also work on bank would not work more hours as a result. DC replied that there were checks in place to ensure that staff did not work more than stipulated within the EU Working Time Directive. These rules are embedded within the new auto-rostering tool. PB raised managing enhanced support, and asked if we were able to follow a target or lag indicator to see if we are moving in the right direction or not. AB responded that there was no clear target as yet, but it was something that could be looked at. PB further asked about Neuro having more nursing associates and why this was not seen in other divisions. AB replied that the Neuro model leant itself to having more associates in post due to the model in place and its structure. RB asked questions as to the increase of occupancy, and how the Charity balances recruitment and quality accordingly and whether some of the expansion could be paused whilst the recruitment of staff was concentrated on. SK replied that as an organisation, quality always came first whilst recognising the financial realities. The strategic view was that there was an occupancy target coupled with a quality strategy that would enable quality to be monitored, as per the Heat Map currently being developed. SK re-iterated that patients would only be admitted to a ward if it was safe to do so. KM confirmed that in some divisions the occupancy growth was based upon previously recognised staff growth and not dependent on new recruitment. The Board **NOTED** the report and **AGREED** to consider the report further in Part Two of the Board meeting.	**DECISION**	
MATTERS ARISING			
10.	**Mental Health Bill** SW joined the meeting and presented the paper, which was taken as read, introducing the background to the changes in the Mental Health Bill and the key points to note from the changes. SW noted that the bill was the basis of a piece of legislation that would transform the Mental Health Act. The main aim of the bill was to make it more challenging to detain individuals for certain conditions. That statutory care plans would be required for every patient who was sectioned, and SW also noted that less restrictive placements within the community were also observed in the bill. SW added that there had also been suggestions that a Commissioner for Mental Health was to be appointed. AL asked how compliance with the changes would work within the Charity. SK replied that responsibility was shared across the Charity. Documentation was looked after by the Mental Health Act team whilst therapeutics were the responsibility of the EMD. SK also outlined the work of the Mental Health Law Steering Group which reported into QSC and would be the source of assurance to the Board. SK noted support for most of the changes, however, system process and procedures would have to change in order to manage the changes to the bill, and that the code of practice would lay out the implications of the bill in a better way. SK added that the Charity needed to start thinking differently in readiness for the legislation. PB asked if the Charity would seek to play a full part in formulation of the code of practice. SK agreed that there would be advantages, however, the Charity had many current priorities which all required attention and was unsure the Charity had the capacity or resource at present to be involved. SN asked if there were a high percentage of patients currently with St Andrew's who had a mental health diagnosis in addition to ASD/LD. SN also		

	asked about the measures undertaken to measure the benefit of treatments. SK replied that he would provide the figures in terms of MH diagnoses and reiterated that the Charity did not admit any patients who solely had a diagnosis of ASD/LD, unless they presented a substantial forensic risk or were detained under Part 3 of the Act. SK added that there was regular monitoring and measurement of therapeutic outcomes already in place which indicated focus on each patient and their care plans. SK agreed to report to QSC on therapeutic outcomes and the percentage of compliance, along with suitable metrics. KT noted that she was a supporter of most of the bill, and wanted to highlight that expectations for implementing the changes was more about additions to existing legislation and the Charity should look at these in a different way and link them to our strategic priorities. KT added that length of stay would be important, coupled with the Charity demonstrating that no patient was kept longer than necessary, these align in general with the strategic direction now being worked on. As a result of discussions, KT asked how patients with complex needs would be cared for in the community with St Andrew's and did the Charity have experience of these services. SK confirmed that whilst we have the capability to do this (and gave Winslow as an example), more work is required on developing the model and the service. RB asked what the Charity could do to prepare itself for the implementation of the bill, and if it had been considered during the preparation of the new operating model. RB also asked if there was any indication whether the government was prepared to invest further in the sector. SK replied that the Charity was positioned favourably for implementation, but that patient involvement did require further input. OM noted that in his experience as Hospital Manager, there were patients who could have been discharged, but had not been due to no home care or social worker being in place and that patient advocacy was key. PB reflected on the discussion and noted that the implications of the code of practice and the Bill would be felt for many years to come and that there will be elements of the development of the new code that will be relevant to the Charity's expertise and that align to our mission of being experts in managing complexity. VMc outlined at a high level how the Charity would respond, whilst keeping in line with the strategy and operating model, noting that it would be a 2 – 3 year project to embed the changes. VMc further added how the new strategy clearly focused on advocacy and how it was about hearing the patient's voice and how we work with them to transform their lives, and this is our number one Strategy Workstream. DB talked about a trend to look at disproportionality in public services and whether a review exercise could be undertaken by the Charity. SK replied that this was currently being undertaken via the Mental Health Law Steering Group. KT asked if the debate on disproportionality could be had within QSC, it was agreed to discuss this with SS. PB agreed and suggested that the work on disproportionality could be overlaid with work on trauma as well. The Board **NOTED** the report.	**SK** **DL**	**18.05.23** **31.03.23**
SERVICE & PATIENT STORY			
11.	**Divisional Presentation (Including Patient Voice): Broom Cottage (Learning Disability and Autistic Spectrum Disorder)** Richard Stedman (RS) and Fiona Hannah (FH) joined the meeting from Broom Cottage and provided some background to both Winslow and Broom and how they worked and fitted into the Charity. FH added that many of the service users from Broom would be joining the presentation.		

	FH introduced two service users, Rosie and Keith and then presented a slide show highlighting Rosie and Keith's journey to recovery at Broom Cottage. OM asked what the Charity provided in terms of therapy at Broom Cottage as he was aware that some historically had been provided by the local council. FH noted that the local council no longer offered support in a therapeutic way and that the only contact was with the social worker and GP, with St Andrew's providing the therapy. Advocates were in attendance in order to ensure that the correct decisions were made for the patients. RS added that they had also introduced fortnightly calls with the Northampton MDT to assist with some of the OT and social work provision. KT asked how many people lived in the cottage. FH outlined that there were 4 service users in total with 2 staff on days and 2 on nights. EL asked what could be done to bring the current Good CQC rating to Outstanding. RS replied that the next steps were to demonstrate the added value from the team at Northampton, along with ensuring that it is demonstrated that Broom is run as a care home and not as a hospital. RB asked what could be learned from the way Broom was set up that could help with a move to more care in community-based settings in the future. RS replied that he was impressed by the resilience of the staff, and staff consistency as seen in Broom and Winslow. There was no silo working, and that care in the round was highly important. RS felt that this would work well in Northampton also. FH agreed with RS and added that communication was key with the wider Charity. The Board thanked FH and RS for their presentation and passed on good wishes to the service users of Broom Cottage. RS and FH left the meeting VMc highlighted to the Board that Broom Cottage was currently for sale, but that the property was under evaluation and that structural changes would be required to the property due to the current configuration of the building and the current service users, which would be discussed further at Exec. Further discussions will also be had on whether to remove it from sale and how the service and premises could be altered to ensure it remains viable.		
ANY OTHER BUSINESS			
12.	**Questions from the Public for the Board** No questions were received for the Board.		
13.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** PB acknowledged that this was EL's last Board meeting and outlined the great service and support she had provided the Charity. The Board members extended their thanks to EL and wished her well for the future.		
14.	**What would our Patients and Staff think about Our Discussions Today?** • PB noted that the focus on staffing and what the implications of the mental health act would be, along with risk management. • DC highlighted the meeting with service users and hearing their voice • AW highlighted the feedback with regard to the community • OM thought they would reflect on the Board's focus on quality • ES highlighted the discussions on patient advocacy and greater involvement in co-production		

	• PB also highlighted the change within the organisation.		
15.	**Date of Next Meeting :** Board of Directors, Meeting in Public – Friday 31st March 2023		

Approved – 31st March 2023

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

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

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
26.05.22 **06**	**Safer staffing – People Committee Assurance** The People Committee are requested to review and provide assurance to the Board on actions being taken to address refusals to re-deploy, specifically in relation to the work being done on the Charity's culture.	PB & MK	~~29.09.22~~ ~~22.11.22~~ 31.03.23	Open	**24.01.23 –** Remains open and due at March Board meeting, as further discussions required at People Committee. Action will remain open until after next PC meeting (9th Feb 23) **31.03.23 –**
26.07.22 **06**	**BAF – Finance Risk** Following the approval of the initial proposed BAF Assurance Ratings, it was agreed that the Finance Committee would complete further reviews on the financial strategic risk.	KM & AL	~~22.11.22~~ ~~31.03.23~~ 21.07.23	Open	**24.01.23 –** This will be part of making the changes to FinCom in line with the Governance Review. This will be done for March 2023 as agreed with the Chair and CEO to give the CEO time to organise the Executive Control Structure. New target date of July Board meeting to allow for committee to complete review within first quarter of new fiscal. **31.03.23** - Remains open and due at July Board meeting.
22.11.22 **01**	**QSC Update – Operations dashboard** DC to present the new Wards Heat Map to the Board at a future meeting in order to illustrate further the new operating model.	DC	31.03.23	Closed	**31.03.23 –** Included within part 2 agenda item **Propose action is closed**

22.11.22 **02**	**ARC Update – Functional resilience** VMc and DL to review resilience within the IA & Risk function and consider appropriate solutions to be shared with the ARC at the April committee meeting.	VMc & DL	17.04.23	Open	**31.03.23 -** Remains open and due at May Board meeting, following the ARC meeting on 17th April.
24.01.23 **01**	**Strategic Risks and Board risk appetite** Existing Strategic Risks (as recorded on current BAF) are to be reviewed and aligned to new Strategy ambitions and directions and Board level risk appetite to be agreed for all strategic risks recorded within the BAF.	VMc & DL	21.07.23	Open	**31.03.23 -** Remains open and due at July Board meeting.
24.01.23 **02**	**ARC programme of assurance activity** New programme of ARC assurance activity to be established in line with revisions to Terms of Reference and in line with matters reserved and authority matrix.	VMc & DL	21.07.23	Open	**31.03.23 -** Remains open and due at July Board meeting.
24.01.23 **03**	**Integrated Quality & Performance Report – Plan detail** AW & MK to include the plan targets referenced within the dashboard to help show where the Charity was aiming to get to. It was agreed that the plan would be included in the next IQPR, following further discussion at People Committee. Note: Next People Committee 11 May 2023	AW & MK	21.07.23	Open	**31.03.23 -** Remains open and due at July Board meeting.
24.01.23 **04**	**Integrated Quality & Performance Report – mandatory training** An assurance report outlining what was being done in relation to mandatory training rates, including timelines and outcomes against targets is to be provided to Board, following review at People Committee. Note: Next People Committee 11 May 2023	DC & DB	21.07.23	Open	**31.03.23 -** Remains open and due at July Board meeting.
24.01.23 **05**	**Integrated Quality & Performance Report – My Voice** PB requested that QSC consider what further steps could be taken to increase the My voice response rates included within the IQPR and provide assurance to the Board on actions being taken. Note: Next QSC 25 April 2023	SK & SS	18.05.23	Open	**31.03.23 -** Remains open and due at May Board meeting.
24.01.23 **06**	**Mental Health Bill – Therapeutic outcomes** SK agreed to report to QSC on therapeutic outcomes and the percentage of compliance, along with suitable metrics. Note: Next QSC 25 April 2023	SK	18.05.23	Open	**31.03.23 -** Remains open and due at May Board meeting.

24.01.23 **07**	**Mental Health Bill – Disproportionality** KT asked if the debate on disproportionality could be had within QSC, it was agreed to discuss this with SS. PB agreed and suggested that the work on disproportionality could be overlaid with work on trauma as well.	DL	31.03.23	Open	**31.03.23 –** Agreed to be scheduled on the agenda at the June QSC meeting.

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of Meeting	Friday, 31 March 2023
Agenda Item	**06**
Author	Vivienne McVey, CEO
Responsible Executive	Vivienne McVey, CEO
Discussed at Previous Board Meeting	Updates have been discussed at the Executive meetings.
Patient and Carer Involvement	A number of these items would have been discussed with patients and carers
Staff Involvement	A number of these items would have been discussed with staff
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☒ Finance & Sustainability ☒ Service Innovation ☒ Quality ☒ Research & Innovation ☒ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☒
Committee meetings where this item has been considered	Executive Meetings

Report Summary and Key Points to Note

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

Appendices – N/A

CEO Report

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

1. **Quality**

- **The Quality Strategy** has been disseminated and is being implemented across the Charity being led by the Divisions and Quality team.

- **Nursing representatives** from Bracken, Seacole and Fenwick with support from the Quality Matrons are presenting their improvement in reducing restrictive practice project at the East Midlands Health and Safety Improvement Programme later in March.

- **Cavell Star awards**: Three nurses will be receiving a Cavell Star award this month following successful nominations. Cavell Star Awards are a national awards programme run by the Cavell Nurses Trust and are given to nurses, midwives, nursing associates and healthcare assistants who show exceptional care to one of three groups of people; their colleagues, their patients or patient families.

- **CQC:** The CQC undertook an inspection of three wards in Nov 2022 following concerns raised with them; Heygate, Fairbairn and Allitson. As a result of this inspection Heygate and Fairbairn's rating remained Requires Improvement. Although only one ward within the Neuro division was visited (Allitson) the whole service has been re-rated as Requires Improvement. The issues highlighted were staffing, management of incidents, management of a deteriorating patient and the use of restrictive practices.

- **The Quality Improvement Plans** (QIP) developed at ward, divisional and Charity level to address the issues continue to be actioned and continue to be monitored through both the operational and quality governance structures. A targeted pre-CQC inspection review process is planned for the Neuro division, and this will then be rolled out across the Charity.

- **CQC:** The report following the CQC inspection for Essex in June 2022 was published on Friday 17th March 2023. Despite areas of good practice being recognised and actions being taken immediately following the receipt of two enforcement notices the service was rated as Inadequate. It is worth noting that prior to the publication of this report Essex was re-inspected 14 – 16 March 2023, and we await the outcome of the re-inspection.

- **CQC Registration**: An application to have the conditions on registration for the Men's and Women's services lifted has been submitted to the CQC and is being processed alongside the application for registering the Northampton site as a single CQC location.

2. **People and Culture**

- **Reward:** The annual pay review has been delayed whilst awaiting further detail on contract negotiations within the NHS. Our staff and unions are being kept updated. A 'Buying and Selling Holiday' scheme successfully launched for the first time, with approximately 150 applications to date.

- **Lead the Change:** Is currently in the design phase with our 6th workshop being held in March where Change Leaders identified their '1 big thing' to focus on for the 9 priority themes. The ideas from Lead the Change have been fed into the strategic ambition workshops to ensure alignment.

- **Diversity & Inclusion**: A week of celebrations were held in March for International Women's Day hosted by our WiSH staff network.

- **HR operations**: Our 'time to hire' end-to-end process was reviewed by a collaborative project team with Operations and HR. As a result all offers are made with an agreed start date and 8 days have been removed from the point of offer to commencing on the Charity induction.

- **Recruitment:**
  - 236 new joiners inducted so far in 2023
  - 99 currently confirmed for the second March induction and the two in April
  - 8 Nurses started in 2023 with another 47 completing pre-employment checks
  - 145 substantive HCAs started so far in 2023
  - Held first Student Nurse Brunch on 15 March 2023 with 32 students attending from six different universities
  - 13 of our 15 International Nurses have passed their OSCE exams and have their NMC PINS

- **Staff wellbeing:**
  - First 6 week yoga programme (started in response to feedback from Change Leaders) completed in February. Very positive feedback from attendees. Second round is underway with 25 people signed up.
  - Initial wellbeing programmes run in partnership with Pink Rooster: yoga and sound bathing both being run in March in the Great Hall, open to members of the public and StAH staff.
  - Time To Talk Day event run in partnership with DAWN network – staff were invited to meet the network and take time to talk.
  - Our Menopause Guidance was officially launched to the Charity for International Women's day 8 March, with positive feedback from a number of managers.
  - WYSA Wellbeing app pilot in CAMHS continues; 41 staff have downloaded the app and initial data is being analysed.

- **St Andrew's College**: West Northants Council visited for a quick tour of the college on 7 March and seemed very impressed indeed, they gave the impression that they are very keen to support the need for extra funding. World Book day was a roaring success as always

- **Education**: A Quality Assurance visit with Dean of School for Medicine for the University of Cambridge took place on Friday 10 March.

3. **Operations**

- **OpComm:** Operational grip continues to increase across clinical services in February and March OpComm received reports on Bed Occupancy, IQPRs (Integrated Quality and Performance Reviews), Staffing, HR Procedures, and from all the sub-groups:

    - Operational Staffing Programme Board
    - EPRR Steering Group
    - Commissioning
    - Security
    - E&F priorities
    - A new sub-group was agreed for Creative Retention & Recruitment.

    Areas of risk and discussion:

    - Qualified Nurses recruitment challenge: this remains a challenge for all health and care providers. Our new Operating model will go some way to mitigating this and we will also be expanding the number of Nursing Associates across the Charity working alongside our Registered Nurses and MDTs.
    - Call bells for CQC compliance on every ward: a temporary solution will be implemented ahead of the more extensive permanent solution.
    - Data challenges in terms of cut-off dates, visibility of data, ease of access and controls: work is being undertaken with the BI team to address these issues.
    - Closed culture at night: again the new Operating model and new ways of working will help to address this issue.
    - Flex management process: control over this process has been extensively discussed at both the OpComm and Executive Team with tightened controls being introduced as a result.

4. **Communications and engagement**

- **2023 Annual Awards**: The nominations for this year's Annual Awards are now open. We will celebrate more staff, with more awards (14 in total), than ever before. There will be a drinks reception, followed by the awards ceremony, a three-course meal and a live band on the evening of Thursday 18 May at The Park Inn, Northampton

- **Strategy Sessions:** We recently held a second strategy session in Northampton, along with a session in Essex and a dedicated session for our carers. Dozens of people across our Charity are attending these events to help define our future, including people in our care. We also have a session scheduled in Birmingham later this month, along with a third session in Northampton. The main purpose of these sessions is for us to collectively decide on milestones for each of our 7 ambitions.

- **Media coverage:** Darran, a person in our care, recently spoke to the Independent newspaper about his life and journey with Huntington's Disease. It is a powerful, candid look into his world and worth reading. Click here to read. A deaf patient, who had alcohol dependency, bravely spoke to BBC Two about his

drinking and how it affected his mental health. Currently living within our community housing, he decided to openly share his experience. His words have been filmed by an actor to protect his identity. Click here to watch

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

Dr Vivienne McVey
Chief Executive Officer

Committee Updates

Audit & Risk Committee
(Rupert Perry)

People Committee
(Dawn Brodrick)

Quality & Safety Committee
Incorporating CQC Inspection Update
(Steve Shrubb)

Committee Update Report to the Board of Directors

Name of Committee: Audit and Risk Committee

Date of Meeting: 23 January 2023

Chair of Meeting: Elena Lokteva

Significant Risks/Issues for Escalation:

- Draft Reserve Policy to return for review and include
  - Free reserves
  - How reserves are built
  - How reserves may be used and on what
- Partial assurance agreed for operational risks
- Adequate assurance agreed for material risks
- Adequate assurance for the BAF process
- Limited assurance via internal audit for EPRR
- Partial assurance via internal audit for Health & Safety
- Number of overdue actions following internal audits rose to 11 (with the Committee wishing the Board to note management's activities in order to address them)
- Draft internal audit plan to be reviewed and include 5 year indicative plan and wider audit universe
- ARC acknowledged the work done by Darren Handley, LCFS on Counter Fraud
- New Terms of Reference to be discussed at a workshop, with the work plan agreed subject to any changes in the Terms.
- The Committee wished to make the Board aware of the fragility of the IA function, bearing in mind resource available when compared to the level of audits outlined with the annual plan.

Key issues/matters discussed:

1. Grant Thornton

Grant Thornton presented the committee with the external audit plan, strategy and schedule of annual fees. Further scope of the audit was discussed, with the Committee agreeing to extend the scope of the audit to cover reserves accounting. The Committee also accepted the statement regarding independence, the ongoing assumptions and the annual fee.

2. Draft Reserves Policy

The draft Reserves Policy was presented to the Committee for consideration, subject to further review by Grant Thornton, in advance of final approval at the April meeting. Once approved, the policy would integrate with the annual budgeting cycle. It was agreed that the policy would follow the methodology of both restricted and free reserves, with Grant Thornton confirming the standing point of reserves from the previous year's accounts.

3. Risk Management

The change in risk management process was noted for both operational and material risks

which involved Divisional performance reviews which considered operational risk management on a monthly basis. This approach would also feed into material risk management at Executive level. Partial assurance was agreed for operational risks with adequate assurance agreed upon for material risks. The Committee thanked the risk management function and the divisions for their work regarding risk management.

4. Board Assurance Framework

The Committee were appraised of the work that was being conducted on strategic risks following the revisions to the Charity Strategy. The Committee agreed to adequate assurance on the process being followed.

5. Internal audit

The Committee reviewed the current internal audit update covering published reports, functional resource, audit actions dashboard, progress versus internal audit annual plan and a thematic review on the implementation of audit actions. It was noted that enhancement was required at the first and second lines of assurance. Discussions were ongoing regarding the integrated assurance framework.

Limited assurance was accepted for EPRR and partial assurance for Health and Safety. It was agreed to escalate the number of overdue actions to Board.

The level of outstanding IA actions were discussed, along with the introduction of a five year plan as opposed to the current 12 month plan. The IA annual plan was considered, with the level of work being discussed compared to the available resource. It was agreed to escalate this issue to the Board.

6. Counter fraud

The Committee received and reviewed the latest counter fraud activity update that included information on local proactive counter-fraud work, referrals for potential fraudulent activity in the previous period and wider horizon scanning for issues that may impact the Charity. The Committee accepted the updates and plan and extended thanks to Darren Handley, LCFS for all his work on the topic.

7. Audit & Risk Committee Terms of Reference

The revised Terms of Reference were discussed with it being agreed that a special workshop would be undertaken in order to scrutinise both the old and the new Terms of Reference against the Authority Matrix.

8. Annual Committee Work Plan

The Committee received the plan and agreed that it was a work in progress and would be revised following adoption of the new Terms of Reference

9. Review of Annual Accounts Timeline

The Committee agreed to the timeline proposed, noting that it followed a similar approach to the previous year.

Decisions made by the Committee:

- Approval of the external audit plan, strategy and fees
- Annual work plan for the Committee approved subject to any changes to the Terms of Reference.
- Approval of the annual accounts timeline

Implications for the Charity Risk Register or Board Assurance Framework:

The Committee discussed revised approach to Risk Management within the Charity, which was still in development, but was welcomed. The approach was also feeding into material risk management at Executive level. This would be an advantage as the risk were being managed holistically across the Executive Team.

The Committee noted the revisions to the BAF that were being undertaken following the revised Charity Strategy. It was suggested that the frequency of assurance reviews on mitigating controls be included in the report to the Committee, which was agreed.

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:

9 February 2023

Chair of Meeting:

Dawn Brodrick

Significant Risks/Issues for Escalation:

- In December, the Nurse fill rate was 81% and 80% for HCAs with the recent MHOST review increasing the vacancy need further. A Nursing workforce plan has been developed focusing on immediate and longer-term need and is being presented to the May People Committee.
- Mandatory training completion was at 87% (89% perm) with non-attendance remaining a core risk. A recovery plan is in progress overseen by the Staffing Programme Board.

Key issues/matters discussed:

Charity culture development

- Lead the change is a key contributor to developing the charity culture focused on empowering and engaging the 'staff voice'.
- Currently in the 'design phase' Change Leaders are working closely with Subject Matter Experts on the nine priority themes derived from the discovery data.
- Leanne Thornton, a Change Leaders and Senior HCA updated the Committee on the local ward impact of Lead the Change.
- The culture survey results continue to be shared, with leaders facilitating team discussion sessions throughout February - April.

People KPIs

An update on the core HR KPIs was provided noting actions linked to the Charity Retention Framework and People Plan to support improvements in the areas currently behind target. Targets are currently being reviewed for 2023/24.

Turnover overview and Charity Retention Framework

An in depth turnover data analysis was presented with the following findings (based on the previous 12 months of data):

- 31% of staff are leaving within their first year with HCAs the biggest contributor
- Turnover is adverse to target in key professions coupled with a challenging recruitment market (HCAs, Doctors, Occupational Therapy, Social work and Psychology when including Assistant Psychologists)
- There are no issues identified when comparing leavers against gender or ethnicity
- 21-30 year olds have a higher proportion of leavers than the workforce demographic (27% vs 16%)

Using insight from the review the most impactful areas to focus on were discussed (aligned to the Framework action plan):

- Operating model roll out - giving managers more time to manage
- New starters support particularly for HCAs
- Flexible working opportunities and different ways of working
- First line management training (e.g. preceptorship programme)

Pay review

A verbal update was provided on pay review noting the current context. A decision to pause pay review has been made whilst clarity is gained on the NHS contracts tariff increase.

Reporting groups

Updates were provided from the following:

- Employee Forum, Learning & Development Group, Inclusion Steering Group and the College Governing Body Meeting

Decisions made by the Committee:

- Bi-yearly assurance review on turnover and 'stability index' to be assessed by the Committee

Implications for the Charity Risk Register or Board Assurance Framework:

- Based on December data (considered at the Committee) Mandatory training was 87%. Areas of concern/behind target include Disengagements, Information Governance & Information Security, MHA, MCA & DOLS and Fire Safety Awareness.
- An increase in vacancies linked to the recent MHOST review for Nurses and HCAs will reduce the current fill rate ratio - a nursing workforce plan is in progress to mitigate this.

Issues/Items for referral to other Committees:

- Lines of accountability and key metrics shared across the People and Quality and Safety Committees to be assessed.

Appendices: None

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 14 February 2023

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- The Committee confirmed that it will continue with the revised approach to the content of the QSC meetings whereby it retains a closer focus on the following key areas of risk:
    - Quality Strategy and Governance Structure
    - Safer staffing
    - Quality Risk Management
    - Quality Improvement
- Risk of failing to appropriately support/resource the new Quality Strategy during implementation and ability to maintain day-to-day activities.
- The transition from the existing approach to quality (and assurance) to the new approach supported by the Quality Strategy and new Operating Model will require the Board to be prepared to tolerate potentially increased risk whilst the new approaches are implemented and bedded in.

Key issues/matters discussed:

- **Quality Strategy and Governance Architecture – focus on implementation, capacity and resource**

  The Committee were provided with a detailed presentation on the implementation of the new Quality Strategy and Governance Structure. Implementation would focus on building capacity through recruitment; developing capability and motivation for the quality approach; developing quality control and assurance systems, and reinforcing culture, structures and processes.

  The full implementation and embedding was to be phased over three years, with the majority and most important elements of the work being done in the first six months.

  The Committee acknowledged the operational work being done was well observed and received in social media and it was good to see so much service user and staff involvement in the process. It was agreed that the Committee would receive regular information on the core narrative and transformation progress at future meetings in order to seek assurance and support accordingly.

- **Safer Staffing**

  The Committee received the latest Safer Staffing report, including an update on the Establishment review and it was confirmed that following changes to the timings of producing the report that it would be in sync with Board reporting.

The Committee discussed key actions around recruitment and agreed to liaise with the People Committee on this area, recognising their input was very important to the debate.

The Committee recognised the good work being overseen by the Executive on safer and more secure staffing, confirming that the challenge was large for the Charity, with connections with the NHS being important to the future. It also requested more assurance over the management of night shifts, highlighting the differences between days and nights, and asked to see assurance regarding targeted help for night shifts.

- **Quality Improvement Plan**

The Committee received a paper on the Charity QIP, highlighting the improved progress being seen in effectively closing actions. Assurance was received that the remaining open actions were all on track and planned to be closed by the end of February. The Committee asked for more detail on the individual actions within the QIP be provided at future meetings.

The Committee were also informed that some of the Buddy work stream exit criteria had been met, with Buddy scrutiny moving into a different phase, confirming the progress made, noting however that there remained some variable quality across the Charity. Buddy workstreams were continuing with the remaining areas of the exit criteria and it was noted that the commissioning group had now moved from monthly meetings to bi-monthly, in recognition of the work done, and the sustainability observed.

- **Quality Risk Management**

The Committee received a paper highlighting the significant progress made with the escalation of quality and operational risks since the implementation of the new process, along with detail of the material risks and new operational risks being escalated to the material risk register. The Committee acknowledged the confidence it gained from the new process and were assured by the introduction of live register reviews at the Operational Performance Meetings.

- **Mental Health Law Steering Group**

The Committee received a comprehensive paper highlighting the recent refresh of the Group, including a new chair, revised terms of reference and an updated scheme of work. In addition to the regular summary updates provided by the Group, the Committee would now receive updates on the demographics and legal criteria of patients. The Committee reviewed the Patient Demographic statistics for 2022.

The Committee were advised of the recent work being done by the Group on restrictive practices and on the updated Mental Health Law legislation. The Committee discussed the resourcing required for the work undertaken by the Group and the relevant functions to seek assurance that it was adequate and that there was the capacity to both maintain the data, as well as investigate any variations seen within it.

The Committee discussed how research into the areas seen within the data would be worthwhile and would contribute to meaningful practice both internally and externally.

The Committee also discussed the recent presentation to Board on the new Mental Health Bill and how it tied in with the data and confirmed that further discussions would be had at a future QSC on a number of elements within the Act, including disproportionality and the measurement of therapeutic outcomes.

The QSC was presented with the annual statistics pertaining to the application of the Mental Health Act and other parameters including those covered by the Mental Health Units Use of Force Act. This data was categorised by demographic factors including

age, ethnic background and sex. The reasons for overrepresentation and underrepresentation of particular groups was explored by the committee

Decisions made by the Committee:

- None

Implications for the Charity Risk Register or Board Assurance Framework:

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

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- A - Quality Strategy & Governance Architecture

Appendix 1

Paper for Quality and Safety Committee	
Topic	Quality Strategy Implementation
Date of Meeting	Tuesday, 14 February 2023
Agenda Item	**5**
Author	Ash Roychowdhury
Responsible Executive	Sanjith Kamath
Discussed at Previous QSC Meeting	Quality Strategy approved by QSC in December 2022
Patient and Carer Involvement	Patients and carers will be involved in the implementation of the strategy
Staff Involvement	There has been broad consultation with staff across different disciplines
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☐ **W** ☐
Strategic Focus Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Previous QSC

Report Summary and Key Points to Note

This report outlines the activities being undertaken to implement the quality strategy including:

- Building the capacity to deliver high quality services
- Developing the capability and motivation for the quality approach
- Developing quality control and assurance mechanisms
- Developing reinforcing cultures, structures and processes

Appendices

Quality Strategy Implementation

Ash Roychowdhury
February 2023

Context

- Quality Strategy approved by Exec and QSC in December 2022
- The strategy will result in significant changes to structures, processes and patterns of behaviour (including culture and leadership)
- Many of these are already underway: OpComm; Policy Oversight Group; content of templates for ward, divisional and IQPR meetings, CQI training plan
- Delivery of the quality priorities will be done by the proposed divisional and central quality structures; this presentation will focus on the additional resources needed to enable effective implementation in the next 6 months- detailed task list appended

Main Requirements

- Building Capacity through Recruitment

- Developing Capability and Motivation for the Quality Approach

- Develop quality control and assurance systems

- Develop Reinforcing Cultures, Structures and Process

St Andrew's HEALTHCARE

Requirements

Recruitment to key roles: SD's, ADN, QM's, KLOE lead, Patient Safety Lead

Identified admin support to ward and divisional governance

TNA and learning offer for Quality Approach – from induction through to targeted training e.g. action planning

Quality Dashboards to support governance – QCAU dashboard, Meaningful Activity, Co-ordinated links to other information sources

Series of engagement workshops

Creation of dedicated intranet and resources page

Extend TNA to leadership competencies aligned to quality culture

St Andrew's HEALTHCARE

Building Capacity

Refresh and update of JD's, Roles and Responsibilities for new and existing posts including
- Ward Managers,
- Quality Matrons

Recruitment of Service Directors (SD)

Recruitment of Associate Directors of Nursing (AND)

Recruitment of General Managers (GM)

Recruitment of Quality Matrons (QM)

Recruitment of KLOE inspections and surveillance lead

Recruitment of Clinical Patient Safety/ Reducing Restrictive Practice Lead

Identification of Safeguarding Navigator/ Champion roles in all divisions

Ensure administrative support for ward governance and community meetings

Recruitment of Patient Safety patient expert

Developing understanding, competence and motivation

Develop targeted resources for different levels of staff explaining approach and their role (new and existing staff)

Create short & long term term training plan for:

~ Development of incident investigation training including Patient Safety Incidents, Safeguarding and Mortality Review

Implementation of training packages:
~ L1 (basic; post incident review)

~ L2 (intermediate; RCA, S42, Mortality)

~ L3 (advanced; PSIRF incident review/ Complex Mortality Review/ SG quality assurance/ Thematic review)

Development of Action Planning training

Implementation of Action Planning training package

Development of Basic Clinical Audit training

Implementation of Clinical Audit training

Training workshops on run charts/ SPC charts and Ward at Risk (9 C's approach)

Develop Quality Control and Assurance Systems

Agreement of responsibilities for assurance processes

Agreement and development of standardised tools for governance processes

Development of standardised control measures (ward level audits/ checks)

Improve ward based Quality Control and Assurance dashboard to enable easy access to data to support governance.(IT dependent)

Develop policy oversight function including:
- policy structure and layout
- policy allocation
- clinical review and update of policy to reflect best practice

Development of Internal quality inspection and assurance system

Implementation of standardised assurance system including reporting structures including QIP and risk registers

Assign all policies to governance groups

Developing Reinforcing Cultures, Structure and Processes
Create resources that link the quality strategy to core purpose and vision of the Charity
Engagement workshops including with patients and staff to identify quality priorities
Create detdicated intranet resource site to collate key documents and FAQ's
Finalise ToR for all second line assurance groups aligned with strategy
Review performance, talent and reward systems to align with the strategy
Create leadership fora to engage leaders and support focus on compassionate and improvement culture
Senior Leaders to engage with ward visits and to emphasise the quality approach and role model

Paper for Board of Directors	
Topic	Safer Staffing
Date of Meeting	Friday, 31 March 2023
Agenda Item	**8**
Author	Chloe Annan
Responsible Executive	Andy Brogan
Discussed at Previous Board Meeting	Safer Staffing is regularly discussed at Board.
Patient and Carer Involvement	Patients are involved in discussions around Safer Staffing levels in Community Meetings, where appropriate.
Staff Involvement	All wards and divisions are regularly engaged with in setting and reviewing safer staffing levels. Heads of division maintain close oversight and have contributed to the narrative in this report.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	

Report Summary and Key Points to Note

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 Committee has oversight of our staffing, alongside the rationale for any changes to base establishments, in order to assure itself that our wards have sufficient staff to operate safely.

The six month fill rate data included in this report evidences some of the recent progress made across all divisions in being closer to reaching our planned staffing more consistently. This is also evidenced in fewer action cards being implemented.

Within the last month we have strengthened our flex management process, in order to more effectively review opportunities where wards could and should be flexing down but are not. We have introduced a weekly flex review report that is sent out to divisions, identifying all of their wards current position in relation to ES and occupancy, compared with their baseline. HoN take accountability for completion of this weekly report and clinical narrative must be provided for all ward positions, with evidence of alternatives, other than increasing nursing, being explored. This may include utilisation of MDT and flexible shorter shift times that target patient acuity. In addition, for every ward request for an increase in staff, the division must review opportunities to flex down. This is then independently reviewed by our eRostering Lead and Deputy Director of Nursing (DDN). Charity flex snapshots are now being sent to the Executive Team daily.

The roster approval process has been strengthened by the introduction of monthly roster assurance groups held with each division. This provides a detailed look of future rosters prior to final approval and publication. This includes review of gaps in NIC cover, skill mix, allocation of annual leave & training, and use of any additional needs above agreed baseline.

Assurance:

Our first annual nursing establishment review, in line with the NQB Developing Workforce Safeguards guidance, has now been completed. This review included a triangulated approach, in which the MHOST results were reviewed alongside quality & safety data, and professional judgement. Our clinical leaders attended MHOST training prior to the use of the tool in this review, enhancing our assurance in the quality of the data collected. Each ward had a dedicated nursing establishment review meeting, including key members of the clinical and divisional team. The new nursing proposal has been taken to the Executive Committee and to Board, and we are now working to agree an implementation plan for the new establishment numbers.

Our Safer Staffing Policy and Procedure is currently in the process of being reviewed and updated to reflect the significant amount of work that has been undertaken in this area. Heads of Division and our clinical senior leaders have been engaged and involved in various workstreams as part of the Operational Staffing Programme Board. This update will be shared Charity wide once completed.

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 that our annual nursing establishment review has been completed in line with NQB guidance, following a consistent triangulated approach. To acknowledge that this will see our establishment gap increase in the immediate term, as we seek to increase our proportion of regular staff and reduce Workchoice/agency use.

Appendices –

Appendix 1: Fill Rates & Divisional Risk Summary

Flex Management & Roster Approval Process

Our staffing model works on the understanding that a ward's day and night planned number is their 'average baseline' requirement; included within this is an average level of ES and occupancy. The model recognises that whilst there may be occasions wards need to work above their planned number (because of increases in ES or occupancy above baseline), there should equally be wards that can work below their baseline number to help offset this.

Within the last month we have strengthened our flex management process in order to more effectively review opportunities where wards could and should be flexing down but are not. We have introduced a weekly flex review report that is sent out to divisions identifying all of their wards' current position in relation to ES and occupancy compared with their baseline. HoD take accountability for completion of this weekly report and clinical narrative must be provided for all ward positions, with evidence of alternatives other than increasing nursing, being explored. This may include utilisation of MDT and flexible shorter shift times that target patient acuity. In addition, for every ward request for an increase in staff, the division must review opportunities to flex down. This is then independently reviewed by our eRostering Lead and Deputy Director of Nursing (DDN). Charity flex snapshots are now being sent to the Executive Team daily.

The roster approval process has been strengthened by the introduction of monthly roster assurance groups held with each division. This provides a detailed look of future rosters prior to final approval and publication. This includes review of gaps in NIC cover, skill mix, allocation of annual leave & training, and use of any additional needs above agreed baseline.

Risks for the Board to Consider

- Current increased reliance on Workchoice and agency due to the current establishment 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.
- Although the number of agencies that the Charity now has contracts with has increased, they are largely only providing HCAs. Very few Q gaps, particularly in the day are being filled by agency.
- CAMHS division continues to have challenges with their Q requirement. Although an operational change has been made to how these wards are managed, the Charity continues to see a number of staff refuse to redeploy there, including agencies. Our refusal to redeploy process continues to be utilised for regular staff, and escalations/restrictions made to agency staff.
- Our new nursing establishment proposal will see our establishment gap (and planned number) increase in the immediate term, for both Q Nurses and HCAs. However, this is in line with evidenced clinical need and an outcome of a rigorous and consistent establishment review process. This increase in baseline will see us move towards increasing our ratio of permanent staff and decrease our use and reliance on Workchoice/agency.

Proposal

- DDN will lead on the review of the Safer Staffing Policy & Procedure to ensure clarity on any changed processes. This will be widely communicated in the Charity once completed.
- DDN will continue to work closely with Operations and Finance to agree an implementation plan for the new nursing establishments, being sure to engage and involve our clinical ward staff.
- Our new temporary eRostering Lead will continue to work closely with our divisional and ward leaders to review and amend our rostering where needed to ensure they meet clinical demand and acuity. They will also review and assess skill mix in areas that are having consistent staffing challenges.

Appendix 1

Fill Rates & Divisional Risk Summary:

The tables below show the fill rates by division, for the last six months (5 September – 5 March) broken down by Qualified (Q) and Healthcare Assistant (HCA). This is the percentage of actual staffing against the wards base planned number (not including any temporary flex). Data has been extended to include the last six months to reflect and compare the most recent three months data, to the previous. A significant amount of progress has been made in the last three months in relation to flex management and roster creation and approval, and with this we have seen a general improvement in fill rates in this period with fewer action cards being utilised also.

Birmingham

5 September – 5 December

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Birmingham	**116.03 %**	**111.87 %**	**93.92 %**	**135.20 %**	**92.7 %**
Birmingham	**116.03 %**	**111.87 %**	**93.92 %**	**135.20 %**	**92.7 %**
MMH Edgbaston	125.35 %	117.50 %	72.82 %	216.68 %	98.6 %
MMH Hawkesley	95.77 %	104.73 %	141.38 %	78.20 %	102.4 %
MMH Hazelwell	108.84 %	105.77 %	90.18 %	127.47 %	98.5 %
MMH Hurst	339.77 %	250.81 %	320.00 %	273.33 %	12.2 %
MMH Lifford	101.24 %	88.37 %	82.23 %	126.20 %	98.5 %
MMH Northfield	120.11 %	117.60 %	108.72 %	140.38 %	106.7 %
MMH Speedwell	124.82 %	99.27 %	99.62 %	101.88 %	96.3 %
WMH Moor Green	134.05 %	153.81 %	82.60 %	250.96 %	92.8 %
Total	**116.03 %**	**111.87 %**	**93.92 %**	**135.20 %**	**92.7 %**

5 December – 5 March

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Birmingham	**107.21 %**	**119.99 %**	**95.52 %**	**145.49 %**	**94.2 %**
Birmingham	**107.21 %**	**119.99 %**	**95.52 %**	**145.49 %**	**94.2 %**
MMH Edgbaston	125.65 %	96.53 %	59.34 %	199.67 %	93.9 %
MMH Hawkesley	86.13 %	121.63 %	155.18 %	106.89 %	90.7 %
MMH Hazelwell	115.99 %	132.47 %	111.63 %	150.72 %	89.6 %
MMH Hurst	107.42 %	110.47 %	100.93 %	123.35 %	84.4 %
MMH Lifford	108.47 %	122.56 %	100.47 %	164.34 %	95.8 %
MMH Northfield	94.13 %	135.39 %	103.40 %	138.27 %	106.6 %
MMH Speedwell	106.40 %	102.15 %	100.15 %	107.97 %	91.8 %
WMH Moor Green	124.01 %	153.45 %	82.37 %	251.00 %	100.0 %
Total	**107.21 %**	**119.99 %**	**95.52 %**	**145.49 %**	**94.2 %**

Birmingham have had a number of ward moves and changes during this three month period, which has affected their fill rates. Their staffing requirements have fluctuated to reflect patient moves, changing occupancy levels and new wards opening in their new name.

Moor Green (old) has moved into Lifford (new). Lifford (old) has moved into Hazelwell (new). Hurst (old) and Hazelwell (old) have combined to become Moor Green (new).

Birmingham's biggest challenge has been their night Q fill rate; however, this has improved within the last three months, moving from 93.92% to 95.52% as a site total. Edgbaston & Moor Green have been consistently more challenged with this, with both wards being planned to have two and these occasionally being unfilled or redeployed. No agency Q have been used. Q shifts have been covered largely by their regular establishment, followed by overtime (regular staff), and then Workchoice staff.

CAMHS

5 September – 5 December

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**87.25 %**	**104.45 %**	**70.70 %**	**123.38 %**	**48.6 %**
CAMHS	**87.25 %**	**104.45 %**	**70.70 %**	**123.38 %**	**48.6 %**
ALS Billing Lodge		0.17 %		0.54 %	100.0 %
ALS Seacole	136.91 %	78.25 %	90.21 %	92.28 %	37.4 %
ALS Sitwell	75.08 %	841.84 %	96.32 %	425.02 %	62.0 %
ALS Stowe	74.60 %	78.14 %	48.14 %	143.17 %	48.2 %
Total	**87.25 %**	**104.45 %**	**70.70 %**	**123.38 %**	**48.6 %**

5 December – 5 March

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**95.70 %**	**108.42 %**	**76.37 %**	**122.63 %**	**66.7 %**
CAMHS	**95.70 %**	**108.42 %**	**76.37 %**	**122.63 %**	**66.7 %**
ALS Billing Lodge		18.04 %		20.20 %	100.0 %
ALS Seacole	159.57 %	89.67 %	93.20 %	86.39 %	67.6 %
ALS Sitwell	68.13 %	601.28 %	92.82 %	325.43 %	50.0 %
ALS Stowe	91.34 %	105.64 %	59.73 %	176.29 %	69.1 %
Total	**95.70 %**	**108.42 %**	**76.37 %**	**122.63 %**	**66.7 %**

CAMHS have been scheduling Billing Lodge HCAs as part of Sitwell, hence reduced fill rates both day and night, and Sitwell being over 400% both day and night. However, it appears this has not been happening consistently, as the latest three month period shows some have been scheduled directly to Billing, this has been picked up with the division to address to ensure consistency.

CAMHS have also had a fluctuating occupancy over the last three months, and as such have been working below their base numbers to reflect when this has dropped. This has been clinically manageable and a temporary reduction to their base numbers has been led by the Heads of Division (HoD) and Nurse Managers (NM). CAMHS are now accepting admissions and have been screening a number of referrals which, if admitted, will change their staffing picture in the next three months. Despite occupancy increasing in the last three months (moving from 48.6% Sep-Dec to 66.7% Dec-March), CAMHS fill rates have steadily improved across Q and HCA roles both day and night. The change in how these wards are operationally managed is likely to have contributed to this improvement.

As from 1 February, the clinical model for CAMHS has been confirmed as below, and will have a direct (positive) impact on staffing in the short term:

- Billing Lodge will be aligned to Seacole (instead of Sitwell).
- Sitwell will run as an 'annexe' to Stowe, as Sitwell has only two patients.

This change has seen a slight reduction to their overall staffing requirement, as the wards work closer together and support and share resource where appropriate. Nursing establishment for Sitwell/Billing has all been realigned to Seacole and Stowe, boosting the skill mix, experience and numbers on both of these wards.

CAMHS Action cards:

A number of actions cards have been used during this period in order to mitigate some of the risks posed with reduced staffing levels or no Q on shift. Despite Sitwell now running as an annexe to Stowe, it still plans for one Q at night. Due to current establishment vacancies, this night Q on Sitwell is not always filled, and has resulted in Sitwell implementing the largest proportion of action cards for CAMHS as a division. It is important to note, none of these action cards have resulted in any reportable clinical harm.

CAMHS have also had a number of agency Q refusing to be redeployed to the division at night. This has been escalated to the individual agencies, statements requested, and these staff restricted from booking across the site. Agencies have been asked to provide information as to why staff are refusing to work in the division and what additional support could be provided.

31/10/22 – Seacole – Reduced staffing levels in the day. A patient requiring 4:1 admission to NGH within the division contributed to this unexpected, reduced staffing level. Managed by the following, for the shortest time period:

- Temporary reduction to patient's enhanced support (ES) – clinically manageable – patient was asleep during this period.
- Section 17 leave suspended.
- Access to courtyard and dining room reduced.
- Physiotherapy appointment cancelled – rescheduled to take place on the ward.

19/12/22 – Sitwell – No Q on shift from 00:00 to 07:45am. There was no capacity on Northampton site to move from any other division to support.

- Night Site Coordinator (NSC) already redeployed to Seacole, covered Sitwell by holding the medication keys and providing Q support.
- Sitwell team briefed on escalation plan and use of action card.

20/12/22 – Sitwell – No Q on night shift, vacancy unfilled. No capacity to redeploy from other divisions. NSC had already been redeployed to fill Q night gap on Seacole. Action:

- NSC covered both Seacole and Sitwell (basing themselves on Seacole) as per acuity and contingency plan.
- HCAs on Sitwell made aware of need to escalate any concerns through to Seacole.

21/12/22 – Sitwell – No Q on shift from 00:00 – 07:45. Regular CNL picked up the shift as overtime until 00:00, however second half of shift remained unfilled. No capacity from Northampton site to redeploy nurse to Sitwell as no other ward had two Q nurses. Action:

- Q support aligned from Seacole (regular staff) – who held medication keys and checked in with the ward regularly throughout the night.
- HCAs on Sitwell made aware of need to escalate any concerns to Q on Seacole.
- Mitigated by presence of NSC who increased visibility.

31/12/22 – Sitwell – No Q on night shift. Unfilled vacancy.

- Support provided by Seacole Q.
- NSC increased visibility and support to CAMHS division as an entirety.

03/01/23 – Sitwell – No Q from 21:00.

- All NSCs and staff on the surrounding wards were aware of the need to respond immediately to any physical health alerts or medical emergencies.
- NSC covered Stowe and had key for Sitwell medication trolley and cupboards on them, and all staff on Sitwell were aware of that and how to reach NSC should any concerns arise.

06/02/23 – Sitwell - No Q from 00:00

- Contingency plan implemented. Stowe to hold keys and support throughout the rest night.
- Night Charge Nurse (NCN) maintained regular contact with the Sitwell ward throughout the night.
- NCN maintained regular contact with the Nurse in Charge (NIC) on Stowe ward.

08/02/23 – Sitwell – No Q after 00:00

- Contingency plan implemented. Stowe to hold keys and support throughout the rest night.
- NCN maintained regular contact with the Sitwell ward throughout the night.

15/02/23 – Sitwell – No Q after 01:00

- NSC covered Sitwell until 01:00hrs.
- All NSC and Clinical Nurse Leaders (CNL) on Seacole ward were aware of the need to respond Sitwell immediately to any physical health alerts or medical emergencies.
- Stowe NIC had key for Sitwell medication trolley and cupboards on them and all staff on Sitwell were aware of that and how to reach NIC & NSC should any concerns arise.

A number of action cards were used for Sitwell, who have had challenges with their Q establishment, particularly at night. Some unbalanced rostering has contributed to this, for which the CAMHS division and NMs have received additional training and support with. The division has also had a number of new starters (Qs) who have needed to complete their medicine management and preceptorship before being able to take charge of the ward or be rostered to nights.

Essex:

<u>5 September – 5 December</u>

We have been unable to include this period for Essex in this report due to identified discrepancies in the data. This was due to a temporary issue in Allocate and how the rosters were set up, whereby some staff were being 'excluded from the safe care calculation' and therefore excluded from the shift fill rate data. This error was quickly picked up on and was resolved for the start of the December roster period.

5 December – 5 March

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Essex	**61.23 %**	**108.74 %**	**79.94 %**	**102.85 %**	**85.0 %**
Essex	**61.23 %**	**108.74 %**	**79.94 %**	**102.85 %**	**85.0 %**
MMH Audley	54.11 %	200.19 %	86.52 %	112.07 %	75.5 %
MMH Benfleet	87.36 %	81.85 %	61.14 %	92.92 %	109.2 %
MMH Danbury	76.74 %	104.73 %	106.39 %	99.63 %	102.4 %
MMH Tiptree	42.08 %	70.56 %	105.56 %	83.69 %	
WMH Frinton	65.88 %	219.01 %	92.38 %	122.27 %	81.3 %
WMH Maldon	42.49 %	59.94 %	60.03 %	95.57 %	30.5 %
Total	**61.23 %**	**108.74 %**	**79.94 %**	**102.85 %**	**85.0 %**

As a site, Essex have had a number of Q challenges across their wards day and night. This is largely due to their current Q establishment gap and ongoing Q recruitment challenges. Essex have used agencies throughout this period, however the Q availability offered has been mostly at night (as it has across the Charity).

Maldon are currently budgeted to have 2.5 Q in the day however they have been scheduling to one due to reduced occupancy and acuity; this has been clinically manageable.

Essex have used two action cards during this period. There have also been occasions whereby Q nurse cover has been provided by a NM or NSC.

Action Cards

31/12/22 & 01/01/23– Maldon – No day Q

- Bleep holder provided support for medication & other queries as per clinical agreed divisional contingency plan.
- No reportable harm.

LDA

5 September – 5 December

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**97.44 %**	**107.36 %**	**91.28 %**	**121.12 %**	**91.8 %**
LDA	**97.44 %**	**107.36 %**	**91.28 %**	**121.12 %**	**91.8 %**
ASD Acorn	78.34 %	80.33 %	101.80 %	91.88 %	106.5 %
ASD Berry	86.48 %	117.63 %	99.69 %	106.77 %	99.0 %
ASD Brook	110.51 %	92.30 %	100.45 %	96.89 %	93.7 %
ASD Fern	86.29 %	113.41 %	98.16 %	147.77 %	98.9 %
ASD Garden Cottage	98.28 %	100.06 %	96.13 %	81.33 %	116.8 %
ASD Marsh	78.33 %	126.57 %	101.24 %	155.70 %	99.3 %
ASD Meadow	88.44 %	124.43 %	103.98 %	161.24 %	96.2 %
ASD Wantage Gate House		110.44 %		111.02 %	100.0 %
LDD Church	109.82 %	102.32 %	101.48 %	117.70 %	86.7 %
LDD Hawkins	98.90 %	91.12 %	64.81 %	115.34 %	66.1 %
LDD Oak	83.49 %	118.49 %	68.63 %	130.29 %	65.2 %
LDD Sunley	107.12 %	126.07 %	99.47 %	144.47 %	100.6 %
LDD Sycamore	137.16 %	92.36 %	102.24 %	99.86 %	100.0 %
Total	**97.44 %**	**107.36 %**	**91.28 %**	**121.12 %**	**91.8 %**

5 December – 5 Marc

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**101.45 %**	**124.09 %**	**93.51 %**	**128.24 %**	**92.8 %**
LDA	**101.45 %**	**124.09 %**	**93.51 %**	**128.24 %**	**92.8 %**
ASD Acorn	54.61 %	72.10 %	100.00 %	69.43 %	81.8 %
ASD Berry	105.93 %	123.18 %	100.61 %	103.40 %	104.1 %
ASD Brook	118.31 %	104.40 %	99.14 %	102.25 %	94.5 %
ASD Fern	75.88 %	103.19 %	99.60 %	120.88 %	106.4 %
ASD Garden Cottage	101.92 %	107.05 %	99.97 %	79.33 %	125.0 %
ASD Marsh	102.87 %	127.49 %	102.45 %	157.20 %	101.6 %
ASD Meadow	94.66 %	139.60 %	101.18 %	161.70 %	95.8 %
ASD Wantage Gate House		212.62 %		194.14 %	100.0 %
LDD Church	140.48 %	162.43 %	115.21 %	163.65 %	99.4 %
LDD Hawkins	89.56 %	108.65 %	66.40 %	143.01 %	74.4 %
LDD Oak	101.12 %	130.84 %	73.10 %	123.16 %	66.4 %
LDD Sunley	121.05 %	134.28 %	102.74 %	144.07 %	95.9 %
LDD Sycamore	145.07 %	98.26 %	100.54 %	97.79 %	100.0 %
Total	**101.45 %**	**124.09 %**	**93.51 %**	**128.24 %**	**92.8 %**

Acorn is planned to have three Q in the day, however, have been scheduling to two Q on occasions due to reduced clinical acuity. This has been led by the ward and division. Acorn did also work below their planned HCA number for a period of time due to reduced occupancy and ES.

Both Oak and Hawkins are planned to have two Q at night, however due to some of the qualified staffing challenges seen across the site, if the second Q has been filled, they have been redeployed to support provision elsewhere.

Oak, Marsh, Fern and Berry have slightly reduced Q fill rates in the day. All wards are planned to have two Q in the day, however, have worked on one when there has been sickness, an unfilled need or a need to redeploy.

Wantage Gate are currently not budgeted/planned to have a Q in the day, however due to the current acuity of the two patients on there (one with epilepsy and one being nursed in Heygate LTS on 2:1), they have had to temporarily increase the Q cover here. As this is not usually planned for, wards from within ASD/LD have redeployed Q to support this need. This has been factored into the latest nursing establishment reviews and proposal.

Action Cards:

24/11/22 – Church – Reduced staffing levels at night. High enhanced support levels on Church combined with challenges in site wide staffing levels, resulted in:

- Patients ES levels being temporarily reduced from 2:1 to 1:1 from 00:00 to 19:45.
- Access to courtyard/outside areas temporarily locked off.
- Datix completed and appropriately escalated through to SMoS on call.

05/01/23 – Berry – No night Q on shift

- Vacancy unfilled. No Q site ward available to be redeployed to Berry.
- NCN completed night medication and then held keys off ward until day staff arrived.
- HCA team advised of how to escalate. Surrounding wards made aware.

05/01/23 – Sycamore – No night Q on shift

- Vacancy unfilled. No Q site ward available to be redeployed to Berry.
- NCN completed night medication and then held keys off ward until day staff arrived.
- HCA team advised of how to escalate. Surrounding wards made aware.

Low Secure

5 September – 5 December

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**81.81 %**	**99.61 %**	**76.99 %**	**119.24 %**	**97.4 %**
Low Secure & Specialist Rehab	**81.81 %**	**99.61 %**	**76.99 %**	**119.24 %**	**97.4 %**
MMH Berkeley Lodge	68.55 %	109.51 %	100.33 %	100.39 %	100.0 %
MMH Heygate	70.57 %	103.09 %	54.21 %	136.28 %	101.1 %
MMH Naseby	97.03 %	93.07 %	82.14 %	137.99 %	
MMH Spencer North	96.21 %	81.46 %	97.93 %	94.82 %	99.8 %
MMH Spencer South	93.04 %	86.61 %	99.75 %	99.13 %	95.7 %
WMH 37 Berkeley Close		74.61 %		65.01 %	99.3 %
WMH Lower Harlestone	75.83 %	180.38 %	77.43 %	208.03 %	72.7 %
WMH Silverstone	82.33 %	85.91 %	52.31 %	134.13 %	90.9 %
WMH Watkins House	85.16 %	94.55 %	100.00 %	90.52 %	93.3 %
Total	**81.81 %**	**99.61 %**	**76.99 %**	**119.24 %**	**97.4 %**

5 December – 5 March

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**87.43 %**	**107.46 %**	**70.12 %**	**122.41 %**	**113.3 %**
Low Secure & Specialist Rehab	**87.43 %**	**107.46 %**	**70.12 %**	**122.41 %**	**113.3 %**
MMH Bayley	80.96 %	111.84 %	61.50 %	147.96 %	
MMH Berkeley Lodge	87.83 %	100.77 %	97.94 %	98.52 %	100.0 %
MMH Heygate	65.77 %	132.03 %	55.43 %	148.65 %	96.0 %
MMH Naseby	97.15 %	85.17 %	57.09 %	118.43 %	
MMH Spencer North	92.64 %	90.44 %	99.70 %	91.71 %	99.9 %
MMH Spencer South	103.71 %	90.87 %	100.00 %	91.59 %	99.9 %
WMH 37 Berkeley Close		71.35 %		66.85 %	100.0 %
WMH Lower Harlestone	71.98 %	199.95 %	67.29 %	213.13 %	69.6 %
WMH Silverstone	115.56 %	106.79 %	48.41 %	143.03 %	85.7 %
WMH Watkins House	89.96 %	96.97 %	99.04 %	91.00 %	100.0 %
Total	**87.43 %**	**107.46 %**	**70.12 %**	**122.41 %**	**113.3 %**

A number of the Low Secure wards are planned to have two Q at night including Silverstone, Lower Harlestone, Naseby and Heygate. The reduced night Q fill rate in these areas reflect the needs either being unfilled, or if redeployed to support Q provision within the division or site.

Similarly in the day, both Heygate and Lower Harlestone are planned to have three Q. If filled, this third Q has often been redeployed to support Q provision elsewhere.

37 Berkeley Close have been scheduling below their planned number on occasions both day and night due to reduced clinical acuity.

Action cards:

03/10/22 – Silverstone - Reduced staffing levels during the day. Partly impacted by current establishment gap and vacancies for both Q and HCAs, and current acuity of patient group requiring temporary flex up of one and NG trained staff. Action taken as follows:

- All ES reviewed, however, unable to reduce due to clinical risk.
- All section 17 leave suspended for the day.
- Access to courtyard & dining room reduced and door closed.

10/10/22 – Silverstone – Reduced staffing levels during the day. Unexpected transfer of patient to NGH on 3:1 contributed to this challenge. Action as follows:

- All ES reviewed, however, unable to reduce to clinical risk.
- All section 17 leave suspended for the day.
- Temporary zonal nursing,
- NM counted in nursing numbers for the day and worked clinically on the ward.

Medium Secure:

5 September – 5 December

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**82.64 %**	**90.72 %**	**79.47 %**	**112.08 %**	**90.9 %**
Medium Secure	**82.64 %**	**90.72 %**	**79.47 %**	**112.08 %**	**90.9 %**
MMH 23a/23 The Avenue		75.79 %		98.34 %	68.8 %
MMH Cranford	62.01 %	131.75 %	78.05 %	133.54 %	106.3 %
MMH Fairbairn	68.35 %	98.32 %	97.01 %	126.10 %	113.3 %
MMH Mackaness	71.99 %	78.10 %	100.10 %	139.24 %	42.6 %
MMH Prichard	74.37 %	94.40 %	64.59 %	119.51 %	102.5 %
MMH Robinson	101.14 %	93.78 %	100.55 %	107.24 %	98.1 %
MMH Rose	122.46 %	76.74 %	106.68 %	85.29 %	86.1 %
WMH 21 The Avenue		92.65 %		97.31 %	50.0 %
WMH Bracken	75.69 %	78.83 %	56.10 %	90.83 %	104.3 %
WMH Maple	89.00 %	82.22 %	99.04 %	142.91 %	73.9 %
WMH Willow	92.68 %	102.43 %	59.79 %	118.23 %	92.5 %
Total	**82.64 %**	**90.72 %**	**79.47 %**	**112.08 %**	**90.9 %**

5th December – 5th March

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**86.21 %**	**105.32 %**	**79.70 %**	**117.55 %**	**91.9 %**
Medium Secure	**86.21 %**	**105.32 %**	**79.70 %**	**117.55 %**	**91.9 %**
MMH 23a/23 The Avenue		89.54 %		97.13 %	75.0 %
MMH Cranford	53.83 %	130.38 %	81.69 %	121.19 %	102.6 %
MMH Fairbairn	82.49 %	98.43 %	96.98 %	102.25 %	113.3 %
MMH Mackaness	76.60 %	97.84 %	100.37 %	146.23 %	54.7 %
MMH Prichard	76.25 %	100.52 %	57.51 %	138.19 %	98.7 %
MMH Robinson	102.35 %	106.65 %	101.30 %	109.31 %	101.6 %
MMH Rose	129.34 %	122.72 %	101.11 %	123.90 %	90.9 %
WMH 21 The Avenue		83.01 %		84.62 %	50.0 %
WMH Bracken	84.60 %	104.09 %	56.10 %	104.77 %	95.2 %
WMH Maple	94.82 %	81.95 %	100.18 %	125.83 %	78.0 %
WMH Willow	87.22 %	113.60 %	70.62 %	122.67 %	89.8 %
Total	**86.21 %**	**105.32 %**	**79.70 %**	**117.55 %**	**91.9 %**

Bracken and Prichard are planned to have two Q at night, with Willow and Cranford both planned to have 1.4 Q. Reduced fill rates on these wards reflect consistent unfilled needs or need to redeploy to support provision elsewhere.

Cranford, Fairbairn and Mackaness are all planned to have 2.5 – three Q per day shift, however again reduced fill rates reflect current Q establishment gap combined with need to redeploy to maintain Q provision across the division.

Action cards

11/10/22 & 26/10/22 – Bracken – Reduced staffing levels during the day. Action taken as follows:

- A number of ES levels reduced temporarily where clinically assessed and appropriate to do so, in order to maintain safety levels on the ward.
- All non-essential patient leave suspended.
- Temporary zonal nursing of patients.
- All wider MDT members advised of challenges and directed to ward to help close action card.

12/10/22 – Rose – Reduced staffing levels during the day. Action taken as follows:

- Temporary reduction in ES levels where clinically manageable.
- Nurse Manager covered seclusion observations.
- Nurse Manager included in nursing numbers throughout the day.
- All non-essential patient leave suspended.

Although not submitted as action cards, both Bracken and Willow have had consistent challenges with their night Q needs. There have been numerous occasions within the last three months whereby the NSC has had to be redeployed to take charge of these wards due to unfilled needs and insufficient capacity to redeploy within the site. Skill mix and leadership on both of these wards is currently being reviewed by the division.

Neuropsychiatry

5 September – 5 December

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**89.43 %**	**91.98 %**	**93.47 %**	**118.88 %**	**99.8 %**
Neuro	**89.43 %**	**91.98 %**	**93.47 %**	**118.88 %**	**99.8 %**
NPS 19 The Avenue	70.89 %	58.16 %	13.44 %	119.83 %	100.0 %
NPS 38 Berkeley Close		84.31 %	278.81 %	78.59 %	100.0 %
NPS Allitsen	79.09 %	123.41 %	103.87 %	164.02 %	108.8 %
NPS Aspen	70.52 %	97.51 %	101.06 %	92.37 %	76.9 %
NPS Cherry	85.19 %	92.07 %	98.46 %	116.88 %	89.2 %
NPS Elgar	111.06 %	95.61 %	83.70 %	114.39 %	99.2 %
NPS Elm	71.84 %	89.49 %	86.18 %	118.80 %	95.4 %
NPS Fenwick	87.50 %	88.24 %	100.01 %	117.58 %	100.0 %
NPS Redwood	78.72 %	105.73 %	95.74 %	120.49 %	100.0 %
NPS Tallis	99.94 %	117.37 %	93.32 %	154.19 %	103.4 %
NPS Tavener	121.07 %	65.81 %	90.80 %	100.81 %	105.1 %
NPS Walton HD	93.54 %	52.76 %	100.25 %	102.64 %	107.7 %
Total	**89.43 %**	**91.98 %**	**93.47 %**	**118.88 %**	**99.8 %**

5 December – 5 March

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night	Occupancy % (Vs Budget)
Northampton	**93.25 %**	**111.59 %**	**96.62 %**	**128.92 %**	**98.1 %**
Neuro	**93.25 %**	**111.59 %**	**96.62 %**	**128.92 %**	**98.1 %**
NPS 19 The Avenue	83.87 %	40.45 %	85.94 %	104.50 %	100.0 %
NPS 38 Berkeley Close	131.73 %	88.56 %	84.85 %	86.71 %	100.0 %
NPS Allitsen	91.51 %	148.71 %	100.61 %	169.33 %	111.1 %
NPS Aspen	89.61 %	130.41 %	100.12 %	143.72 %	79.4 %
NPS Cherry	89.33 %	116.56 %	103.56 %	144.05 %	97.0 %
NPS Elgar	114.24 %	138.68 %	92.46 %	139.23 %	88.3 %
NPS Elm	69.74 %	90.72 %	98.86 %	88.96 %	89.4 %
NPS Fenwick	80.99 %	108.15 %	99.17 %	130.11 %	97.0 %
NPS Redwood	83.83 %	122.64 %	99.88 %	138.18 %	102.7 %
NPS Tallis	92.91 %	125.43 %	93.80 %	155.21 %	110.0 %
NPS Tavener	112.32 %	78.27 %	90.62 %	98.73 %	104.8 %
NPS Walton HD	106.12 %	79.82 %	100.89 %	104.66 %	94.8 %
Total	**93.25 %**	**111.59 %**	**96.62 %**	**128.92 %**	**98.1 %**

19 the Avenue are planned to have 1.5 Q in the day, however mostly work on one Q as the 0.5 Q is often redeployed to support Q provision elsewhere within the division. This has been clinically manageable, and the lone Q has been supported with break cover.

A number of wards are planned to have two Q in the day, however work on one on occasions. This is due to current Q establishment gap, combined with LTS and occasional need to redeploy. Regular NM presence on these wards help to mitigate this. Overall Q fill rates have been improved within the division both day and night.

Action cards

14/10/22 – Redwood – No Q on night shift from 00:00

- Q on the Houses refused to redeploy to Redwood from 00:00, escalated to SMoS, continued to refuse, formal process followed.
- Adjacent ward (Elm) opened the connecting doors and provided Q support to Redwood post-midnight.

21/12/22 – 19 the Avenue – No Q on night shift

- Day Q agreed to stay on and complete night time medication.
- NSC held the medication keys during the night and provided on call qualified support.
- Q nurse from Watkins House completed early morning medication.

01/01/23 – 19 the Avenue – No Q on night shift from 01:00

- NCN held the medication keys off ward. Nearby houses made aware.
- Staff reassured and advised of escalation processes.

04/01/23 – 19 the Avenue & Redwood – No Q on night shift

- Agreed clinical contingency plans implemented on both wards.
- Medication keys for 19 the Avenue held by NCN and surrounding houses made aware of need to respond.
- Doors opened between Elm & Redwood (forming one ward) and Elm Q provided Q nurse cover to Redwood throughout the night.

Paper for Board of Directors

Topic	Quality Workstreams Update
Date of Meeting	Friday, 31 March 2023
Agenda Item	**9**
Author	Andy Brogan, Chief Nurse
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	Updates previously provided and discussed at the Board meeting in March 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 Priority Area	Education and Training ☒ Finance & Sustainability ☒ Service Innovation ☒ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☒
Committee meetings where this item has been considered	Updates have been discussed at the Executive Team meetings and weekly Quality Improvement meetings.

Report Summary and Key Points to Note

The paper focuses on the quality improvement offer via the Mental Health Alliance, progress to date and the closure of the formal support. The improvement offer, led by an External Quality Improvement Director, consisted of targeted support through buddy workstreams focusing on the areas of greatest opportunity for improvement. Each workstream was supported by an external organisation with expertise in the improvement areas. Explicit exit criteria were developed, with a number of these being achieved in January and February this year, with the remainder due to be closed at our final Workstream meeting in March. The Chair of the Alliance, NHSE and other system partners recognised the improvements made, and the work we will continue to do, and proposed we close the formal support from the end of March. We will continue to work with the buddy trust on an informal basis and ensure the new operational model that strengthens the quality support at the frontline will be sustained and improved.

Appendices - None

QUALITY WORKSTREAMS

This report outlines the quality improvement work undertaken as part of the support put in place via NHSE and the East Midlands Mental Health Alliance to respond to the findings of the CQC Inspection carried out on 1 July 2021, and the subsequent report received in November 2021.

Following the CQC inspection of our Men's and Women's services in July 2021 the Charity was rated as Inadequate for the Women's Service and Requires Improvement for the Men's Service. We engaged with the wider Health and Social Care system to improve the quality of services.

This resulted in the Mental Health Alliance and NHSE/I providing a system wide support offer. This is a tried and tested process in the NHS but is unprecedented in the independent sector.

The CQC re-inspected the Women's Service in April 2022 and the Men's Service in June 2022, with the Women's Service improving to Requires Improvement and the Men's service, although improving significantly in individual domains, remaining as Requires Improvement.

The offer consisted of:

- The appointment of an external Quality Improvement Director.
- Buddy Trust – NHFT.
- Development of nine Workstreams, each supported by a system partner from a range of NHS Trusts.
- Monthly Monitoring of progress by the MH Alliance and NHSE/I.

In addition, we received a direct support offer from NHSI/E MH Improvement Directorate to support in the following areas:

1. Safer Staffing
2. Restrictive Practice
3. Risk Assessments
4. Data Quality and Benchmarking

In response to the initial feedback, we developed a robust quality improvement plan and a range of support initiatives to respond to the CQC initial concerns and subsequent report. This included:

- Quality Improvement Plan (QIP), which responded directly to the Improvement notices and Must Do actions. This was led by the Director of Nursing for Quality and Physical Health and overseen at a weekly meeting with all divisions, chaired by the CEO initially and subsequently by the Chief Nurse. At each of the meetings, a deep dive was undertaken of an individual area, in order to monitor progress and provide support where this was required. This was reported on in detail at the Quality & Safety Committee.

- In recognition of the need to develop and improve our working relationship with CQC, fortnightly meetings were held, and continue to be held, between the CQC and the Chief Nurse and the Director of Nursing for Quality and Physical Healthcare, The CQC provided a series of ongoing workshops to explain their inspection process, which were well attended by our staff.

- Specific targeted support was provided to the Women's wards with the most concerning issues. This was led by a Consultant Psychiatrist and included direct support to the wards, with specific targeted work on closed cultures, enhanced observations, updating of contemporary clinical language and descriptions.

Buddy Workstreams

Part of the improvement offer was to buddy up with Alliance partners in workstreams to provide specific focus on areas of improvement, including patient safety, restrictive practices, and enhanced observations. These were supported by enabling workstreams, including Culture (Lead the Change Initiative), Communication and Continuous Quality Improvement.

The range of initiatives to bring about sustainable improvements and respond to immediate concerns were comprehensive, complex and required leadership and management. Substantial improvements in quality have been made over the past 18 months, as evidenced by the improvement in our ratings in Men's and Women's services.

Progress has been monitored via monthly meetings with the East Midlands Mental Health Alliance and NHSE. Each buddy workstream developed a plan on a page – part of well-established Quality Improvement methodology, and subsequently developed exit criteria. Most of the workstreams had met the exit criteria by February, and a further closure meeting is due to be held in March to formally close down the support process. It is anticipated that the relationships with the NHS Trust will continue on an informal basis.

It is important, in conclusion, for the Charity to recognise the leadership provided through the Alliance, our buddy NHS Trusts and Julie Shepherd, the Quality Improvement Director, in supporting the improvements in quality. Our implementation of the new operating model for clinical service, will lead to enhanced quality improvement and support and ensure the improvements realised will be sustained and improved over the coming months and years.

Paper for Board of Directors	
Topic	Integrated Quality & Performance Report
Date of Meeting	Friday, 31 March 2023
Agenda Item	**10**
Author	Anna Williams, Director of Performance
Responsible Executive	Vivienne McVey, CEO
Discussed at Previous Board Meeting	Routine Board paper
Patient and Carer Involvement	Patient and Carer voice is captured via My Voice inclusion
Staff Involvement	Staff are involved in the performance processes that feed the analysis and actions
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Quality, Workforce and Finance metrics are considered at their associated committees.

Report Summary and Key Points to Note

<u>Review of the period ending January 23</u>

Quality

- December & January discharge data is shared – showing 69% of patients (non-PICU) were transitioned to a lower level of security, with just under half returning to their usual place of residence.
- Division level SPCs show 20 improvements and 10 concerns, explanation of the concerns is shared. At ward level 5% of the metrics show concern and 7% show improvement, with the remaining 88% in control, having little or no data or showing a statistically insignificant trend.
- Assurance is provided through the performance and governance processes.
- The quality scorecards for each division and ward are routinely shared with Quality & Safety Committee.
- My Voice positive response (very good or good) is at 72%. Feedback themes are shared.

- The Quality strategy and framework continue to be implemented.

People

- Whilst the majority of people metrics remain adverse to target there is a notable swing towards improvement. With favourable trends across: turnover, nursing establishment and sickness (with a corresponding improvement in non-patient facing shifts).
- The turnover and sickness improvements are apparent for both the divisions and the enabling functions.
- MDT establishment shows a marginal reduction – correlating with national and local shortages across clinical roles and to be considered in the context of occupancy levels.
- Training levels are notably challenged – a rectification plan has been implemented, February's KPI shows improvement, demonstrating progress towards the July 23 target to return the actual back in line with target.

Review of the period ending February 22

Finance

February 2023 Actual Performance v Full Year Forecast (FYF)

- Net deficit £6.6m - £0.1m behind FYF. Operating Deficit £0.7m worse than FYF
- £0.7m operating variance has been offset by £0.6m lower Project Costs.
- At February 2023 cash held was £3.6m (inline with FYF) and no covenant risk existed.

Accessing metrics

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

Appendices -

St Andrew's Healthcare Integrated Quality Performance Report

reviewing the period ending January 2023 for Quality & People, ending February 2023 for Finance & IT

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

Concerns Improvements In Control

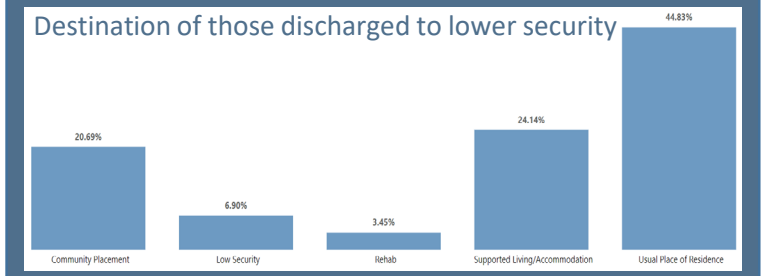
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

Quality

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

Discharges – during December & January (excluding PICUs) 42 people moved on from St Andrew's. The majority, 69%, transitioning to a lower level of security, including just under half returning to their usual residence.



PICUs transitioned a further 32 people.

Division	Wards	SPC Concern	SPC Improvement	SPC Common Cause	Trend Concern
Birmingham	8	3 %	2 %	11 %	13 %
CAMHS	4	9 %	5 %	23 %	17 %
Community Services	2	0 %	6 %	13 %	3 %
Essex	6	0 %	4 %	14 %	19 %
LDA	13	12 %	9 %	24 %	10 %
Low Secure & Specialist Rehab	10	4 %	5 %	9 %	7 %
Medium Secure	12	4 %	7 %	17 %	7 %
Neuro	12	3 %	10 %	20 %	7 %
Totals	**67**	**5 %**	**7 %**	**17 %**	**10 %**

When aggregated, ward level SPC concerns have remained static with improvements increasing by 1% to 7%. Common cause has reduced by 2%. The remaining % is metrics with little or no data or trends with too little data for statistical significance.

Exceptions –20 improvements, continued clusters in Neuro (7) and Essex (6). Decrease to 10 concerns – performance & governance processes confirm clinically appropriate management:

- **LDA** – consistent LTS concern, due to inappropriately placed patients. All external reviews completed. Every effort made to secure suitable next placement (weekly discharge meeting with regional and national system partners). Increased scrutiny of the appropriateness of an inpatient setting for all referrals. ES – monthly scrutiny panel, ensuring ES is reduced as soon as is safe for each patient.
- **CAMHS** – OBD measures are inherently less useful for small patient numbers. Incident levels have returned to within common control. Consistent LTS concern, with patients experiencing delayed discharges due to onward placements not being able to admit.
- **NEURO** – ES is utilised for safeguarding, serious aggression, high risk of falls and physical health complications of brain injury; which have required longer term use of ES. There are regular reviews.

The following wards are receiving focus within their division, with targeted quality team support; Moor Green, Sitwell, Church, Sunley, Silverstone, Prichard, Fairbairn & Elgar. The new wards of concern process alongside the implementation of the new Quality Strategy will further strengthen clinical management, patient care and experience. Emerging focus: LDA increase in incidents.

My Voice – Good or very good proportion has reduced marginally to 72%, the rate of response remains in focus - a QSC update is planned. Verbatim comments suggests varied experience, with positive themes focusing on supportive and caring staff. Less positive feedback focuses on food, staffing levels, activity & leave. Community Partnerships tailored My Voice very positive c90% good / very good.

People

Measure	Voluntary Turnover In Year		Voluntary Turnover In Month		RN Establishment Ratio		HCA Establishment Ratio		MDT Establishment Ratio		Mandatory Training		Agency Spend		Sickness % In Month		Non-Patient Facing Shifts	
Target	12%		1%		95%		95%				90%		5%		6%		25%	
	Jan	Trend	Jan	Trend	Jan	Trend	Jan	Trend	Jan	Trend	Jan	Trend	Jan	Nov	Jan	Trend	Jan	Trend
St Andrews	14.3%	↓	0.9%	↓							86.4%	↓			6.1%	↓		
Functions	10.8%	↓	0.4%	↓							89.8%	↓			4.5%	↓		
Divisions	15.9%	↓	1.1%	↔	82.3%	↑	81.8%	↑	91.3%	↓	85.6%	↓	6.6%	↑	6.9%	↓	36.6%	↓
Birmingham		↓		↓		↓		↑				↔		↑		↓		↓
CAMHS		↑		↑		↑		↓				↓		↓		↓		↑
Community Partnerships		↑		↑								↓				↓		
Community Services		↓		↑		↑		↑				↓		↓		↓		
Essex		↓		↓		↓		↓				↓		↑		↓		↓
LDA		↓		↓		↓		↑				↓		↑		↓		↔
Low Secure & Specialist Rehab		↓		↓		↑		↑				↑		↓		↓		↓
Medium Secure		↓		↓		↑		↑				↔		↑		↑		↑
Neuro		↓		↓		↑		↑				↑		↑		↓		↑

Waterfall – month on month net growth, correlates with slight increase in HCA establishment. Headline vacancy rate is 15.4%, this will be routinely shared moving forward.

Voluntary turnover – attrition has reduced following the October cost of living support and pay rise.
RN & HCA establishment – positive trend (marginal) for both RN & HCA. The current establishment gap is compounded by additional staffing requests and the impact of above model non-patient facing shifts. This situation is partially mitigated by a combination of bank shifts and increased agency. Implementation of the establishment review is designed to address the current challenges (solution in Board Part 2).
MDT – reduced 91% (93%), correlating to national and local supply issues. Consider alongside occupancy.
Mandatory training – whilst clinical training remains unchanged from December (BLS (69%), Safeguarding level 3 (89%) and SIT (64%)), the number of training shifts undertaken has increased and the overall training KPI% for February is showing improvement. The multifaceted training plan, with phased focus on different staffing groups, is tracking positively with the target KPI rectification date remaining July 23.
Agency Spend – adjustments have increased bookings, supporting key vacancies.
Sickness – notably positive trend, with January seeing the lowest sickness rate since August 22.
Non-Patient facing shifts – the reduction correlates with falling sickness. Improved management of discretionary leave is taking time to reflect in the outturn.

*trend is to the prior month

Finance Board Report
31st March 2023

Transforming lives together

Financial Performance 2022/23

February 2023 Actual Performance v Full Year Forecast (FYF)

- **Net deficit £6.6m - £0.1m behind FYF. Operating Deficit £0.7m worse than FYF**
- Significant occupancy increase in last Qtr. **February closing occupancy 626 was 1% below forecast**
- Nurse staffing costs exceeded FYF in Qtr4, partially due to higher patient acuity offset by income. Other contributing factors have been reviewed and action plan in place to mitigate any recurrent financial risk.
- **£0.7m operating variance has been offset by £0.6m lower Project Costs.**
- At February 2023 cash held was £3.6m (**inline with FYF**) and no covenant risk existed.

Full Year Outlook Performance v Full Year Forecast (FYF)

- Berkley Close property disposal delayed until 2023/24 but impact offset by positive movement in Investment Portfolio.
- Ongoing focus for March 2023 and beyond – continued occupancy growth & controlling costs
- Cash held and covenants are expected to track in line with FYF, although lower loan repayments.

	February 2023 YTD			Full Year		
Financial Performance - £m	**Actual**	**Forecast**	**Variance**	**Forecast**	**Budget**	**Variance**
Income	156.82	155.80	1.02	171.45	176.08	(4.6)
Direct & Indirect Costs	(117.96)	(116.28)	(1.68)	(126.93)	(130.41)	3.5
Net Contribution	**38.86**	**39.52**	**(0.66)**	**44.52**	**45.67**	**(1.1)**
Enabling Services	(29.57)	(29.55)	(0.02)	(32.25)	(31.88)	(0.4)
Depreciation	(9.89)	(9.89)	0.00	(10.74)	(11.26)	0.5
Operating Surplus/(Deficit)	**(0.60)**	**0.08**	**(0.68)**	**1.53**	**2.53**	**(1.0)**
Non Operating Costs	(0.50)	(0.46)	(0.04)	(0.51)	(0.37)	(0.1)
Exceptional Costs	(2.56)	(2.57)	0.01	(2.68)	(1.00)	(1.7)
Disposal of Fixed Assets & Impairment	0.01	0.01	0.00	0.86	(0.25)	1.1
Project Costs - OPEX	(1.98)	(2.62)	0.64	(2.88)	(3.33)	0.5
Investment Gains/Losses	(0.94)	(0.94)	0.00	(1.34)	0.00	(1.3)
Net Surplus/(Deficit)	**(6.57)**	**(6.51)**	**(0.06)**	**(5.02)**	**(2.42)**	**(2.6)**

Balance Sheet February 2023

St Andrew's Consolidated Balance Sheet	Mar-22 Audited	Jun-22 Actual	Sep-22 Actual	Dec-22 Actual	Feb-23 Actual
	£M	£M	£M	£M	£M
Intangible and tangible fixed assets	196.6	193.9	191.9	190.5	189.1
Investments					
Stock Market Investments	11.6	11.6	11.7	10.8	10.8
Investment Properties	5.7	5.7	5.7	5.7	5.7
Current Assets					
Stock	0.4	0.5	0.5	0.5	0.5
Trade debtors	8.2	9.4	10.0	9.4	10.4
Other Debtors & Accrued Income	4.1	4.4	4.6	5.0	4.6
Prepayments	1.8	1.2	1.0	2.1	2.0
Cash	6.0	5.1	6.0	4.7	3.6
	20.5	**20.6**	**22.1**	**21.7**	**21.0**
Current Liabilities					
Trade Creditors	(3.3)	(3.7)	(3.1)	(3.9)	(3.3)
Taxation and Social Security	(2.8)	(3.3)	(2.8)	(2.8)	(2.8)
Other Creditors & Accruals	(8.5)	(8.5)	(8.8)	(8.1)	(7.9)
Staff Accruals	(4.3)	(3.4)	(3.5)	(4.2)	(3.8)
Deferred Income	(2.9)	(2.6)	(3.3)	(2.6)	(2.7)
	(21.8)	**(21.4)**	**(21.4)**	**(21.7)**	**(20.6)**
Net Current Assets/(Liabilities)	**(1.3)**	**(0.8)**	**0.7**	**0.0**	**0.5**
Total Assets Less Current Liabilities	**212.6**	**210.5**	**210.0**	**207.0**	**206.1**
Bank Loans (between 1 and 5 years)	(20.0)	(20.0)	(20.0)	(20.0)	(20.0)
Pension Scheme Liability	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)
Total Assets Employed	**192.0**	**189.9**	**189.4**	**186.4**	**185.5**
Reserves	**192.0**	**189.9**	**189.4**	**186.4**	**185.5**

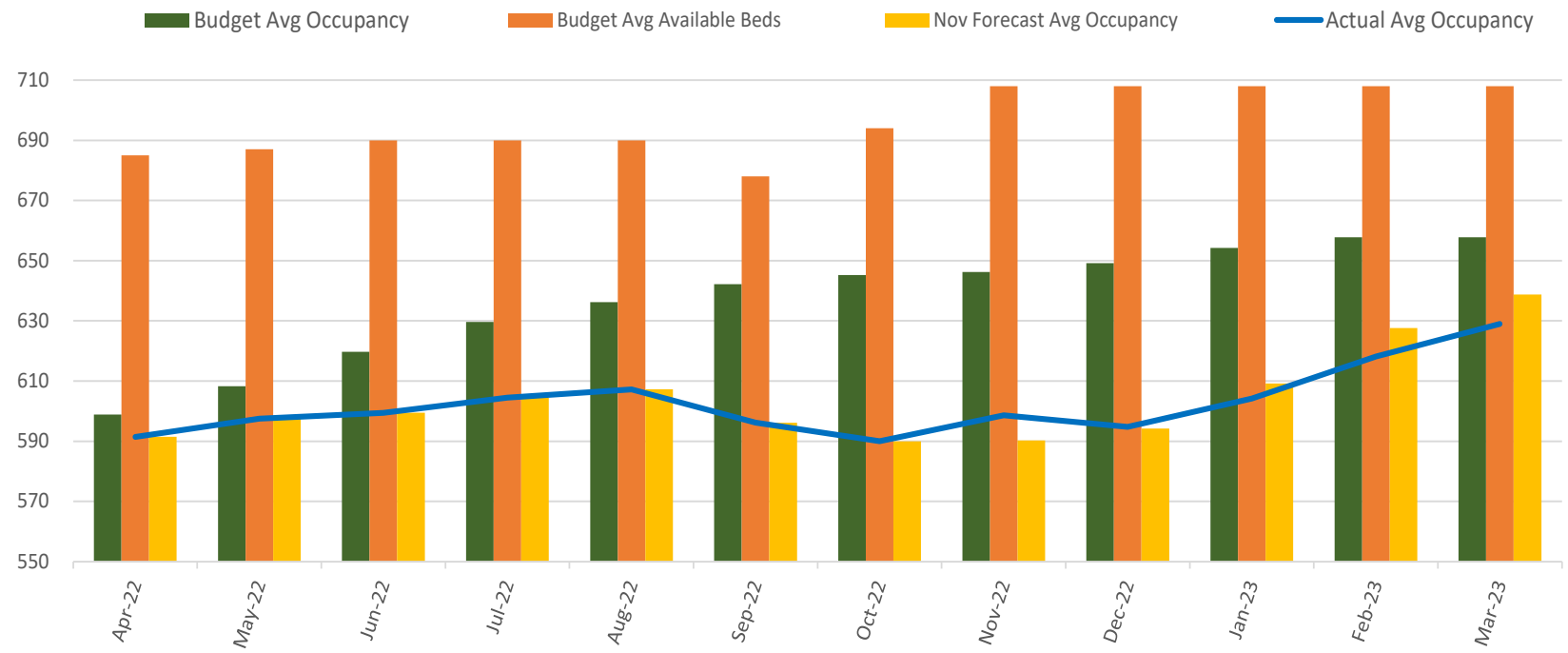
Cashflow February 2023 YTD

Cashflow Summary - £m	February 23 YTD			Full Year		
	Actual	Forecast	Variance	Forecast	Budget	Variance
Net Surplus/(Deficit)	(6.6)	(6.5)	(0.1)	(5.0)	(2.4)	(2.6)
Add Back Non Cash Items						
Depreciation	9.9	9.9	(0.0)	10.7	11.3	(0.5)
Fixed Asset Impairment/(Profit on Disposal)	0.0	0.0	0.0	(0.9)	0.3	(1.1)
Investment Portfolio Valuation Movement	0.9	0.9	0.0	1.2	0.0	1.2
Net inflow/(outflow) from Operations	**4.2**	**4.2**	**(0.1)**	**6.1**	**9.1**	**(3.0)**
Total inflow/(outflow) - Working Capital	(4.1)	(1.6)	(2.5)	(0.6)	(0.4)	(0.2)
Total inflow/(outflow) - Capital Expenditure	(2.5)	(3.7)	1.2	(4.5)	(5.9)	1.4
Total inflow/(outflow) - Asset Disposal	0.0	0.0	0.0	1.2	0.6	0.6
Total inflow/(outflow) - Investment Portfolio	0.0	0.0	0.0	0.0	0.0	0.0
Total inflow/(outflow) - Loan Facility	0.0	(1.5)	1.5	(4.5)	(5.5)	1.0
Net Cash (Outflows) / Inflow	**(2.4)**	**(2.6)**	**0.2**	**(2.3)**	**(2.1)**	**(0.2)**
Cash at the 31.3.2022	**6.0**	**6.0**	**0.0**	**6.0**	**6.0**	**0.0**
Total Cashflow Movement	(2.4)	(2.6)	0.2	(2.3)	(2.1)	(0.2)
Cash at the end of the period	**3.6**	**3.4**	**0.2**	**3.7**	**3.9**	**(0.2)**

Net Debt - £m	February 23 YTD			Full Year		
	Actual	Forecast	Variance	Forecast	Budget	Variance
Cash Held	3.6	3.4	0.2	3.7	3.9	(0.1)
Bank Loan Balance	(20.0)	(18.5)	(1.5)	(15.5)	(14.5)	(1.0)
Investment Balance	10.8	10.8	0.0	10.3	11.6	(1.3)
Net Debt	**(5.7)**	**(4.3)**	**(1.3)**	**(1.5)**	**1.0**	**(2.4)**
Credit Facility	27.0	27.0	0.0	27.0	27.0	0.0
Credit Facility Headroom	7.0	8.5	(1.5)	11.5	12.5	(1.0)

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

Occupancy



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Budget Avg Available Beds	685	687	690	690	690	678	694	708	708	708	708	708
Budget Avg Occupancy	599	608	620	630	636	642	645	646	649	654	658	658
Nov Forecast Avg Occupancy	591	597	599	604	607	596	590	590	594	609	628	639
Actual Avg Occupancy	591	597	599	604	607	596	590	599	595	604	618	629
Actual Closing Occupancy	594	602	601	608	605	592	587	600	594	619	626	632
Actual % Achievement of Budget	99%	98%	97%	96%	95%	93%	91%	93%	92%	92%	94%	96%
Avg Occupancy of Available	86%	87%	87%	88%	88%	88%	85%	85%	84%	85%	87%	89%

Actual closing occupancy for February 2023 was 626 v FYF of 634

IT Security Metrics (Dec – Feb 2023)

Legend	No Change	Trending Down	Trending Up

	DEC	JAN	FEB	RAG Rating	February	
					Causal	Remediation
Vulnerabilities not fixed within SLA Highlights the amount of vulnerabilities that haven't been fixed within the agreed timescales with no dispensation.	0	0	0		**Causal Analysis**: Vulnerabilities are actively tracked to ensure compliance, any breaches in terms of SLA's are either presented for risk acceptance or dispensated to investigate a fix.	**Remedial Actions:** IT Security will continue to monitor and track SLA breaches and raise any Non-Conformances if required.
Overdue Penetration Test Remediation The last Pen test for the Charity was in July 2021. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: The network segregation penetration test was conducted, awaiting results.	**Remedial Actions:** None
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 0 P3 0	P1 0 P2 0 P3 4	P1 0 P2 0 P3 1		**Causal Analysis**: There was one phishing incident in February. This was investigated and blocked with no staff interaction. IT Security continue to proactively monitor for phishing threats.	**Remedial Actions:** 1:1 conversations with staff who click on links have been implemented to provide more targeted awareness as well. A Phishing simulation exercise is due in April to test selected staff's resolve and knowledge.
Blocked Network Attacks These are blocked network attacks directed at our external network edge	91467	55929	37950		**Causal Analysis**: We are constantly being port scanned and probed by external threat actors. High risk IPs are automatically dropped and blocked at the firewall. This trend is seen globally and follows NCSC and NSA trend analysis due to present conflicts.	**Remedial Actions:** A new network threat detection tool is fully operational and is monitored 24/7 by a third party Security Operations Centre. (SOC)
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	0	0	0		**Causal Analysis**: None to report.	**Remedial Actions:** Nothing to report.
% of Fully Patched Systems % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 82% Client = 84%	Servers = 89.43% Client = 94.4%	Servers = 88.2% Client = 91.6%		**Causal Analysis**: An Overall percentage - an average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). A small amount of servers did not auto patch to 100%.	**Remedial Actions:** The team are working through the non-patched to ensure they are fixed and up to date.
Anti-Malware Installation Compliance % of machines on the network that have anti-malware protection installed and enabled	98%	96%	97 %		**Causal Analysis**: Older versions will be updated as computers come back online, the update process is fully automated.	**Remedial Actions:** IT Security will continue to monitor and chase Advanced for any stragglers.
Network Security Events Critical/High cases detected by 'SenseOn' which monitors for unusual or suspect network/user activity.	**New Tool Embedding**	22	8		**Causal Analysis**: There have been 8 high cases in January, all of these are false positives. SenseOn will learn what is 'normal' as the tool monitors our network, these cases will decrease as the tool matures.	**Remedial Actions:** All events are monitored by a 24/7 SOC. IT Security are working with Advanced to ensure all devices on the network are monitored by SenseOn.
Security Awareness % of applicable staff who have completed their e-learning module on cyber security & information governance	88%	90%	91%		**Causal Analysis:** L&D are seeing challenges in staff booking and being released to attend training with the current staffing challenges. Not at the required level of 90% for the Data Security & Protection Toolkit.	**Remedial Actions:** All staff who are out of date with any of these areas prioritise completion of this e-learning. Managers to check via SAP to ascertain who in their times has outstanding e-learning and enable them to complete.

Paper for Board of Directors	
Topic	Board Code of Conduct
Date of Meeting	Friday, 31 March 2023
Agenda Item	**11**
Author	Melanie Duncan, Board Secretary
Responsible Executive	Duncan Long, Company Secretary
Discussed at Previous Board Meeting	Via previous Governance Project updates to Board
Patient and Carer Involvement	There has been no patient or carer involvement in the production of this Code of Conduct
Staff Involvement	There has been no staff involvement in the production of this Code of Conduct
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	This Code of Conduct has been discussed and reviewed by the Governance Oversight Group.

Report Summary and Key Points to Note

The Board is asked to approve for adoption this Board Code of Conduct. This document will require acceptance and sign off by Directors on an annual basis, with a review process of a minimum of 2 years in place. The Charity Code of Conduct is included at Appendix B in order to provide context and should be read in conjunction with the Board Code of Conduct. The Governance Oversight Group has reviewed the document and recommends it for approval and adoption by the Board.

Appendices - A – Board Code of Conduct v1.7

B – Charity Code of Conduct (for information only)

Board Code of Conduct

St Andrew's Healthcare

Introduction

St Andrew's Healthcare ("The Charity") Board of Trustees ("The Board"), Officers, Committees, and Employees observe high standards of business and personal ethics in the conduct of their duties and responsibilities. The Board, is expected to act in accordance with the principles outlined in this document, as well as the principles outlined in the Charity Commission Trustee Code of Conduct and Charity Code of Conduct.

The St Andrew's Healthcare Board Code of Conduct is a set of rules, principles, values and standards which guide how the Board conducts its business so that it achieves its objectives and respects the rights of all stakeholders in the Charity.

No code can anticipate every situation that may arise. Accordingly, this Code is intended to serve as a source of guiding principles and should be read in conjunction with the Charity Code of Conduct. All Board members are expected to comply with the spirit of this Code of Conduct.

Key Principles

Every Board Member must adhere to a high standard of ethical conduct and to act in accordance with the Charity's Values and Purpose. The reputation of the Charity depends upon the way Board Members conduct business and the way the public perceives that conduct. This Code describes the behaviours which the Charity believes are important and is a guide for both new and existing Board Members which aims to encourage positive behaviours.

All Board Members shall read this Code at least once a year, and confirm through the annual declaration process that they continue to conform to the principles and spirit of the Code. Each Board Member will ensure they are familiar with the contents and meaning of:

- The Charity's Values
- The Charity's Purpose
- The Charity's Articles of Association
- This Code of Conduct

This Code will be reviewed periodically and any proposed changes will be referred to the Board for approval when deemed appropriate. More information on the above can be found on the Charity's Hub here.

Charity Values

The Charity's CARE values outline how everyone who works for, or volunteers for the Charity must behave to help the Charity achieve its strategic goals. The CARE Values act as a framework for how Trustees work together:

- **COMPASSION** – Be supportive, understanding and care for the Charity's people
- **ACCOUNTABILITY** – Take ownership, be responsible and do what you say you will do
- **RESPECT** – Act with integrity, be open and honest
- **EXCELLENCE** – Innovate, deliver and do everything you do well

The Charity's Purpose

The Charity's purpose is Hope:

- For Patients, Service Users and their families – we help people to determine their future and overcome the barriers to achieving it; we believe in people and their potential; we will help them to find hope
- For Colleagues – we nurture a hopeful workforce which meets every challenge with curiosity and fresh ideas
- For our Charity – we define how we will be a thriving Charity; hopeful and relevant for today and the future
- For Society – we are clear about the role we will play in creating the society we wish to live in

Commitment

Board members should be fully committed to contributing to the continual improvement of governance processes and to developing an atmosphere which enables ideas to be shared with mutual respect. As a Board Member, conduct should be above reproach. This includes being mindful of how conduct may be perceived. There is a responsibility as an individual and as a member of the Board to lead by example and contribute positively to setting the culture, vision and values for the Charity. Board Members should always act in the best interests of the Charity providing that it is not contrary to legislation.

Board Members will undertake open and honest communication, listen to the voices of colleagues and stakeholders, and contribute to a culture of accountability in order to both give and receive constructive challenge and support. Openness, equality, diversity and inclusivity will be championed, with Board Members being role models for the behaviours which are consistent with that commitment.

The Role of the Board Member

Board Members should be aware of the needs for quoracy and continuity of understanding and decision-making. As such, they should make every effort to attend all of the meetings of the Board and Committees that they are members of. If a health issue or other unforeseen issue prevents attendance, apologies should be offered to the person chairing the meeting (or the Company Secretary) as early as possible.

It is expected that Board Members:

- Are fully prepared for meetings, including reading papers prior to the meetings, thinking through issues and querying information.
- Are appropriately briefed and report back accordingly when representing the Board in meetings with stakeholders either internally or externally.
- Actively engage in discussion, debate and decision making.
- Provide constructive challenge and contribution to the development of strategy.
- Are clear and succinct in expression with a clear focus on strategic issues, including listening to those with lived experience.
- Are open to, and sharing new ideas and ways of working
- Respectfully challenge and critique proposals where appropriate, ensuring the right decision is made for stakeholders.
- Provide a positive contribution to the effectiveness of the Board by making objective observations, where appropriate, based on independence from the day to day running of the Charity's affairs.
- Exercise independent judgement

- To consider Board decisions when attending external meetings.
- Only act within their powers as Trustees or Executive Directors
- Be mindful that any public statements made, including on social media, may be seen as being made on behalf of the Charity. Public content must be considered carefully and any comments directly relating to the Charity must be agreed with the Chair and/or Chief Executive first.
- Be aware and mindful of comments and views aired within public fora, including the public element of Charity Board meetings, ensuring confidentiality where appropriate and expected.
- Seek out learning opportunities and understanding that an effective Trustee must keep up-to-date on how the Charity works and the environment in which it operates.
- Are an ambassador for the Charity in order to promote and reflect its Purpose, Vision and Values.
- Will be supportive and encouraging to all colleagues.

Conflicts of Interest

Board Members should avoid personal interests from conflicting with (or appearing to conflict with) making decisions which are in the best interests of the Charity. Conflicts should be registered, declared and resolved, including on appointment, when new ones arise and via the completion of the annual self-declaration and recording of other interests.. The Board Member, nor anyone connected with them, will gain materially or financially from the Charity unless specifically authorised to do so. All declarations are to be made to the Company Secretary, who will also provide advice where needed.

Summary & Declaration

I, as a member of the Board of Directors will support and encourage all of my colleagues. I will respect the different roles of Trustee and Executive. My intention is to build trust and my actions will demonstrate this. I will communicate in a positive and professional manner, and will focus on solutions rather than problems. I will respect organisational, Board and individual confidentiality, while never using confidentiality as an excuse not to disclose matters that should be transparent and open.

As a member of the Board of Trustees of St Andrew's Healthcare, I will abide by this Code of Conduct.

Date:_____.

Signed: _____

Name: _____

Position: Member of the St Andrew's Healthcare Board of Directors (Trustees)

Version History

VERSION	AUTHOR	DESCRIPTION
v1.0	Melanie Duncan	First Draft
v1.1	Rachel Brown	Draft – Legal Review
v1.2	Melanie Duncan	Second Draft
v1.3	Melanie Duncan	Governance Oversight Group Review
v1.4 – v1.6	Melanie Duncan	Drafts & Project Review
V1.6a	Melanie Duncan	GOG Review and Approval
V1.7	Melanie Duncan	Board review and Approval

TITLE	Board Code of Conduct
APPROVED BY	St Andrew's Healthcare Board of Directors
APPROVAL DATE	31 March 2023
EFFECTIVE DATE	01 April 2023
REVIEW DATE	01 April 2025
STATUS	Current

St Andrew's HEALTHCARE

Code of Conduct

Transforming lives together

Contents

Why do we need a Code of Conduct?

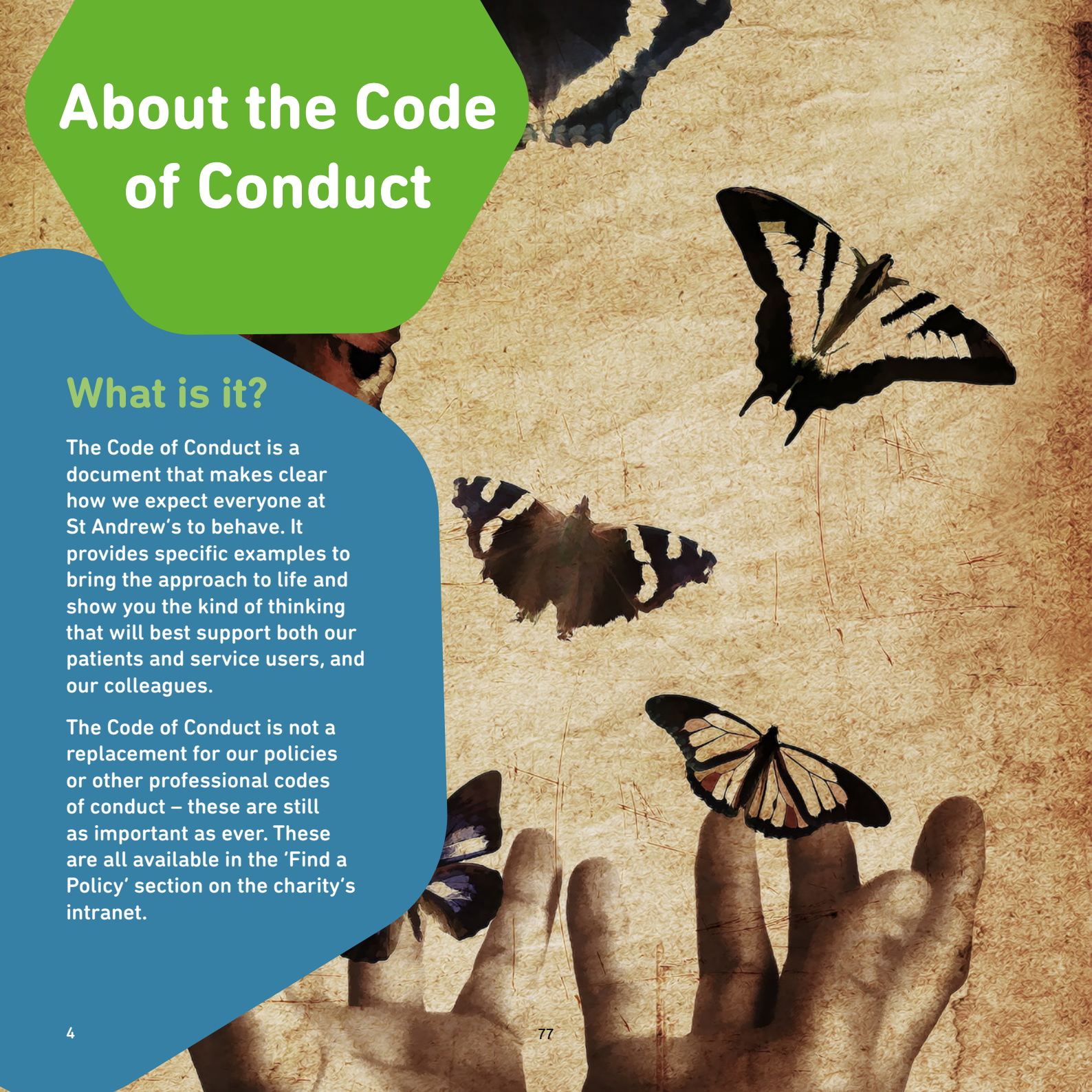
A Code of Conduct is important within any organisation because it sets out how we expect staff and volunteers to behave. This document is not a compilation of policies but a summary of the key points that are contained within your contract of employment, policies and procedures, and some legal and regulatory rules that we need to follow.

St Andrew's vision is to be a charity that promotes wellbeing, gives hope and enables recovery. We will focus on recovery and quality outcomes for everyone we support; co-produce innovation, new therapies and treatments; become a champion for those we help and provide a rewarding, safe place to work.

Following the St Andrew's Code of Conduct means:

- Living our CARE values every day.
- Acting as role models for our patients, service users and colleagues.
- Speaking up when we know or feel something to be wrong.
- Showing through our actions that we are leaders in our field.

About the Code of Conduct



What is it?

The Code of Conduct is a document that makes clear how we expect everyone at St Andrew's to behave. It provides specific examples to bring the approach to life and show you the kind of thinking that will best support both our patients and service users, and our colleagues.

The Code of Conduct is not a replacement for our policies or other professional codes of conduct – these are still as important as ever. These are all available in the 'Find a Policy' section on the charity's intranet.

Who the code applies to and what it means in practice

The Code of Conduct applies to all staff and volunteers for the charity, at every level.

Here's how the charity is committed to behaving:

1. **Supporting vulnerable people**

   We act as a voice for our patients and service users. We ensure that we protect their rights, their privacy and provide appropriate care and treatment with the least restrictions possible.

2. **Compliance with the law**

   We always abide by the legal requirements that apply to us, whether it's employment law, criminal law, administrative, data protection or any other form of law or regulation. Where a breach is proven to have occurred, we ensure the appropriate sanction is applied fairly.

3. **Protecting the health and safety of patients, service users, staff and all visitors**

   We are committed to providing a safe and healthy environment for all our patients, service users, staff and visitors, with everyone playing a part in achieving this.

4. **Financial integrity**

   As a charity, we are conscious that all funds we receive are to be used to improve the lives of those with mental illness. We therefore reinvest any surplus for the benefit of our patients and service users.

5. **Political involvement**

   We speak up when we feel Government policy could affect our patients, service users or staff. We do not fund any political parties or political events.

6. **Open and honest communication with all our stakeholders**

   We are straightforward and honest in all our communications with people, whether they are internal stakeholders or external to St Andrew's.

7. **Being a responsible employer**

   We take care of our employees and provide a healthy and positive work environment.

   We do not tolerate negative work behaviours such as discrimination, harassment or bullying.

8. **Respect for our communities**

   We listen to our stakeholders and respond to all concerns. We make information available to those who seek it and build trust through integrity.

9. **Using our resources wisely**

   This means all of our resources including:

   - Environmental: Minimising waste and our use of energy/water, and continually seeking to improve our environmental performance.
   - Financial: Ensuring that any surplus is invested back into the charity to enhance or improve facilities, environments, services and equipment essential to the work we do.
   - Workforce: Ensuring that we have the right staff in the right place at the right time.

Why is the Code of Conduct important?

It's essential to create a supportive environment in which everyone feels able to raise concerns without fear of reprisals.

The Code of Conduct supplements the charity's policies which govern what we do, and reflects the behaviours we expect all staff and volunteers to demonstrate.

How do I comply with the Code?

- Behave honestly, fairly and responsibly.
- Comply with the policies set out by the charity at all times.
- Speak up if you think anything at work doesn't support our Code.

What are Managers expected to do?

Managers are expected to lead by example by ensuring that the Code of Conduct is understood and adhered to by everyone in their teams. They should provide advice and guidance on interpreting the Code in everyday situations.

Our Strategy, Values and the Code of Conduct

Our purpose and our strategy sets out what we stand for as an organisation and what we want to achieve. The values are how we should behave as we go about achieving our goals.

The Code of Conduct summarises some of our policies and sets out simple rules to follow, to make sure that we're acting honestly, fairly and responsibly in everything that we do.

Our Strategy:
Sets out what we want to achieve

Our Values:
How we behave in delivering our strategy

COMPASSION – ACCOUNTABILITY – RESPECT – EXCELLENCE

Code of Conduct:
How we ensure we live our values and are responsible in how we deliver our strategy.

Our purpose:
Promote wellbeing, give hope and enable recovery

OUR PROMISE...

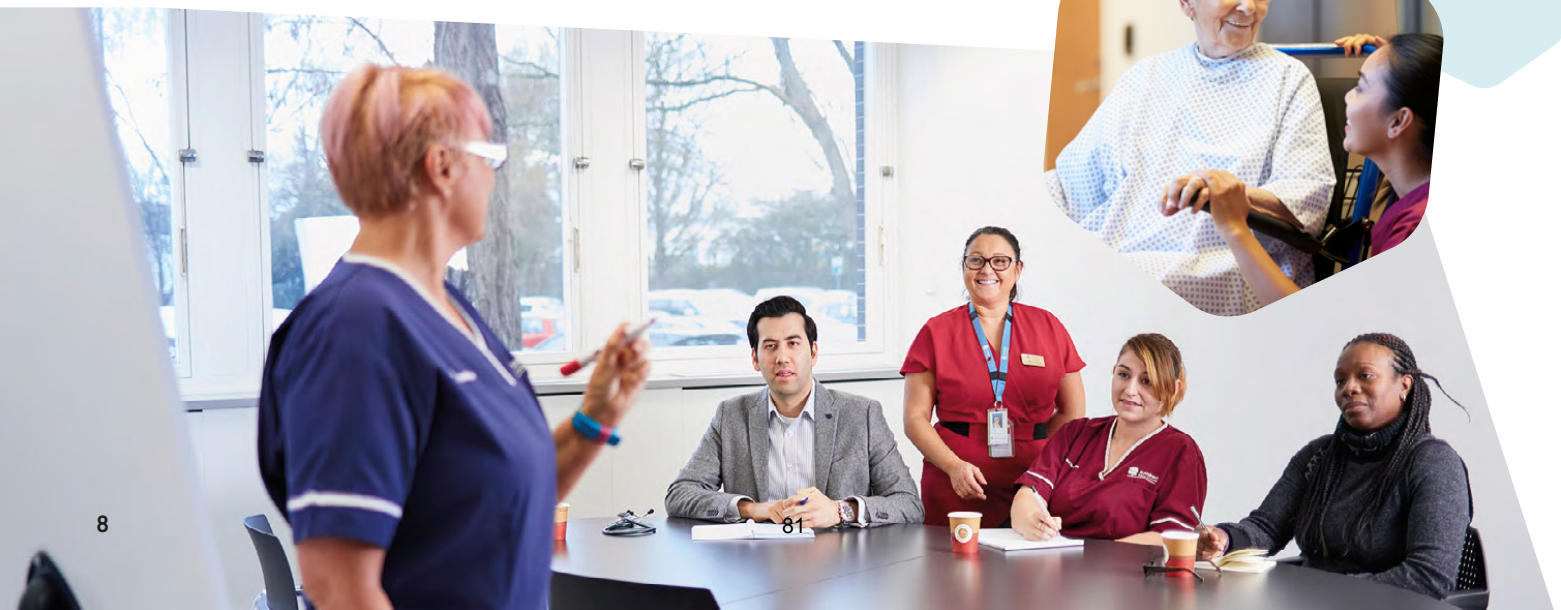
St Andrew's promises all staff that:

- You will be treated with respect and fairness
- You will have a voice
- We will invest in your development and strive to promote from within
- You will always know how you are performing, through thoughtful and comprehensive feedback
- We will do everything we can to ensure you are safe and supported
- We will make time to have fun and celebrate success
- Your contributions and accomplishments will be appreciated and recognised
- We will strive to ensure that you have the tools and resources you need to be successful

YOUR PROMISE

In return, staff promise to:

- Put patients at the heart of everything you do
- Treat everyone with compassion and respect, and value their contributions
- Continually learn and grow
- Embrace innovation and change
- Share your ideas and opinions and listen to others
- Speak up
- Do everything to the best of your abilities
- Do what you say you are going to do
- Always live, embrace and promote our values



DRESS CODE

Please consider the following guidance in choosing clothing to wear at work, personal protective equipment (PPE) and bare below the elbows (BBE) especially if you work in or pass through patient areas in your day to day role.

When entering clinical areas there is a requirement for all individuals to be bare below the elbows as detailed in the Hand Hygiene Policy. Sleeves must be short as cuffs at the wrist become heavily contaminated and are likely to come into contact with patients. Hand Hygiene must be performed before and after contact with patients regardless of whether contact with uniform fabric has occurred. Those individuals who have specific religious requirements are permitted to use disposable sleeves, or wear items of clothing under their uniform as long as the sleeves on clothing only reach the mid-forearm.

Protective gloves and plastic aprons must be worn when undertaking any contact with a patient with a suspected or confirmed infection, or where there is a risk of uniforms becoming contaminated with blood and body fluids. All hospital staff, both clinical and non-clinical, must continue to wear a fluid resistant surgical mask.

The following items of clothing are unacceptable, either on the grounds of health and safety, managing risk in patient areas or for the Charity's public image:

- Skin tight or revealing clothing
- Crop tops
- Frayed or torn clothing
- Tee-shirts with offensive messages
- Excessively high heeled shoes, if entering clinical areas staff must wear shoes with a fully enclosed upper and heel with non-slip soles
- Scarves should be removed in patient areas

For further information please refer to the Charity's Dress Code Procedure.

The Charity provides uniforms to staff who are ward based, or who provide services on a ward or in one of our community services. This is to strengthen our infection control practices by making it easy for everyone who works with our patients to be bare below the elbow.

COMMUNICATION

We have an important role in influencing others for the benefit of our patients and service users, and to address misconceptions about mental healthcare. Our communications team co-ordinates our interactions with the media, in line with an agreed strategy and plan.

Our clinical experts, charity Executive Committee and other nominated individuals act as spokespeople for St Andrew's.

Unless staff are called upon by any of the teams above, they are not expected to act as external spokespeople for the charity.

Here's what's expected of you:

- Press and media. If a journalist makes contact with you in connection with St Andrew's, ALWAYS pass them to the communications team (**communications@standrew.co.uk)**. Do not make any comment which may be attributed to St Andrew's.
- Social Media. Always be meaningful, appropriate and respectful when using social media and do not make offensive, derogatory, discriminatory or inappropriate comments, or act in any way that would be considered unacceptable in the workplace.

- You must respect the confidentiality of patients and colleagues when using social media, in both comments and images. Any breach of this could lead to disciplinary action being taken against you.
- Information on the St Andrew's Healthcare intranet site is intended for staff only, and should not be published on social media. Internal messages, including those from the CEO and CEC are not meant for people outside of the charity. Again, any breach of this could lead to the Charity taking disciplinary action against you.

How should our people behave?

Every single person who works for or volunteers for St Andrew's plays a vital role in protecting our patients and service users, staff members and our reputation.

The choices we make on a daily basis can have a considerable and lasting effect on the people around us, the work environment and the charity as a whole.

The following sections cover the main areas of focus and how we should behave within each one. Examples of typical situations and the behaviours we should display are given in each section. If you have any questions on anything set out here, please speak to your line manager in the first instance.

1. Put people – especially patients – first

Our strategy centres on caring for each patient or service user as an individual. But we must also show kindness and care to everyone we meet in the workplace, including patients' families and carers, colleagues and members of the public.

At St Andrew's we expect our people to:

- Treat people with dignity and respect.
- Act as an advocate for those in your care – help them access information and support.
- Respect people's confidentiality both in a formal work situation and informally, outside of work.

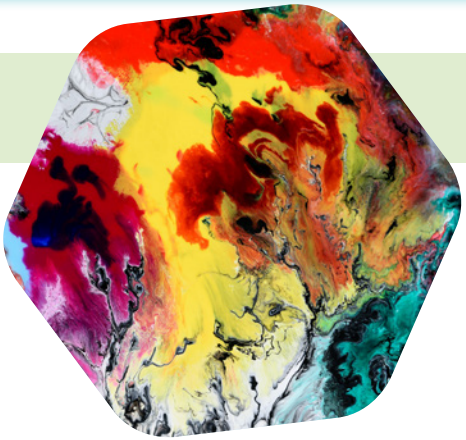
- Understand and respect people's cultural and spiritual needs and beliefs.
- Maintain your professional boundaries with patients, service users and colleagues.
- Challenge unethical behaviour.
- Be accountable for your actions.
- Work collaboratively to inspire others to be the best that they can be.
- Work within the CARE values and strategy placing patients and service users at the centre of all that we do.
- Accept feedback (both positive or constructive) to change practice where needed to improve quality of care for staff, patients and service users.

Q&A

Q: I've overheard colleagues speaking to a patient in a demeaning manner. I know this isn't right but what should I do about it?

A: Speak up. Everyone deserves to be treated with dignity and respect – especially those who are in our care. Challenge your colleague about the way they interact with patients and service users. If this behaviour continues, it should be reported to your line manager. For more information about what language should be used when communicating with patients, please refer to the 'Language Procedure' on the intranet.

2. Security



As a healthcare organisation we are trusted to protect vulnerable people in many important ways. We must physically protect patients, service users, staff and visitors from harm, but we must also protect people's data and St Andrew's property and equipment, too.

Below are some of the most important considerations for us all:

- NEVER take banned items through the airlock into our units. If you're unsure about an item, ask reception staff.
- Your ID pass is a very important security tool. Keep it with you at all times when working at St Andrew's. If it's lost or stolen, report it immediately to the security team.
- Never let people tailgate you into the building. If they don't have a pass, send them to reception.
- If you invite visitors to our site, you are responsible for them throughout – make sure they're accompanied.
- Familiarise yourself with the charity's Acceptable Use Policy which sets out the expected IT behaviours from staff and those working on behalf of the charity.
- Be secure at your desk: lock your screen if you leave your computer unattended, never leave confidential information out in the open, and dispose of old paperwork securely.

- Protect your IT password – never disclose it to anyone, including your colleagues and the IT Service Desk. Always set strong passwords and do not reuse passwords across different logins.
- If you suspect your account may be compromised or you identify an information security breach, report it immediately to the IT Service Desk.
- Be smart to online security. Don't click on suspect emails or links and always question the integrity of enquiries from people you don't know.

There are policies and procedures which apply to everyone. These are available on the 'policies' page on the intranet; please take the time to familiarise yourself with them.

Q&A

Q: My colleague is picking up some work for me while I'm on holiday. It's a lot of hassle to get her the permissions she needs for some of the drives/sites I use, so can I just give her my login details and password?

A: No – never share your login details or password with anyone. This is a breach of our security policy and any wrongdoing will be in your name. Talk to the IT Service Desk to make the arrangements you need.

3. Data protection and confidentiality

There is a delicate balance to strike between the need to share information and the requirements of privacy and data protection. St Andrew's has a duty of confidentiality to our patients, service users and staff. Information relating to a patient's identity, treatments and other aspects of their care at St Andrew's is confidential information.

While there are a number of regulatory and legal frameworks which all staff must comply with, how we behave can also impact our duty of confidentiality.

For example:

1. Patient/service user information should never be discussed in public places or with anyone who is not directly required to have knowledge of that patient or service user.
2. When escorting patients, staff should adhere to the 'escorting patients procedure' available on our intranet. This means not wearing anything which may identify you as St Andrew's staff, such as lanyards, pit alarms, belts and pouches. Please refer to the Charity's Dress Code Procedure when wearing a staff uniform or other charity equipment.
3. All charity information relating to patients, service users and/or staff, including paper records should be handled and stored securely and only used in line with current policies, procedures and guidance. Patient or staff information or images must never be shared on social media.

All staff who have access to patient, service user or employee information should ensure that they are familiar with these policies, procedures and guidance.

Information Governance (IG) is the practice used by all organisations to ensure that information is efficiently managed and that appropriate policies, system processes and effective management accountability provide a robust governance framework for safeguarding information. There are a number of policies and legal regulations which govern how information is used, stored and shared. All employees should ensure that they adhere to these important guidelines.

Patients, service users and staff have a number of rights in relation to how the charity handles their personal information. If you receive any requests in relation to how someone's personal data is handled, or they want to receive a copy of their information, contact our IG department for guidance. The team can be contacted via:
InformationGovernanceTeam@standrew.co.uk

Q&A

Q: I've received an email from someone asking about a patient and for information about their care and treatment. Is it okay to supply them with this information?

A: Patients and service users have a number of rights under Data Protection law and the Mental Health Act. You should never give out patient information unless it is clinically necessary and adheres to the guidance set out within the Caldicott principles. Even when you do share information you must make sure it has adequate protection in place.

Q&A

Q: I am looking after a patient who has been risk assessed as being able to use their mobile phone and internet on the ward. I am concerned that they are doing something that they shouldn't be doing.

A: Remember that our patients have a right to privacy, just like anyone else. If you are concerned about a patient's use of their mobile phone or the internet you should raise it with their multi disclipinary team. Any searches of phones must comply with our search policy and procedures - never access a patient's phone and go through their emails, text messages and photos without following procedure.

4. Conflicts of interest

A conflict of interest is where something in your life outside of St Andrew's could have a negative impact on your role within the charity. Simply put, you should not engage in activities which conflict with the interests of the charity or our patients.

A conflict of interest can take many forms, including but not limited to:

- **Recruitment (of a friend/relative).** We actively encourage people to recommend their friends and family to join us as long as we are made aware of their relationship to an existing employee. This is so that we can avoid creating conflicts of interest – for example, it may not be appropriate for someone to line manage their family member or close friend.
- **Other work.** Staff should not engage in non-St Andrew's employment or activity that would conflict with the charity's interest or impact the performance of their duties. For more information, see the 'Working Outside of St Andrew's' Procedure.
- **Personal links with suppliers/ competitors/ commissioners/ patients/ service users, their families or carers.** There are some roles within the charity where a personal relationship with an external business partner or supplier could create a conflict of interest. For example, it wouldn't be appropriate to award a contract to someone you have a relationship with.
- **Relationships at work**. If a relationship starts in the workplace it only needs to be reported if the people concerned work in the same team, and particularly if one person manages the other. It might be necessary to find one person an alternative role within the charity if this is the case. For more details, see the St Andrew's recruitment procedure.
- **Charity or political involvement.** If you are actively working with an organisation that has beliefs or policies that could potentially adversely affect St Andrew's operations, you need to make your line manager aware. For example, if you volunteer for a charity that campaigns for all Learning Disability patients to be cared for in the community.

Q&A

Q: I'm looking for a supplier to provide some equipment the charity requires. My husband is a manager at a local company which supplies this equipment – can I place the order with his company for this equipment?

A: If you follow the procurement process and can justify giving the business to your husband's company, that's fine. However, if you don't follow the procedure it may be seen as a conflict of interest because your husband could benefit from the business, either directly or indirectly.

5. Acting with integrity

Integrity is defined as 'the quality of being honest and having strong moral principles'. As we're a charity, it's even more essential that our staff work with integrity every day. Having integrity is important as an individual, but we should also make sure that we keep a watch on others' behaviour, too. Acting with integrity means:

- **Challenging unethical behaviour.** If we see people behaving in a dishonest way, or doing something against the Code of Conduct, it's our duty to challenge it. Depending on the situation you might choose to directly address the person, or report them to a manager. Contact a Speak Up Guardian or contact SafeCall for support (see Speaking Up page 23).
- **Gifts and hospitality.** You may on occasion be given a gift or invited to an event by a supplier, partner or patient's family. You should think before accepting whether the gift would change how you work with the giver, and discuss it with your manager. Either way, you should record details of the gift and whether you accepted it in the Gift and Hospitality Register. Logging gifts in this way helps us to be fair and transparent.
- **Travel and expenses.** It's right and fair that any personal spending as a direct result of work should be reimbursed by St Andrew's. But it's also fair that staff are careful with their spending and don't create excessive costs. Compare prices for travel and other items before buying in line with the appropriate policy.

Q&A

Q: You are out in town with a patient and they want to buy you a drink while in the local café. You thank them but say that you are ok. They insist, as they get on well with you and would like to treat you to a drink, they also explain they don't like drinking on their own. What do you do?

A: It is advised that you don't accept patients or service users buying you anything as this can lead to complications. However, it is really important to value the importance of social activities with patients and sharing a drink in a local café is a normalising intervention. If escorting a patient out, always try to take a small amount of ward funds with you so that you can buy yourself a drink. Patients and service users usually respond well if you thank them and tell them you have some ward funds to buy your own.

There are policies and procedures which apply to everyone. These are available on the 'Policies' page on the intranet; please take the time to familiarise yourself with them.

6. Following the law

It goes without saying that St Andrew's as an organisation is committed to abiding by the law in all situations – and we expect the same of our staff.

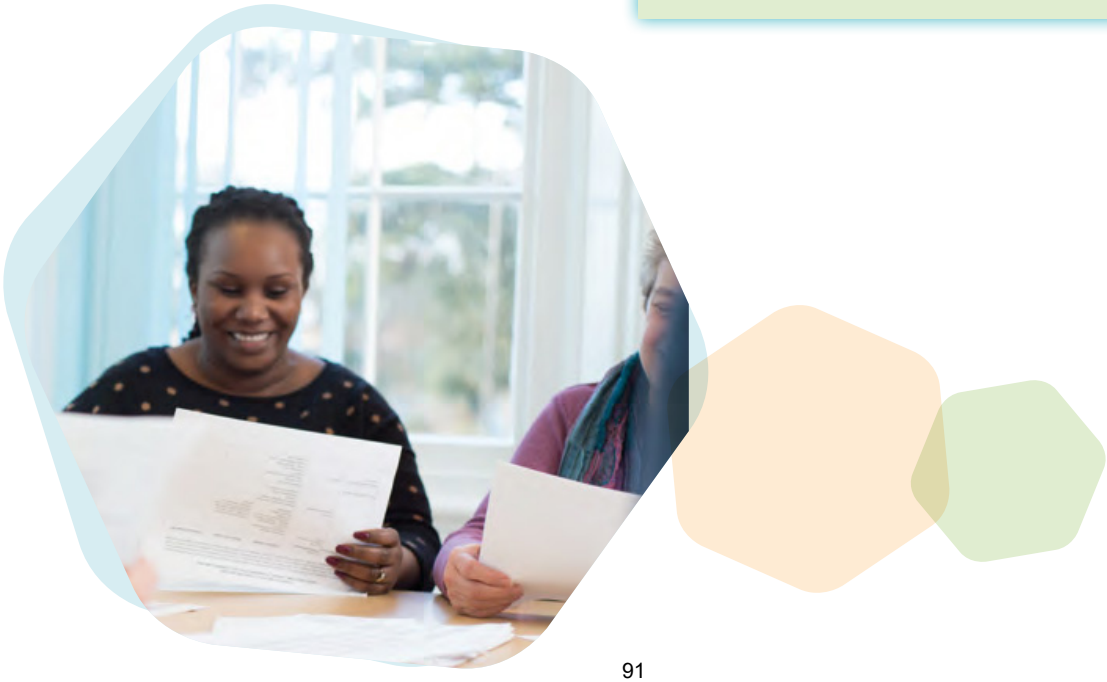
We are equally intolerant of law-breaking by patients or service users, and will seek police involvement wherever appropriate, including for offences involving violence, property damage and those that are drug or alcohol-related. As always, we rely on our staff to report any criminal activity within St Andrew's.

If you have any suspicions that fraud or bribery is taking place within the charity, they should be reported in accordance with the Counter Fraud Procedure which is available on the intranet.

Q&A

Q: I'm aware that a colleague I work with has a substance abuse problem. I've witnessed them taking illegal substances while at work and on social occasions.

A: While having a problem isn't illegal, the possession and taking of illegal substances is. Furthermore, their behaviour is not in compliance with the Code of Conduct and could put the safety of patients or service users at risk. You should discuss the issue with your line manager or HR Business Partner and seek assistance in notifying the correct authorities.



7. Keeping ourselves and others safe

As members of St Andrew's staff, we all have a duty to act and behave in a safe and responsible manner towards our colleagues, the patients in our care and visitors to our sites.

The charity is committed to achieving the highest standards of health and safety at work, and to ensuring that our services and environments are safe and healthy for our patients, service users, staff, volunteers and others who may be affected by our work activities.

You are expected to:

- Co-operate with any arrangements or procedures put into place by the charity to protect your health and safety, and the health and safety of others.
- Promptly report any incidents, accidents or 'near-misses'.
- Immediately bring to the attention of management any hazardous or high risk situations.
- Set a personal example in representing good health and safety practice and not acting in a way that could endanger yourself or others.
- Promote the charity's policy towards health and safety and support its strategy to continually improve safe working practices and procedures.

Q&A

Q: When I was leaving the ward I noticed there was tea spilt on the floor tiles. I'm sure someone has been told to clean it up. I didn't need to do anything, did I?

A: We all have a responsibility for the health and safety of ourselves and others, therefore if you spot an unsafe situation or an unsafe act you shouldn't assume this is 'someone else's job' to sort it out. Simply asking a question can be enough to prevent an accident later. Don't walk by!

8. Working with others

At St Andrew's we're proud to have a culture of equality, inclusion, acceptance and support. We want to create a welcoming environment for everyone to create a supportive workplace, where everyone feels respected and valued.

Your responsibilities within this cover a few areas:

- **Supporting your colleagues.** We work as a team to support and care for our patients, which means that we listen to, validate and help our colleagues wherever we can. We work in challenging environments and everyone may experience difficult times in their lives. Supporting each other also means that we look out for each other and raise concerns if we think human rights are being violated, or that anyone is being forced to work against their will.
- **Zero tolerance to bullying/discrimination**. Nobody deserves to be singled out for any reason, but especially in connection with their gender, ethnicity, religion, relationship preferences, physical abilities or beliefs. Be kind in how you work with others.

  What some see as 'banter' can be upsetting to others. If you come across any inappropriate talk – call it out, you can often defuse a situation without causing any upset. If you don't feel able to tackle the situation directly, report it to your manager or via the Freedom to Speak Up Guardians.

- **Embracing diversity and inclusion.** St Andrew's is passionate about ensuring everyone feels accepted and can be true to themselves. We have various diversity networks, which allow different groups to come together for support, celebration and to share their views. All staff, patients and service users should be treated with dignity and respect, with difference respected. Further information can be found by visiting the Diversity & Inclusion intranet pages.
- **Speaking up.** Don't stand by while others are behaving inappropriately. Make a stand and say that you don't appreciate offensive or non-inclusive comments or behaviour. See page 23 for guidance on how to speak up.

- **Working with and supporting carers.** It is important that we recognise what carers want and how they can be involved in the care of their friend or relative, in service development, training and improvements. We must include them, listen to and validate their concerns and understand their needs around information and support. In Northampton, direct carers to the Carers Centre for support and resources.
- **Working with external organisations.** When you work with organisations outside of St Andrew's, remember that you're a representative of our charity and our brand. Always act professionally and respectfully, in any situation. If you are made aware of a supplier operating unethically, you should report this to your line manager.

Q&A

Q: I've just encountered a carer who wanted help with something. I don't have anything to do with the patient they want to see or the ward, what should I do?

A: As members of St Andrew's staff we pride ourselves on the support we provide to carers. Encourage the carer to explain, then listen, validate and support. You might not have all the answers straight away but reassure the carer that the concerns can be dealt with by directing or contacting the team who is responsible for their friend or relative care. It may mean that you contact the appropriate team who can come and meet you/them or you walk with them to the appropriate building.

PATIENT PROMISE

This Promise has been developed by patients and staff to explain what every patient at St Andrew's can expect from their care.

'No decision about me, without me!'

- You will get the most suitable, useful, least restrictive, evidence based care.
- Your care plan should be co-produced by you and suitably qualified staff.

We will...

- Be polite, respectful and thoughtful at all times looking after your dignity and privacy.
- Do our best to keep you safe.
- Treat you as an equal, whatever your ethnicity, religious/ cultural beliefs, gender, social class, disability or age.
- Update and involve you in your care.
- Involve your family in your care (while respecting your wishes).
- Include your views in reports about your care, ward rounds and any other meetings.
- Respect you as an individual, your interests, and meet your needs: physical, psychological, social and spiritual.
- Work hard to give you the highest standards of care at all times.

We ask you to...

- Please work with staff and take on board advice about treatments.
- Please treat everyone - including staff and other patients - with respect.
- Please ask questions if you don't understand anything or would like more information.
- Please be open and honest with staff, especially about how you are feeling.

SPEAKING UP

The success of our Code of Conduct rests on people adhering to it – and speaking up when it's not followed.

We encourage everyone to stand up if you see things that you don't think are right. Here's how:

1. Talk to your line manager
2. Talk to HR
3. Contact a Freedom to Speak Up Guardian in person, or via at **freedomtospeakup@standrew.co.uk**
4. Speak to SafeCall, our confidential helpline on 0800 915 1571

We want people to speak up without fear of any consequences. No action will be taken against anyone reporting a concern, even if it's found to be unproven.

More information

You can find all the St Andrew's policies and details of many of the topics in this document on the charity's intranet. Please take the time to familiarise yourself with them.

If you have further queries feel free to contact the relevant team:

HR: HRInformation@standrew.co.uk

Communications: Communications@standrew.co.uk

POhWER Advocacy: STA@pohwer.net

Patient Experience: PatientExperience@standrew.co.uk

St Andrew's
HEALTHCARE

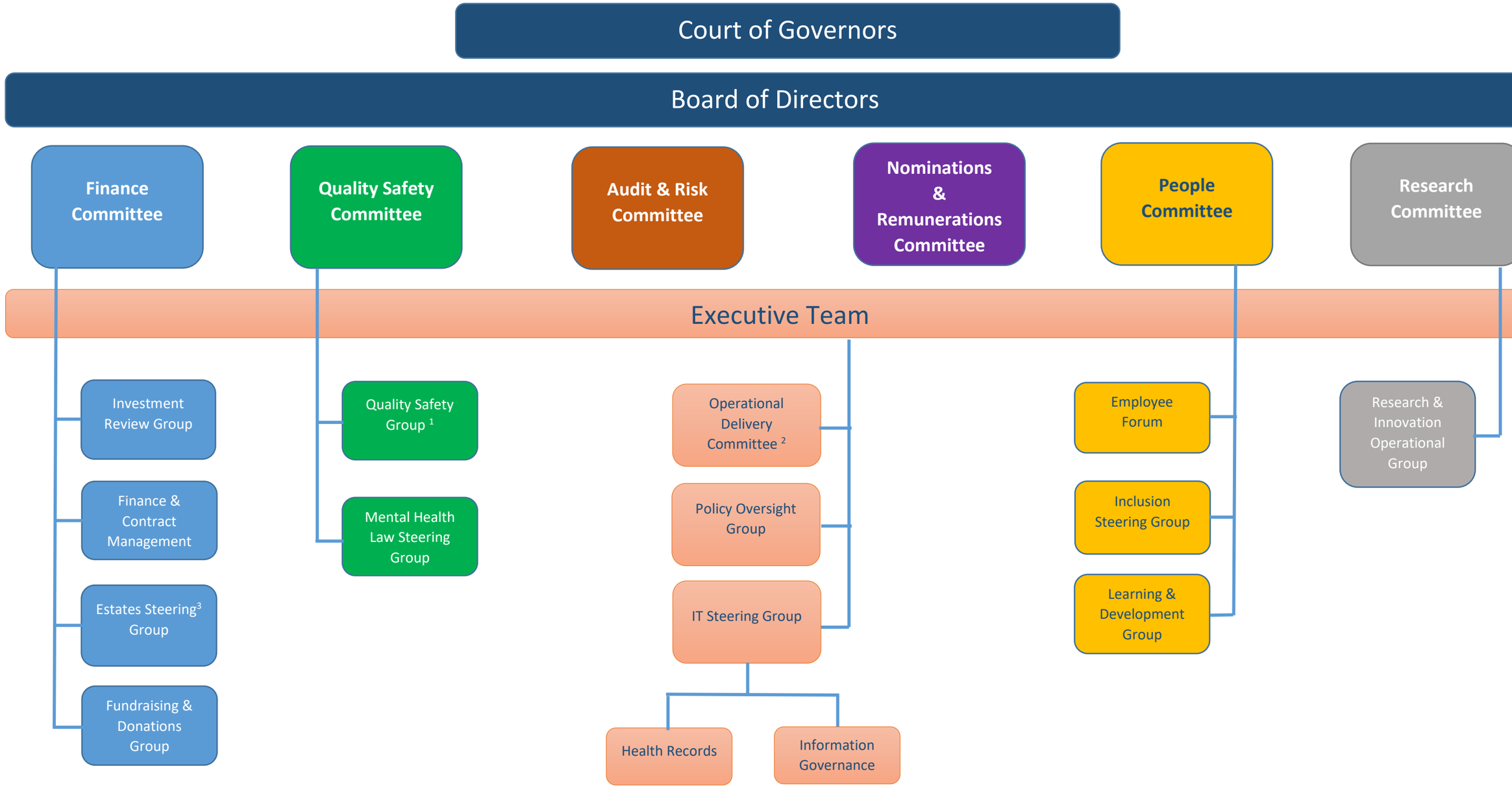
Registered Company Number 05176998
Registered Charity Number 1104951

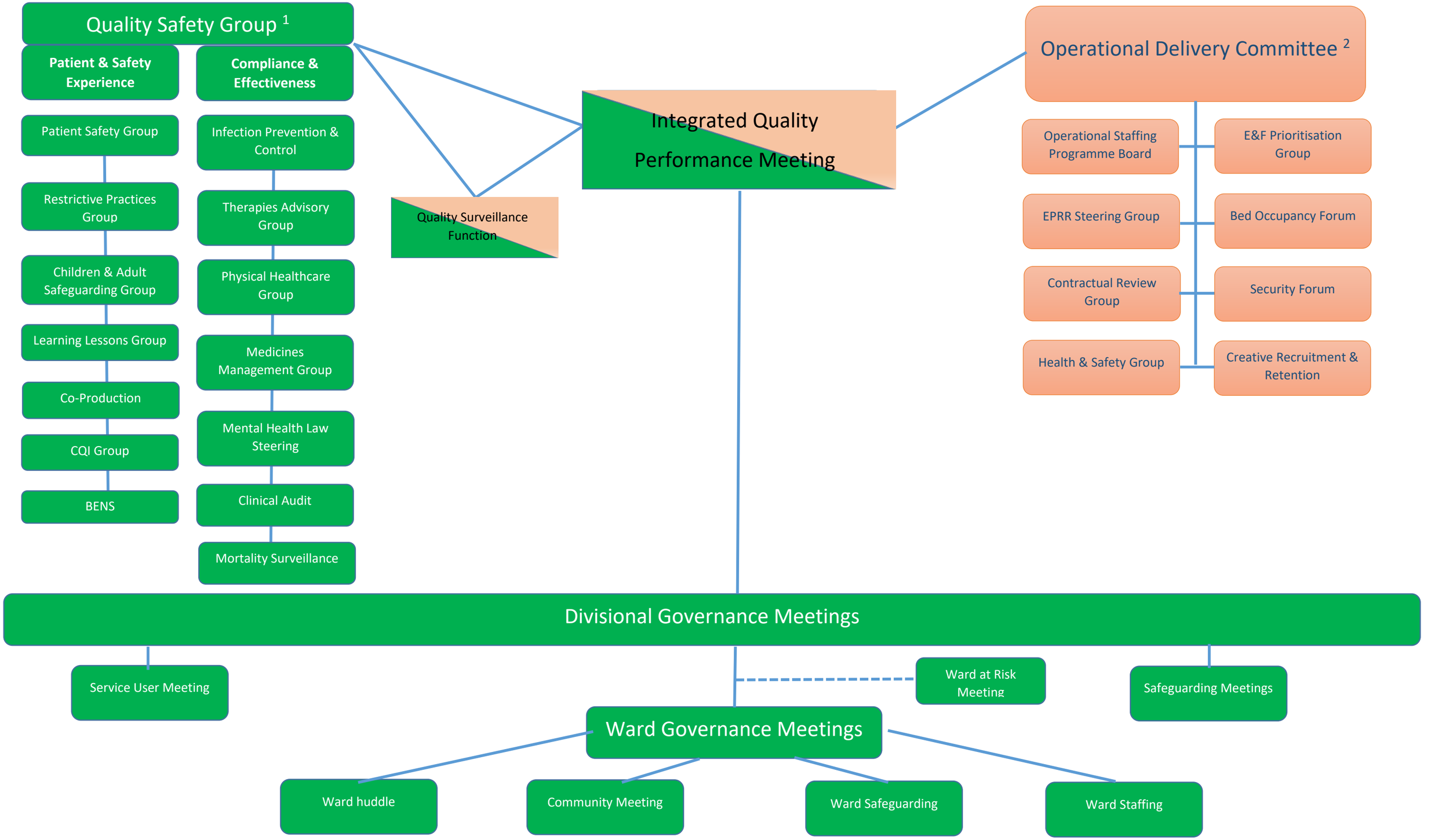
Paper for Board of Directors	
Topic	Revised Charity Governance Structure
Date of Meeting	Friday, 31 March 2023
Agenda Item	**12**
Author	Melanie Duncan, Board Secretary
Responsible Executive	Duncan Long, Company Secretary
Discussed at Previous Board Meeting	Not discussed at previous Board Meetings
Patient and Carer Involvement	There has been no Patient or Carer involvement
Staff Involvement	There has been no staff involvement
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	This structure chart has been discussed and agreed for presentation to the Board by the Governance Oversight Group.

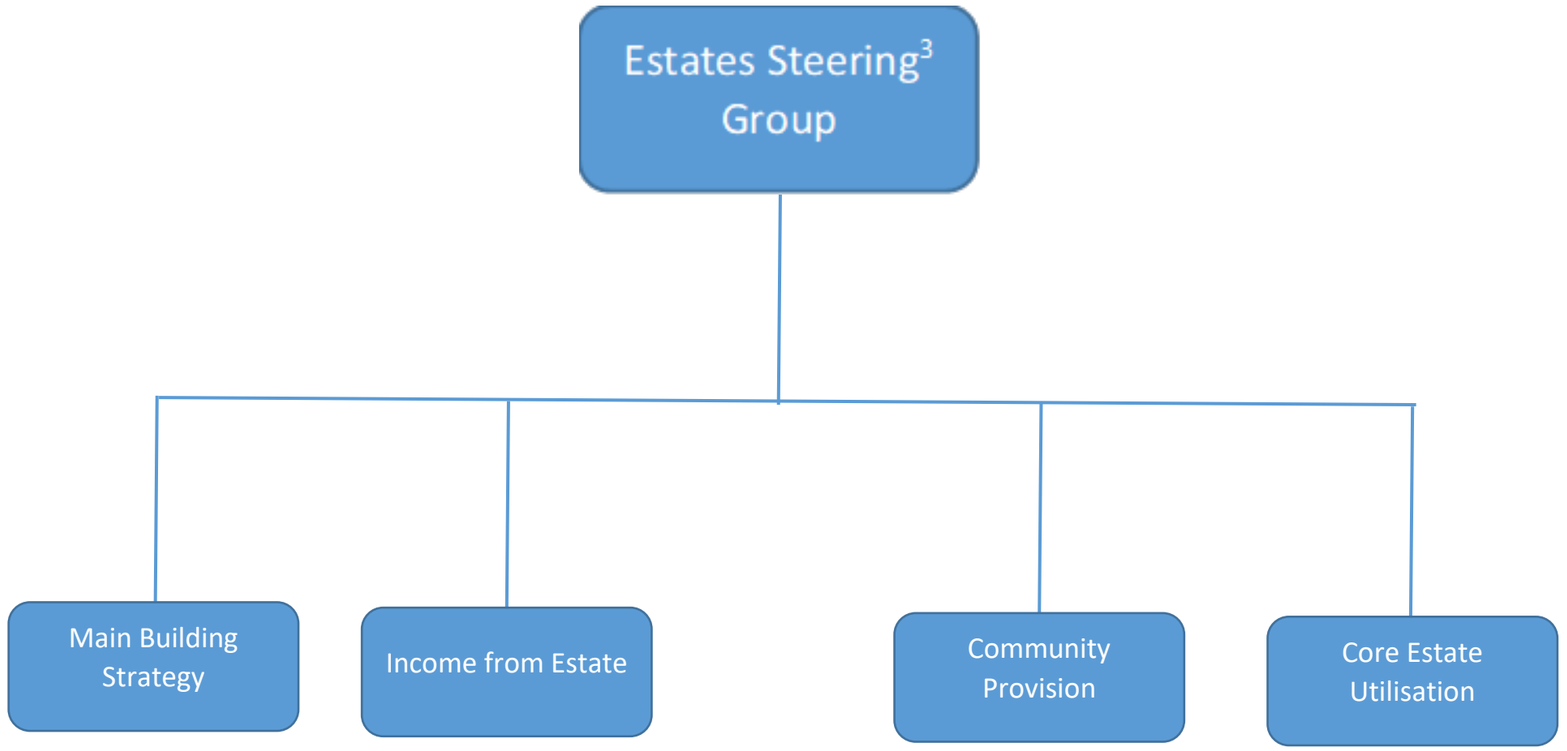
Report Summary and Key Points to Note

The Board is asked to note and approve the attached revised Governance Structure Chart for the Charity.

Notable amendments to the structure are the addition of the newly formed Operational Delivery Committee and the meeting structure which sits below it, the inclusion of the IQPR report which gives assurance to the Board from financial, quality, people and Executive perspectives and the Estates Steering Group structure which now reports into Finance Committee. This chart now shows a clear assurance structure from Ward Governance through Divisional Governance, upwards to Quality Safety Group and onto Quality Safety Committee and the Board.


Court of Governors
Board of Directors
Finance Committee
Quality Safety Committee
Audit & Risk Committee
Nominations & Remunerations Committee
People Committee
Research Committee
Executive Team
Investment Review Group
Finance & Contract Management
Estates Steering[3] Group
Fundraising & Donations Group
Quality Safety Group [1]
Mental Health Law Steering Group
Operational Delivery Committee [2]
Policy Oversight Group
IT Steering Group
Health Records
Information Governance
Employee Forum
Inclusion Steering Group
Learning & Development Group
Research & Innovation Operational Group


Quality Safety Group 1
Patient & Safety Experience
Compliance & Effectiveness
Patient Safety Group
Restrictive Practices Group
Children & Adult Safeguarding Group
Learning Lessons Group
Co-Production
CQI Group
BENS
Infection Prevention & Control
Therapies Advisory Group
Physical Healthcare Group
Medicines Management Group
Mental Health Law Steering
Clinical Audit
Mortality Surveillance
Quality Surveillance Function
Integrated Quality Performance Meeting
Operational Delivery Committee 2
Operational Staffing Programme Board
E&F Prioritisation Group
EPRR Steering Group
Bed Occupancy Forum
Contractual Review Group
Security Forum
Health & Safety Group
Creative Recruitment & Retention
Divisional Governance Meetings
Service User Meeting
Ward at Risk Meeting
Safeguarding Meetings
Ward Governance Meetings
Ward huddle
Community Meeting
Ward Safeguarding
Ward Staffing


Estates Steering[3] Group
Main Building Strategy
Income from Estate
Community Provision
Core Estate Utilisation

Service & Patient Story

Oliver McGowan Training

On

Learning Disability & Autism

(Martin Kersey, Liam Freestone & Jo York)

Questions from the Public

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Meeting Reflections

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

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public -

Thursday 18th May 2023 9.30am

(Paul Burstow - Verbal)

Annexes

A – Governance Oversight Group Update

B – Board Skills Matrix

Governance & Risk Project

Board Update March 2023

Project Headlines

- Project plan updated for final months prior to project completion in July 2023
- Board Code of Conduct – feedback received following review by Oversight Group.
- Board Skills Matrix – feedback received following review by Oversight Group.
- Meetings templates currently under review.
- Draft Governance Map has been produced along with backing document which gives meetings information.
- Governance Framework Document is being populated with agreed items.

Timeline Summary & Milestones

The revised project plan remains on target for July 2023, with the following milestones in the coming weeks:

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

Work in Progress

- New Board Terms of Reference being developed following review of Matters Reserved
- Board Code of Conduct – Comments received. Final version ready for adoption by the Board.
- Skills Matrix – roll-out imminent. (See Annex B)
- Assurance Map – drafted, and now includes the new Quality Governance structure. Alignment with assurance levels is currently in progress.
- Meeting templates – revisions and benchmarking to comparable trusts currently being undertaken in readiness for review prior to adoption.

Risk Summary

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

- Risks have been reassessed with two being re- rated and now classed as Low:
  - April002 – Priorities
  - April003 - Communication
- Other risks remain stable with the same ratings as previously reported

Board of Directors Skills Matrix

The Charity Good Governance Code, Principle 5 states that a Board should work as an effective team, using the appropriate balance of skills, experience, backgrounds and knowledge to make informed decisions.

As a result, the formation of a Board Skills Matrix assists the Charity in ensuring that a wide spectrum of experience and knowledge is in place, as well as highlighting where skill gaps potentially exist. This Matrix will be updated on an annual basis in order to keep an up to date view of experience across the Board.

The output from the responses will help form the on-going development plans for the Board, as well as assisting with future Board membership requirements.

* Required

* This form will record your name, please fill your name.

1

Name *

2

Position *

3

How many years have you served on the Board of Directors?

4

Below are a wide range of skills deemed to be required for the Board of Directors. Not all Directors will be highly proficient in all areas, however, in order to build a 'map' of skills, please indicate your level of knowledge for each of the areas: *

	None	Basic	Some Knowledge	Highly Skilled	Professional
Finance Accounting	◯	◯	◯	◯	◯
Technology IT Cyber	◯	◯	◯	◯	◯
Audit / Risk Management	◯	◯	◯	◯	◯
Corporate Governance	◯	◯	◯	◯	◯
HR Reward Organisation Structure	◯	◯	◯	◯	◯
Pensions / Investments	◯	◯	◯	◯	◯
Ethics & Compliance	◯	◯	◯	◯	◯
Property & Acquisitions	◯	◯	◯	◯	◯
Regulatory - CQC and/or Charities Commission	◯	◯	◯	◯	◯
Environmental	◯	◯	◯	◯	◯
Health & Safety	◯	◯	◯	◯	◯

5

Please indicate any further relevant skills you may consider to be applicable

Leadership / Stakeholder Management	◯	◯	◯	◯	◯
Academic Research / R&D	◯	◯	◯	◯	◯

6

Please indicate below if there are any areas in which you feel further training and/or personal development would be of benefit to you.